Tuning into Psychosis

What can the work of Psychiatrist, Psychoanalyst and Author R. D. Laing contribute to a better understanding of how to listen and tune into psychotic patients?

A dissertation submitted by

Claire Stafford to **Auckland University of Technology**

in partial fulfilment of the requirements for the degree of Master of Psychotherapy.

2019

Supervisor: Joanne Emmens

Faculty of Health and Environmental Sciences

Discipline of Psychotherapy

Table of contents

List of Tables

List of Figures

Abstract

Research suggests that many mental health institutions are disconnected from their patients needs.[1] Patients report that they are not being listened to, taken seriously or having their experiences validated. The way to treat serious mentally ill patients is still a mystery to science and in an underfunded health system, quick fix solutions are the treatment of choice.

A famous psychiatrist and psychoanalyst from the 20th Century, Dr. R. D. Laing was able to listen to his psychotic patients and provide a healing environment. This research asks how this man was able to listen and contain his psychotic patients and what did he draw on that was conducive to healing his patients?

[1] Research from the National Health Service (NHS) Mental Health Taskforce (2015) survey of 20K services users and the UK Schizophrenia Commission (2012) strongly indicates that mental health services are disconnected from their patients needs (Brabban, Byrne, Longden & Morrison, 2017).

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which, to a substantial extent, has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Claire Stafford

20th September 2019.

Acknowledgements

I would like to acknowledge the following people who have supported me in writing this dissertation.

Firstly, to my supervisor Joanne Emmens.

I would like to thank you for your patient and open presence throughout the writing of this dissertation. From the very beginning, you supported my exploration of all the ideas that emerged from this hermeneutic process and gently encouraged me to think more deeply, to wander and to wonder.

Thank you to Natasha Emmens for making little works of art (pages 27, 36, 42 & 49), out of my stick drawn images.

I would like to thank my husband Richard and children Alex and George for being so supportive and encouraging of all my studies over the years. We can share the cooking again Richard...

Lastly, I would like to thank my teachers and peers at AUT who I have learnt so much from and with, over the past three years – with special thanks to Hayden and Debbi who read over the final draft of this dissertation, I appreciated your time and comments.

Chapter One

Introduction

Man's *being* can be seen from different points of view, and one or other aspect can be made the focus of study. In particular, man can be seen as a person or a thing (R. D. Laing, 1990 p .20).

*Figure 1: Rubin's Vase. From Wikipedia, 2020 (*https://en.wikipedia.org/wiki/Rubin_vase)

Each of these figures can be viewed as two faces or a vase. Edgar Rubin's doctoral thesis in 1915, entitled Visually Experienced Figures, explored how the visual experience of *figure and ground* can take us by surprise. Rubin argued, this is specific to our own perceptual processes (Pind, 2012).

The 2018 New Zealand Government Inquiry into Mental Health and Addiction (He Ara Oranga, 2018) reported that **one in five** of us **each year** experience mental illness or significant mental distress and over 50-80% of New Zealanders will experience mental distress or addiction challenges, or both, in their lifetime. The annual cost to taxpayers is an estimated NZ $12 billion or 5% of gross domestic product. Widespread concern from inside and outside the mental health services prompted this inquiry, they heard from those that work in the system, those that use the services and those affected vicariously (family and friends, etc.) concerning the current approach and what needs to change. The last government led inquiry in 1996 (known as the Mason Inquiry) also resulted from a call for change, but little progress was made (He Ara Oranga, 2018). The main theme that emerged from this latest inquiry, from the voices of the people were, "for help through the storms of life, to be seen as a whole person not a diagnosis, and to be encouraged and supported to heal and restore one's sense of self" (He Ara Oranga, 2018, pp. 8-9). As the report states, other countries are facing similar challenges. In 2015, the United Kingdom's National Health Service (NHS) Mental Health Taskforce surveyed 20K service users. Similar key themes emerged, of users not being listened to by clinicians and their concerns not being taken seriously. In 2012, the UK based Schizophrenia Commission heard that patients wanted to be

listened to and have their experiences validated, to be seen as a person and not just a set of symptoms (Brabban, Byne, Longden & Morrison, 2017).

Over half a century ago an outspoken Scottish psychiatrist talked and wrote extensively about the failings of psychiatry and mental health systems, he was eventually outcast from the profession. His approach was thought too controversial, it was said he was possibly mad himself. However, someone who challenges the status quo, the medical orthodoxy, as much as R. D. Laing was always going to make enemies within the establishment – other paradigm shifters have suffered the same fate. And yet, R. D. Laing's statement, written in 1985 seems to resonate with 2019:

> *Psychiatry tries to be as scientific, impersonal and objective as possible towards what is most personal and subjective. The disordered suffering treated by psychiatrists has to do with what are our most personal and private thoughts and desires. No other branch of medicine has to contend with this domain so much. Nothing whatever in Western medical training exists to adapt students and young doctors to integrating this personal aspect into clinical theory and practice. The result is that when doctors are faced with this inner suffering, they are disoriented, insofar as they refer themselves back to their conventional training for orientation (p. 146).*

About the research question.

This dissertation is a hermeneutic literature review exploring in depth R. D. Laing's book *The Divided Self*, but also drawing from other works of Laing, his biographers and those relating to psychiatry. I have chosen this text to explore the research question "what does the work of R. D. Laing contribute to a better understanding of the process of listening and tuning into psychotic and schizophrenic patients?" In researching this question, my hope is to comprehend more of Laing's perspectives. To clarify my terms listening and tuning into psychotic patients, my focus is toward how Laing, with his many years working with psychotic patients, came into relation, reached and connected with those termed insane. One of my decisions to write about this topic was a hint I picked up from Laing's preface to *The Divided Self*, that he was "still writing...too much about Them and too little of Us" (Laing, 1990 p. 11). As I have already stated the latest outcomes from mental health inquiries in New Zealand and the UK point towards the need to focus on how professionals are responding to patients. Mental health inquiries have enabled consumers of mental health systems to have a voice. They desire something more from clinicians, something vital that is

missing in the professional-patient interaction. Another passion for this topic is more personal, as follows.

About the researcher.

Many years ago, whilst living in the UK I experienced a breakdown after a close friend committed suicide. I received treatment from an elderly gentleman from Victim Support in weekly sessions for three months. He listened to my *madness* whilst helping me to process the tragedy of my friend's death and my horror of finding them. This was my first experience of any therapy and I am most profoundly thankful that I found myself with a person who was able to stand my confusing state, listen with humanity and empathy and help me process this trauma. As my understanding of community mental health has grown, I am also thankful that I stayed out of the medical system. I would have fulfilled the diagnosis of psychosis, where the guidelines for treatment are medication and therapy targeting symptom relief, known as Cognitive Behaviour Therapy (CBT). CBT can help to work out how to change unhelpful thoughts and behaviours and to teach new skills that you can apply in daily life (NHS, 2019). However, although CBT might have addressed an aspect of my behaviour, I know that at this time I needed someone to listen to all of me, the me that was suffering an extreme disturbance and at the same time trying to make sense of a traumatic event and the loss of a dear friend.

Many years later I began the process of becoming a therapist myself. I undertook degrees in Psychology and English at The University of Auckland. In my psychology degree I spent time in a laboratory with pigeons, placing them in Skinner boxes, observing them peck coloured key lights for food. The data I gathered would then be used to understand human behaviour momentum in addiction. I questioned the logic of these experiments, of how this qualitative research could match the complexity of the human mind and body. One of my lecturers helped me turn towards another direction of study. Professor John Read relayed a story of an incident when he was a young nursing aid at a New York psychiatric hospital. He joined a catatonic schizophrenic patient in a padded cell – she had not spoken in weeks. Having had no training, he asked "It's OK if you don't want to talk, but if you want to, I will listen" (Reed, 2004 p. xx). Over the course of a few days the patient began to say one word after another leading to a declaration of her trauma. This stimulated my wonderings and I looked for

books in the university library outside my psychology degree curriculum and came across R. D. Laing's *The Divided Self* and the world of psychoanalytic and psychodynamic psychotherapy opened up to me. I completed my degrees at The University of Auckland and began studying psychotherapy through Postgraduate and Master degree programmes at Auckland University of Technology (AUT).

Overview of Chapters.

In this chapter I have introduced this study. Chapter two provides a brief biography of R. D. Laing. In order to begin gathering data for my research question*, "*what does the work of R.D. Laing contribute to a better understanding of the process of listening and tuning into psychotic and schizophrenic patients?" I read biographies and autobiographies of Laing's early history, his experiences in mental health hospitals and his psychoanalytic training. Chapter three describes the ontological perspectives that frame this study. Chapter four describes my epistemology, methodology and method of researching my topic. Chapter five contains my process of data gathering. As I read and re-read *The Divided Self*, themes began to emerge through my hermeneutic process. I found that a synopsis of these themes from each chapter was necessary for an overall perspective, an easier movement from the whole to the parts. Chapter six is an account of my findings. Chapter seven provides a discussion relating to the findings of this study.

Chapter Two

R.D. Laing - A brief biography.

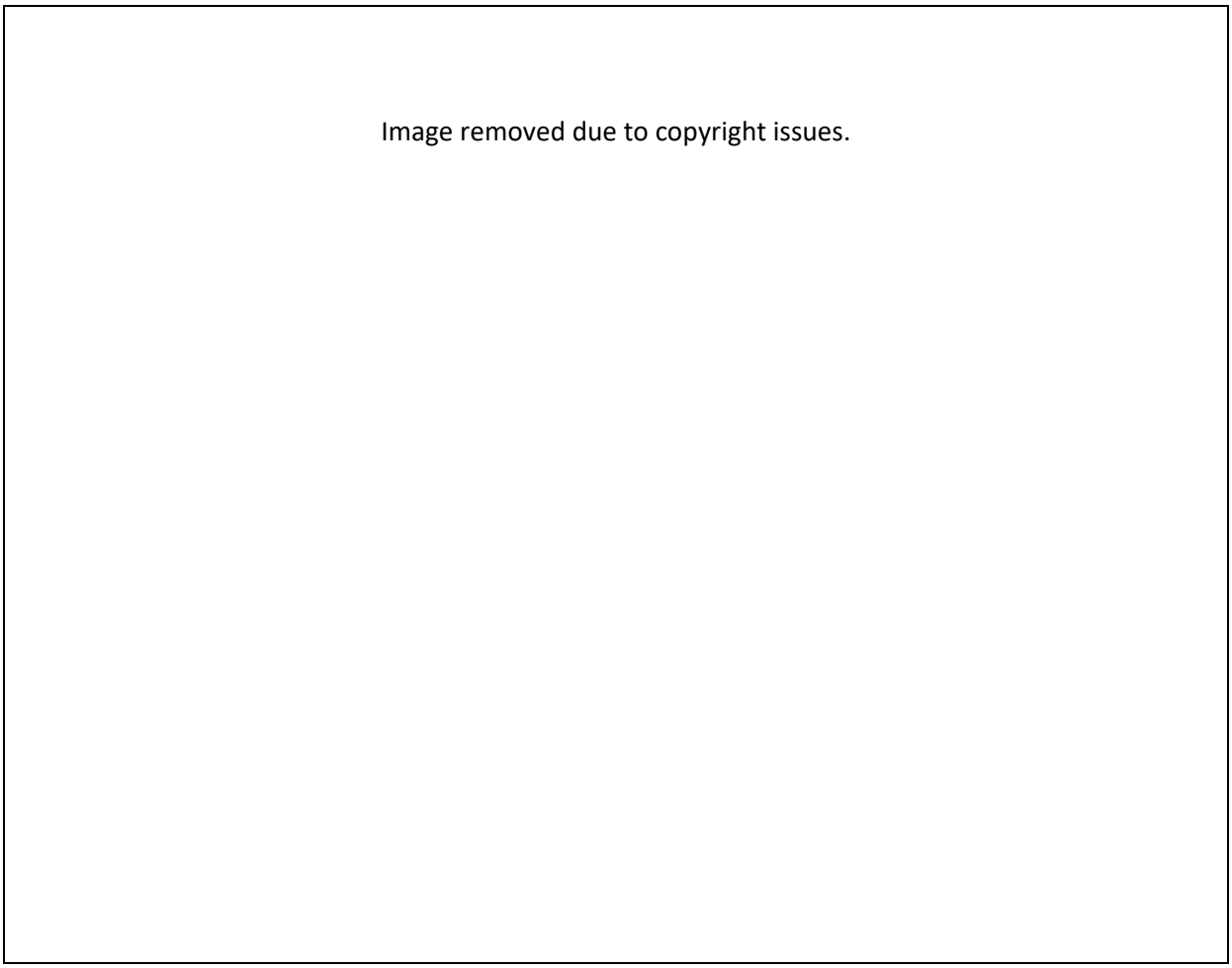

Figure 2: Childhood: Laing and his little wooden horse (Laing, 1985 p. 72)

...the initial *structuralization of being*
into its basic elements
occurs in early infancy.
In the schizoid character structure
...there is an insecurity
in the laying down of these foundations,
Laing (1990, p. 77)

The early years

Laing grew up in Govan, Scotland with his mother Amelia (who was thought of as mad by their neighbours) and his father David, who was treated by Amelia as second to her son. His father slept in the spare room (nicknamed the dog kennel). Mother and son slept in separate

beds in the main bedroom. His father was jealous of his son and beat him at any sign of transgression of the house rules. Laing learnt to *be good* (Clay, 1996).

Laing's mother Amelia was known as an oddity who kept herself apart from the neighbours, burnt her own rubbish and was rarely seen out. Walter Fyfe, an old school friend, recalls whenever he visited Laing's home, what struck him was "the darkness, the heavy curtains drawn, not the usual lace curtains but real curtains, whereas most people had blinds that were pulled up in daytime" (Clay, 1996, p. 7). Fyfe recalls walking back from school with Laing to his home, stopping to talk below the first-floor window of Laing's flat. His mother's gloved hand would appear summoning Laing "we could see in his face that he had to go, it was a painful moment" (Clay, 1996, p. 13). Fyfe would remain playing below, Laing would be attending to his homework, his mother alongside impatiently waiting for him to finish so they could watch the passers-by. Was Laing a companion or a son? His mother's need for his undivided attention was made clear. Laing's favourite toy was a wooden horse on wheels that he pretended to feed and keep up conversations with. He came home from school one day to find it had disappeared - his mother sensing his attachment had it burnt (Clay, 1996).

Laing followed a tightly structured routine from the age of 7. He was expected to get himself ready and off to school, returning at 4.30pm for either music lessons, play or be with his mother. 6pm was teatime, listening to some radio, then homework, bath, bed with lights out with no reading or talking. Laing states that he could lie in bed in any position he wanted provided he was quiet, he did not have to be asleep. Except for one or two incidents and apart from some minor frictions Laing reports that "if he smelt and sounded alright, kept good thoughts and his heart was pure, he was free as a bird" (Laing, 1985, p. 35). However, the following incidents that Laing recalls suggest that this *freedom* had in fact, steely and brutal boundaries.

Laing's father lost his fountain pen and accused Laing of theft. Laing had not stolen it, but his father refused to believe him. His mother, trying to protect him, believing that Laing would be doubly punished for stealing and lying, told his father that Laing had confessed. This confused Laing all the more. His father went ahead and beat him. His mother later discovered that Laing indeed had not stolen the pen and requested he "come and kiss your mummy and make it up" (Laing, 1985, p. 39). Part of him longed to go to her, but another

part thought this would be wrong or twisted, so he stood his ground, his mother retorting "well if you don't love your mummy, I'll just have to go away" (p. 40) and she walked out of the room. Laing recalls that the room started to spin, his head in turmoil, but then suddenly everything was different yet the same, he was himself, he saw his mother and family for the first time and retreated to his own inner core. Laing later recalls this incident as crucial in his life, connected to others and yet not connected, a split that was becoming a way of life (Laing, 1985).

By Laing's 15th year Amelia's intrusions came to a climax. Laing was expected to have a hot bath every night, in the winter a cold bath in the morning. Amelia had always scrubbed Laing's back, although this had dwindled over the years to a tiny spot in the middle between his shoulders and only for a few seconds. Laing, with a growing concern that his mother would catch a glimpse of his sprouting pubic hair, made the water sufficiently dirty. He was not allowed to lock the door and had to call her when he was ready. Laing found this situation more and more humiliating to a point where he finally locked the bathroom door. His mother stood outside yelling and beating on the frosted glass to be let in, rising to screams. At this point his father dragged her away from the door, yelling at her that if she did not stop, "he would go onto the stairs and shout his bloody head off!" (Laing, 1985, p. 56). The thought of what the neighbours would think quietened her down. Laing was deeply grateful for his father's intervention and for taking his side, stating that "it would have been awful if he too had ordered him to open the door" (Laing, 1985, p. 56).

Experience and exposure.

Laing went onto medical training at Glasgow University, choosing later to specialise in psychiatry. In 1951 there was universal conscription for military service in the UK, however, Laing was exempt because of his asthma, choosing instead to enlist as a psychiatrist. Most of his time was spent in a "neurotic-psychopathic - alcoholic-battle-neurosis - anything-goes-miscellaneous ward" (Laing, 1985, p. 94). There were pre-tranquilizer drugs – barbiturates, chloral hydrate, paraldehyde, electric shocks, 'modified' insulin, straitjackets, padded cells, injections, tube-feeds, amytal abreactions, antabuse, hypnosis (Laing, 1985, p. 94).

One night, as Laing was doing his late-night look-in on the ward, he was caught up in the ravings of a manic character coming from one of the padded cells. Ordering an injection if

the patient did not quieten down, Laing opened the cell, sat down and listened for a while and the patient began to calm down. Over the next few nights Laing stayed longer, feeling strangely at home there, lounging on the floor. This was, Laing noted, the first time he had settled down and relaxed with a patient without trying to make a diagnosis. Laing felt he could almost understand him, he listened to the patient's delusions; that he was a very accomplished cat burglar, able to access any place he chose with incredible getaways, handing his booty to the poor. After some weeks, calmed and reflexive the patient was discharged from the psychiatric ward and the army. Laing writes that it never occurred to him that what had taken place might be called therapy (Laing, 1985).

Psychoanalytic training and analysis

At 28, Laing undertook four years of psychoanalytic training at the Tavistock Clinic, London. Alongside and integral to psychoanalytic training is the candidate undertaking their own analysis. Laing spent 4 years, 5 times a week in analysis with Charles Rycroft [2] who assessed Laing a schizoid type with intact defences (Clay, 1996, p. 66). Laing was surrounded and lectured by the most prominent thinkers in psychoanalysis of the time, the likes of Melanie Klein, Wilfred Bion and Donald Winnicott, the latter as one of his supervisors.

LSD, Kingsley Hall and Struck off.

After qualifying from the Tavistock in 1960 Laing set up a private practice in Wimpole Street, London where his patients included famous novelists, musicians and actors. Experimenting with LSD was of the 1960's era, and legal for Laing at this time. Several high-profile patients describe taking *trips* at his clinic (Clay, 1996). Although shortly afterwards LSD became an illegal substance, in contemporary medicine there has been a surge in interest regarding psychedelic drugs. For example; the Food and Drug Administration (FDA) USA has recently approved phase 3 trials for MDMA-assisted

[2] Charles Rycroft (1914 – 1998) was a British psychiatrist and psychoanalyst. He studied medicine at University College London and authored many notable books, including *A Critical Dictionary of Psychoanalysis* (1968), *The Innocence of Dreams* (1979) and *Psychoanalysis and Beyond* (1985). Rycroft was a consultant psychoanalyst at the Tavistock Clinic from 1956 until 1968, and for a period of time, was an assistant editor of the *International Journal of Psychoanalysis*. He was elected a Fellow of the Royal College of Psychiatrists in 1973. Retrieved from https://psychoanalysis.org.uk/authors-and-theorists/charles-rycroft.

psychotherapy for PTSD (Multidisciplinary Association for Psychedelic Studies, n.d) and, courses are now available offering certification in Psychedelic-assisted therapies, seeking to meet the demand for future FDA approved psychedelic-assisted psychotherapy research (California Institute of Integral Studies, n.d).

Kingsley Hall

In 1965, Laing and his associates (the newly formed Philadelphia Association) set up a residential establishment where patients and clinicians lived side by side, where "those in a state of near-disintegration or madness could come, be tolerated…while a 'natural' healing process took place" (Clay, 1996, p. 121). Kingsley Hall was a household community where people could get to know each other, to find out who they were *underneath*. Being able to express yourself freely was perhaps linked to the 1960's counter-culture, and Kingsley Hall drew attention from many different quarters. As its fame spread clinicians came to explore and learn. Kingsley Hall's neighbours were not so enamoured with this community at such close quarters and Kingsley Hall closed after 5 years when the lease ran out and was not renewed (Clay, 1996).

Laing continued to work in private practice, lecture toured the USA and wrote or co-authored a dozen more published books (The official website for R. D. Laing, n.d).

Struck off...

In 1985, Laing received a letter from the General Medical Council, questioning his fitness to practice citing a misuse or abuse of alcohol and that there had been allegations of serious professional misconduct from a former patient. Laing had asked this patient to pay for his previous sessions – this had ended in a row between the two. By 1987, the Council suggested that Laing withdrew from the medical register and no further action would be taken. Laing agreed, as although he would no longer be able to prescribe medication he could still practice as a psychotherapist. Two years later, in 1989 Laing died of a heart attack whilst playing tennis in St. Tropez, France (Clay, 1996).

Chapter summary.

In this chapter I have introduced the parts of Laing's history that I found pertinent to my research topic. In the following chapter I discuss this dissertation's ontological framework.

Chapter 3

Ontological perspectives

What are my understandings about the nature of reality?

Figure 3: Einstein and the Dark Universe. From "Elettrico" Creative Commons, 2020 (https://search.creativecommons.org/photos/bfe89335-be3d-44a4-bb70-065001efd20a)

"A human being is part of the whole, called by us 'universe,' a part limited in time and space. He experiences himself, his thoughts and feelings, as something separate from the rest — a kind of optical delusion of consciousness. This delusion is a kind of prison for us, restricting us to our personal desires and to affection for a few persons nearest to us. Our task must be to free ourselves from this prison by widening our circle of compassion to embrace all living creatures and the whole of nature in its beauty."

Quote taken from Dear Professor Einstein: Albert Einstein's Letters to and from Children, Alice Calaprice (Ed.), Princeton University Press (2002, p. 184).

****

"Einstein's theory of relativity increasingly recognized the inseparability of the observer from the thing observed" (Bolognini, 2006, p. 2).

In this chapter I offer my rationale for choosing a pluralistic rather than a dualistic ontological framework. I investigate some of the pluralistic concepts put forward by Karl Popper, Burrhus Skinner and Sigmund Freud. I then study Freud's concepts further, investigating a little of their history. Lastly, I write of Laing's ideas concerning the importance of research from a pluralistic stance and an existential-phenomenological perspective.

A Dualistic Ontology (Scientific).

In my psychology degree, my work with laboratory pigeons was based on the assumptions of a dualistic natural scientific method. This method refers to observable, factual activities in the outside world. Dualism relies on a belief that there is an objective reality out there to be discovered. The pigeon's behaviour provided observable data that could then be translated into natural world understanding. By repeatedly observing this behaviour a pattern begins to emerge and a hypothesis can be confirmed, replicated and generalised to the human population. This is the basis of the dualistic natural science method for psychology.

My issue with a dualistic ontological basis of scientific discovery is that it does not capture the multiple realities that exist in human nature, it is too simplistic. As Carl Jung wrote "science works with concepts of averages which are far too general to do justice to the subjective variety of an individual life" (Jung, 1989, p. 3). Human beings are aware of multiple realities, the physical (atoms, trains, planes, planets), experiential (pain, feelings, thoughts), institutional (languages, cultures, family relations, world views) and abstract (theories, mathematics, geometry). We may not be able to relate or reduce these to one another, but by not noticing these other realities we can become impoverished, things get lost if we only explore our world from a dualistic perspective (Perez-Alvarez, 2017).

Pluralistic Ontology. (The humanities).

In my search for an ontological perspective that is more encompassing I researched the pluralistic viewpoint. These have been put forward by the likes of Sigmund Freud (psychoanalytic), Karl Popper (scientific) and Burrhus Skinner (behaviourist). An example of each follows:

Table 1.

Freud – Psychoanalytic (Freud, 1986)

It (ID)	I (Ego)	Upper I (Superego)
Instinctual drives. Bodily wants, desires and impulses e.g. aggressive, sexual. Unconscious. Irrational.	Attempts to mediate between the id, superego and reality. The assertiveness we often feel when we say "I" is an image of how the person's "I" tries to assert its will over the ID, Superego and external world. The conscious, rational aspects of oneself. *I* or *me*	Reflects the internalization of cultural rules, mainly taught by parents applying their guidance and influence whether positive or negative.

Table 2.

Popper – Scientific (Popper & Eccles, 1977, cited in Perez-Alvarez, 2017)

World 1	World 2	World 3
Physical	Mental	Beyond themselves, transcending themselves whether in art, science or thought.

Table 3.

Skinner – Behaviourism (Skinner, 1981, cited in Perez-Alvarez, 2017)

1	2	3
Survival response for natural selection of the species.	Contingencies of reinforcement responsible for the repertoires acquired by its members.	Special contingencies maintained by an evolved social environment.

All three theorists (some of the most influential scientists from the 20th century) seek to describe something beyond a dualist human condition. Popper describes a concept of transcendence, Skinner a concept attached to special contingencies. Freud's concepts, like Skinner and Popper, are pluralistic in nature, however, he includes a fourth that overarches his other three. This fourth dimension offers further rationale for following a pluralistic

frame, as this helps me to make connections to Laing's existential phenomenological science of persons.

Freud's fourth concept: Treatment of the Soul.

In The New Introductory Lectures on Psychoanalysis*,* the chapter entitled *The Analysis of the Psychical Personality*, Freud, speaking of the I (Ego), the it (ID), and the above-I (Super-Ego), describes them as "***the three provinces of the apparatus of the soul"*** (*die drei Provinzen des seelischen Apparats*) (Bettelheim, 1989, p. 72). To further comprehend this concept, in the opening passage of an article entitled *Psychical Treatment (Treatment of the Soul)* Freud writes:

> *"Psyche" is a Greek word and its German translation is "soul". Psychical treatment hence means "treatment of the soul". One could thus think that what is meant is: treatment of the morbid phenomena in the life of the soul. But this is not the meaning of this term. Psychical treatment wishes to signify, rather, treatment originating in the soul, treatment – of psychic or bodily disorders – by measures which influence above all and immediately the soul of man (Freud, 1905, cited in Bettelheim, 1989, p. 73).*

Lost in translation.

However, in the translations of Freud's works *Seele* (soul) becomes rendered as a *mental apparatus* or *mental organisation (Freud, 1964, p. 104)*. We cannot know perhaps why Freud's references to the soul was mis-translated into mind/mental, although the Austrian and Freudian psychoanalyst Bruno Bettelheim's belief was that there was no reason apart from a desire to interpret psychoanalysis as a medical speciality.

In common American usage, the word *soul* has been more or less restricted to the sphere of religion, however, this was not the case in Freud's Vienna, and it is not the case in German speaking countries today (Bettelheim, 1989). In German the word *Seele* has "retained its full meaning as man's essence, as that which is most spiritual and worthy in man. *Seele* should have been translated in this sense" (Bettelheim, 1989, p. 76).

Suppression of spirituality/any form of transcendence.

Suppression of spirituality or any form of transcendence of man, Laing points out, "can easily be a technique in psychiatry of *brainwashing*, inducing behaviour that is adjusted" (Laing,

1990 p. 12). In the early 20th century Freud described our civilization as a repressive one, that there is "a conflict between the demands of conformity and the demands of our instinctive energies, explicitly sexual" (Laing, 1990, p. 11). By the mid-20th century Laing (1990) expanded on this repression including, not just the instincts, but any form of transcendence:

> *Among one-dimensional men, it is not surprising that someone with an insistent experience of other dimensions, that he cannot entirely deny or forget, will run the risk either of being destroyed by the others, or of betraying what he knows (p. 11).*

Further, what is termed *normal*, our normal frame of reference is ambiguous and equivocal, for example, "…that a man who says he has lost his soul is mad. A man who says that men are machines may be a great scientist" (Laing, 1990, p. 12). Laing's ontological preference was an existential phenomenological one, that offers space and an openness for each individual's experience of their world. Freud also concluded that meaning making comes from the subjectivity of the patient. Early in his career Freud's ideas of psychoanalysis was as an exact science, he believed an analyst could translate the content of dreams for the patient. Bettelheim (1989), said that in Freud's later writings there was a shift in his beliefs, that dream symbols could only really be deciphered by the dreamer and only a study of the individual's unique associations to a symbol permitted understanding of what is signified. It would appear that Freud and Laing were aware of, and willing to be open to other dimensions or experiences of being in the world (the subjective nature of man). Laing further elaborates that this place or essence is suppressed in our culture if there is nowhere for it to be received (Laing, 1990). A pluralistic approach then, in contrast to a dualist dichotomy, helps us to understand subjectivity as an extended part of the world, not a world apart (Perez-Alvarez, 2017). How do these ontological perspectives help us to gain an understanding of the schizophrenic individual? R. D. Laing (1990) highly respected the subjectivity of the individual and explained his ontological perspective in terms of an existential-phenomenological foundation for a science of persons:

> *... existential phenomenology attempts to characterize the nature of a person's experience of his world and himself. It is not so much an attempt to describe particular objects of his experience as to set all particular experiences within the context of his whole being-in-his-world. The mad things said and done by the*

> *schizophrenic will remain essentially a closed book if one does not understand their existential context (p. 17).*

Laing pursued an ontological basis that did not begin from a splitting up of the individual but rather focused on the whole individual and his being in the world – Laing emphasised the subjective world of another as the starting point for scientific investigation and for that matter treatment. Laing's own foundations of scientific enquiry, named existential phenomenology, attempts to "characterize the nature of a person's experience of his world and himself" (Laing, 1990, p. 17).

Freud (1986) also wrote of his concerns regarding the dualist approach and how psychoanalysis can help fill the gaps:

> *...psychiatry as a part of medicine sets about describing the mental disorders it observes and collecting them into clinical entities; but at favourable moments the psychiatrist themselves have doubts, of whether their purely descriptive hypotheses deserve the name of a science. Nothing is known of the origin, the mechanism or the mutual relations of the symptoms of which these clinical entities are composed. These mental disorders are only accessible to the therapeutic influence when they can be recognised as subsidiary effects of what is otherwise an organic illness. This is the gap which psychoanalysis seeks to fill. It tries to give psychiatry its missing psychological foundation. It hopes to discover the common ground on the basis of which the convergence of physical and mental disorder will become intelligible (p. 45).*

Chapter summary.

In this chapter I have offered my rationale for following a pluralistic ontological perspective to frame my research. In the following chapter I outline my epistemology, methodology and method used in this dissertation.

Chapter 4

Epistemology, Methodology
and Method

In this chapters I offer the epistemological and methodological underpinnings for a hermeneutic literature review of *The Divided Self* and the steps that guide the process of this study.

Epistemology.

Interpretivism draws from existential philosophies that seek to "understand what it is to be human and the meanings that people attach to events in their lives" (Grant & Giddings, 2002, p. 16). The hermeneutic step is to consider that some part of the truth of a situation can be found in self understandings, that "truth must be discovered by thought rather than by sensory observation" (Cocks', 1989, cited in Grant & Giddings, 2002, p. 16). In keeping with this step my approach is not to duplicate what Laing has already written or spoken of, but rather to interpret the significance of his work from my own self-understandings (Grant & Giddings, 2002).

Methodology.

In keeping with a Laingian approach of phenomenological inquiry my methodology is a hermeneutic literature review. Hermeneutics stems from an interpretive paradigm, the core belief of which is that reality is socially constructed. Interpretivism accepts and seeks multiple perspectives - that the researcher is influenced by their world view and theories (Willis, 2007). The aim of phenomenological research is to draw near to an understanding of a particular phenomenon through a reflection and fascination with its meaning (Van Manen, 2014). My research focuses predominantly on *The Divided Self*, by R. D. Laing whose life works were dedicated to a better understanding of being with psychotic patients. In order to draw nearer to an understanding of how Laing listened to his psychotic patients my method of data collection is a hermeneutic literature review. Hermeneutics is concerned with the process of creating meaning through interpretive understanding, whilst a literature review facilitates a deeper understanding of relevant texts and individual ones.

Method.

My research method is grounded in the basic philosophical concepts of Hans-Georg Gadamer, influenced by Martin Heidegger. From Gadamer's philosophical framework, Kitt Austgard (2012) offers 4 steps to develop a research plan for studying and interpreting texts.

Step 1 - Belonging to tradition.

Gadamer emphasises the need for a historical horizon (Austgard, 2008). To acquire a horizon, one learns to look beyond what is close at hand. Gadamer writes that it may be difficult to reconstruct the original situation in which the text arose, but the hermeneutic demand is to understand a text in terms of the specific situation in which it was written. My task is to understand these texts according to the authors aim and to keep my prejudices and my cultural self *out of play*, to understand what the author is saying, not building an objective truth (Gadamer, 2013).

To find a historical horizon I investigated the social and political arena at the time of Laing composing *The Divided Self* (circa 1960's), expressly around psychiatry. I found *antipsychiatry* was a headline topic in the 1960-70's. The movement accused psychiatry of neither healing mental illness nor being a legitimate branch of medicine, of presenting itself as a healing art yet actually policing and controlling behaviour deemed abnormal, irrational or socially unacceptable. Opposition to psychiatry and asylums reached a broader audience during the 1960's. There was growing public awareness of controversial treatments such as electroconvulsive therapy (ECT) and lobotomy. The antipsychiatry movement contributed to a move away from asylums and towards treatment focused on outpatient care and psychiatric drugs. This had positive and negative consequences. There is still no consensus on the role psychiatry should play in determining when socially unacceptable behaviours become a medical problem (Tinning, n.d.).

Laing found himself lumped into this category (anti psychiatry) although he repeatedly stated that he was not anti-psychiatry (Gilford, 2016). According to remembered accounts, Laing would, if a patient was so distressed and asked for something to calm themselves

down, give them something immediately (Gilford, 2016). Associates report Laing was not against drugs – he said they had their place, but there was far more to offer a patient.

Step 2 - Hermeneutic preparation: Identification of fore-understanding.

My own fore-understanding is based on the ideas of Heidegger, in that to gain an understanding of *Being*, "what is shadowy and latent is to be brought into the clear light of day" (Crotty, 1996, p. 89). To return to the things themselves Heidegger states that our task is to return to *Being*, to allow the structures of *Being* to present themselves. In this process, existential structures of our being come into view and in turn we can then return to our "concrete existence in the world and discover possibilities in the light of them" (Crotty, 1996, p. 89).

In order to attend to this step, it is necessary to have an overview of the existing research and literature relating to listening to psychotic patients. This prepares me for entering the hermeneutic circle, being conscious of my hermeneutic situation.

Brief Psychoanalytic and Psychodynamic literature review pertaining to mental health.

Psychoanalytic literature asserts that we live in a quick-fix age of psychiatric solutions (De Masi, 2009). In the USA the current treatment of psychotic patients, especially those in crisis, relies almost exclusively upon dispensing medication, brief hospitalization programmes steeped in cognitive-behaviour paradigms (Dowling, 2017). According to the psychiatrist and psychoanalyst Quinodoz (2008), those treating psychotic patients psychoanalytically state that when all the conditions were right, and this is rare, psychoanalytic treatment provides the most hope for those suffering from psychosis, as it deals with the very root of the disturbance of his personality. Further, the importance and value of psychoanalysis, to the community, lies mainly in its research aspect. The knowledge of psychopathology that psychoanalysis can give has enabled the development of other psychotherapeutic approaches such as supportive, group and individual therapy and community care (Quinodoz, 2008). However, after decades of study and research (psychoanalytic, behaviourist, biomedically), very little is known about the nature of psychosis. "The psychotic state is still a mysterious world that no discipline has so far been able to explain convincingly" (Pao, 1979, cited in De Masi, 2009, p. 19).

David Bell (2013) supports the idea that containment is a central part of all work with psychiatric patients. Bell describes this "as resting upon an understanding of the dynamic relation between two psychic elements: the "container" and the "contained" (p. 230).

Step 3 - Hermeneutic dialogue with the text and analysis.

This stage involves the search for meaning. Austgard (2008) makes clear that it is important at all times to make clear what is the original text and what is my interpretation of its meaning. The interpretation moves from the text as a whole to its parts and back to the whole again. This is guided by a dialectic movement between the questions and the answers I find in the texts (Austgard (2008).

Step 4 - Fusion of horizons.

As the hermeneutic process continues in a back and forth movement, my fore-understanding, in a state of flux, deepens my understanding of the texts. Patterns or themes emerge as the fusion of old and new horizons merge under a new horizon. This culminates in an understanding of the text that produces new knowledge based on my research question. This in turn opens my question to further research and deeper understanding (Austgard, 2008).

Ethics – principles that guide my research.

Levinas argued that responsibility to the other is rooted within our subjective constitution (Turner, 2012). Subjectivity is formed in and through our subjection to the other. Subjectivity is primordially ethical, not theoretical; that is to say, "our responsibility for the other is not a derivative feature of our subjectivity, but instead, finds our subjective being in the world by giving it a meaningful direction and orientation. Ethics as first philosophy means that the traditional philosophical pursuit of knowledge is secondary to a basic ethical duty to the other" (Levinas, 1981, cited in Sriraman & English, 2010, p. 59)

Exclusionary factors

I have chosen to focus on one piece of writing, *The Divided Self.* This is my primary source of data in researching my question. I am excluding all other works by this author, apart

from his biography, due to time constraints and the richness of Laing's own enquiry into the topic I am addressing in this text.

Chapter summary.

In this chapter I have provided an outline of my epistemology, methodology and method used in this dissertation. The following chapter is dedicated to gathering data from *The Divided Self*.

Chapter 5

Gathering data

Although I entered the hermeneutic process whilst researching Laing's biography and autobiography, my main source of data is to be found by an immersion in his text, *The Divided Self*. I found that a synopsis of the themes that emerged from each chapter (from my hermeneutic process) was necessary for an overall perspective, an easier movement from the whole to the parts.

A synopsis of each chapter of *The Divided Self* (1990), follows;

Chapter 1. The existential-phenomenological foundations for a science of persons.

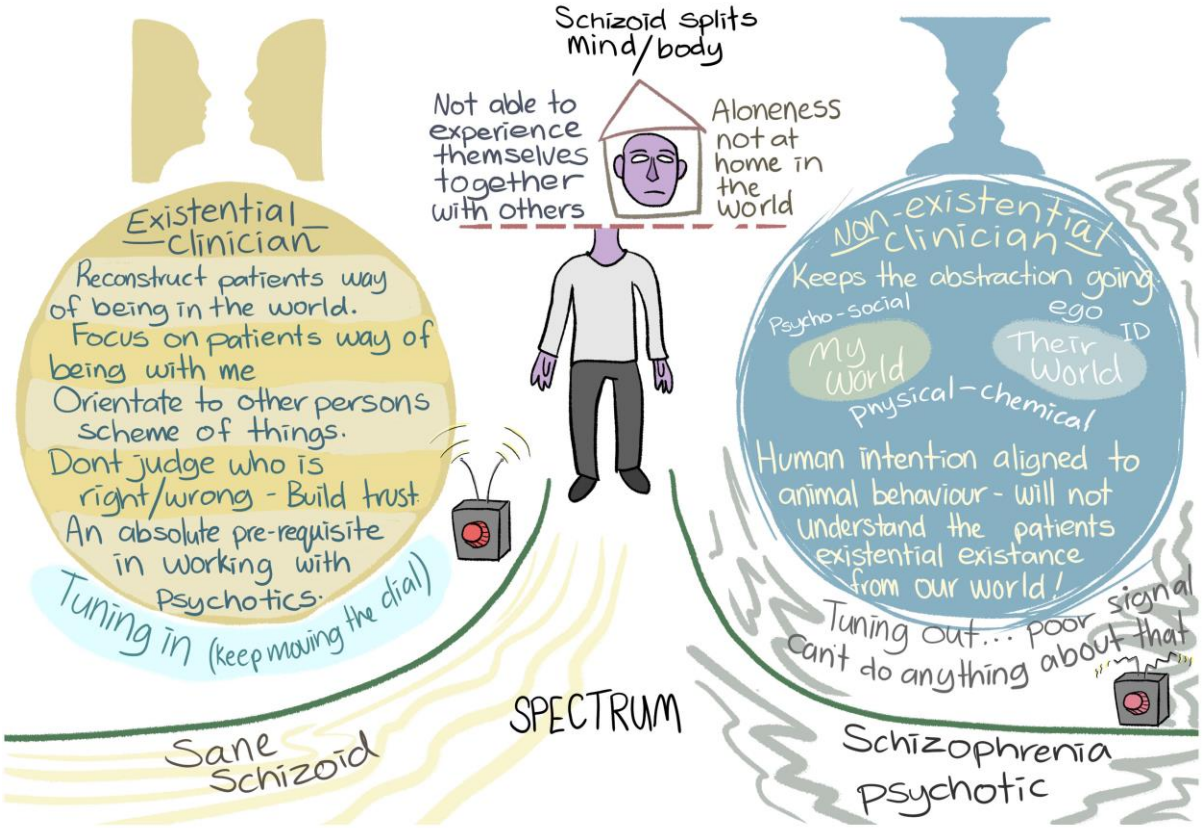

Figure 4: The schizoid condition and two ways of engaging with it.

This diagram highlights an existential phenomenological foundation for a science of persons and a non-existential foundation. Laing describes the schizoid condition as split in two ways (a mind and a body), a disruption of attachment to the world and to themselves. Existing in this way brings alone-ness and isolation, an inability to experience togetherness with others and feelings of being *not at home in the world*. A schizoid individual can be

mis-understood unless their existential context can be grasped. Laing states that the language used by clinicians can be distancing; schizoid, ego, superego, id, treatment/reintegration, psycho-physical, psycho-social, psycho-biological, these cause more abstraction, already the relationship has moved away from you and I and is incompatible to forming relationships. Thinking in terms of their world/my world is also not compatible with comprehending their existential existence. A physical-chemical notion is depersonalising and reading human intentions into the animal world is in no way addressing the complexity of a human being. Therapeutic relating reconstructs the patient's way of being themselves in their world (existential-phenomenological), focusing on the patient's way of being with the clinician. Laing writes that **one needs to orientate oneself as a person in the others scheme of things rather than one's own world – without prejudging who is right/wrong. The ability to do this is an absolute and obvious prerequisite in working with psychotics[3].** Further, Laing questions a theory that transmutes people into animals as crazy, yet we think that those who say they are robots or bits of machinery as equally crazy. In the 1950's it was thought that the emergence of a scientific psychology was still in transition from organic to personal (MacMurray, 1957, cited in Laing, 1990) and this would still seem to be the case in 2019.

Chapter 2. The existential-phenomenological foundations for the understanding of psychosis. (Note: Existential – the experience of existence. Phenomenological - investigating or inquiring into the meanings of our experiences as we live them). Psychiatrist Eugen Bleuler[4] remarked that when all is said and done, they (mental health patients) were stranger to him than the birds in his garden. Laing writes that "**the behaviour of the patient is to some extent a function of the behaviour of the psychiatrist in the same behavioural field" (p. 28)**. Laing furthers this point by recanting a lecture that Emil Kraepelin[5] gave to his students, during which they observed a patient showing signs of catatonic excitement. Kraepelin observed the signs of disease, questioning the patient and

[3] Throughout this data gathering process I have embolden words and sentences that I found the most meaningful in each chapter.
[4] Eugen Bleuler (1857-1939) Swiss psychiatrist who coined the term schizophrenia. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3339235/
[5] Emil Kraepelin (1856-1926) professor of psychiatry first in Heidelberg then Munich, originated modern psychiatric diagnosis. Retrieved from https://oxfordmedicine.com/view/10.1093/med/9780190881191.001.0001/med-9780190881191-chapter-4

noting that nothing useful could be gleaned from the exchange. Laing's summation however offered meaning from the dialogue, that the patient had objections to being measured and tested. **Empathy encourages us to listen for what the patient is trying to communicate,** negative reactions can be clues, including how the patient makes the clinician feel (the transference and countertransference phenomena) (Laing, 1990).

Laing wrote that i**t is possible to have thorough knowledge of** what has been discovered about heredity, recognizing schizophrenic symptoms, indeed all there is to know about **psychopathology without being able to comprehend a single schizophrenic. The therapist's orientation is to transpose himself into the strange subjective world of the schizophrenic and draw on his own psychotic possibilities, without forgoing his sanity. Only then can we understand the existential position of the patient (Laing, 1990).**

Chapter 3. Ontological insecurity.

Laing writes that the ontologically secure individual has a firm sense of his own and other people's reality and identity. From birth they will have encountered foundational experiences and data that are self-validating; feelings of being alive, autonomous, genuine and of worth, secure in themselves, that relatedness can be anticipated as potentially gratifying (these people may have difficulty in transposing themselves into the world of an individual whose experiences may be utterly lacking in any unquestionable self-validating certainties). The reverse can be true of those who have experienced their foundations as ontological insecure (an incomplete or absence of an existential position) and the consequences of dealing with a world filled with anxiety and danger. From this position there is a preoccupation with preserving the self rather than gratification of the self. The threat is to one's existence, and everyday life constitutes a continual and deadly threat (Laing, 1990). Winnicott (1960) wrote that the failure of environmental provision (maternal/paternal/carer role) is related to schizophrenia, infantile psychosis or liability to psychosis in later life (p. 592).

Laing states that understanding this helps us to comprehend how psychosis can develop. For the ontologically insecure, preserving identity is an effort to prevent losing the self. Everydayness takes on a deep significance and the self begins to live in a world of his own

or is already doing so. Laing cites the three main anxieties encountered from this position, engulfment, implosion and depersonalization/petrification (Laing, 1990).

Engulfment: Relationships with another person threaten to overwhelm him as a firm sense of one's own autonomous identity is required in order that one may be related as one human being to another, otherwise any and every relationship threatens the individual with loss of identity. The defence against this is isolation (Laing, 1990).

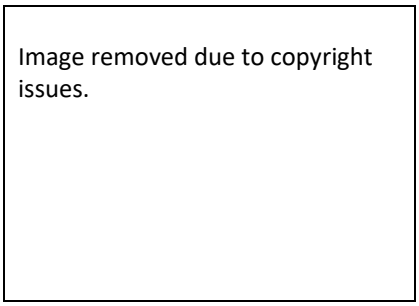

Figure 5: Relationships felt as overwhelming and engulfing.

Implosion: Laing's use of the word implosion was the most extreme he could use to describe Winnicott's impingement (which Laing felt did not fully offer an idea of the impact of this state). However, I decided to revisit Winnicott's theory of impingement (briefly) to understand its foundations.

The main function of an infant's early holding environment is the reduction of impingements to the formation of an emerging ego. The mother wards off impingements that might disturb this growing aspect of self. If impingements to this state are breached (in spite of maternal care or lack of it) then the central core is affected, the very nature of psychotic anxiety. This adds to the quality of isolation and a hiding of the true self. This, Winnicott hypothesised, is a defence against annihilation and the continuity of being. The alternative to being is reacting, and reacting interrupts being and annihilates. Being and annihilation are the two alternatives. Favourable environments establish a continuity of existence that make it possible for impingements to be gathered into the area of omnipotence (Winnicott, 1960). Laing describes the schizoid state where there has been a lack of favourable conditions (and this is carried forward in life); a sense of emptiness (this emptiness is him), that the world is liable to crash into and obliterate all identity, as a gas

that rushes in to obliterate a vacuum. Contact with reality is a persecutor, a threat, threatening engulfment or implosion (Laing, 1990).

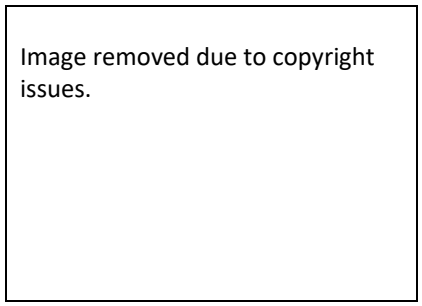

Figure 6: Implosion.

Petrification and depersonalisation: Laing states that this can be a normal occurrence in our daily lives, we depersonalize those around us to some extent, (forget that others are people with feelings). From the schizoid state, this can kill the life in them, being turned to stone, being regarded as a thing, into a dead thing, a robot, means living in a constant fear of being depersonalised by others. The defence? These very dangers, most dreaded, can themselves be encompassed to forestall their actual occurrence by turning oneself into a stone, feign death. To consume oneself by one's own love prevents the possibility of being consumed by another. **The task in psychotherapy is to make an appeal to the freedom of the patient. The effectiveness of this lies in the skill of the psychotherapist (Laing, 1990).**

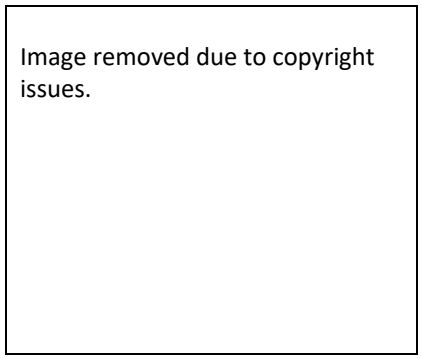

Figure 7: Petrification

Chapter 4. Embodied and unembodied self.

The remainder of *The Divided Self* is concerned with this split. Laing asks what form of relation with the self is developed by the ontological insecure person? The mind and body are severely disrupted (Laing, 1990).


Mind (schizoid closely identified here – psychotics are more or less exclusively identified with this part, a severe disruption - **discarnate**). Mind and Body Split – an attempt to deal with the basic underlying insecurity.

Versus the ontologically secure individual.


Mind and Body, flesh, blood and bones, alive, real, substantial – **incarnate**.

Two different ways of being human. Laing reported he encountered the split between self and personality again and again. The schizoid organisation then is usually more or less unembodied and experienced as a mental entity. The own true self is masked by an observable false-self system, of persona's, none of which are fully developed. Individual actions are not felt as expressions of the self, the extreme of this are further dissociations from the self, increasingly false and futile (lacking spontaneity, not properly alive). The self is shut up with itself, usually highly critical and feels in danger of the overall spread of the false-self system or from a particular part of it (this is complex and never quite the same from person to person). Terrifyingly self-conscious, and feeling observed by the other, safety is sought in isolation (Laing, 1990).

Chapter 5. The inner self of the schizoid condition.

The schizoid condition persists as a scission between the self and body, the true self is more or less disembodied, bodily experiences and actions are part of the false self-system. Laing considers this in more detail. Firstly, this dissociation can be experienced by *normal* people in life threatening situations; sexual assault survivors describe dream like states, that nothing is touching them, nothing seems real, they are out of body, a psychic withdrawal. However, the mind can be excessively alert and exceptionally lucid. This is similar to descriptions given by concentration camp survivors. These temporary schizoid states are where the mental self becomes an observer, detached, impassive to what his body is doing or what is being done to his body. The unembodied schizoid transcends the world and hence is safe to everything that is outside there, although longs to take part in

the world but is consumed by needing to keep it at bay. The paranoiac has specific persecutors, for example, some are against him, plots are a foot. This detachment of the self is never revealed directly in his expressions or actions, but the self is precluded to having any direct relations with real people and real things. A vicious circle. The split deepens. The person who does not act in reality and only acts in phantasy becomes himself unreal (actual world – shrunken, impoverished and less significant). Without an open two-way circuit between phantasy and reality anything becomes possible in phantasy. Unchecked the schizophrenic state of the world is in ruins and the self is (apparently) dead (Laing, 1990).

Therefore, the false self must remain distant from the self in its actions. They must never be what can be said of them. They must remain ungraspable, elusive, transcendent. If they were what their act was, then they would be helpless and at the mercy of any passer-by. Laing reiterates that he is only following one line of development of the schizoid condition and his generalisation is intended only to cover this limited area. Participation of the self is possible, but only in the face of intense anxiety. Franz Kafka knew this very well, when he said that it was only through his anxiety that he could participate in life, and for this reason, he would not be without it (Laing, 1990).

Chapter 6. The false self-system.

Laing writes that we all wear a mask to some degree or another, that we do not always put ourselves fully into all our interactions, choosing instead how much or little of ourselves comes forward. For example, we may choose a different version of ourselves when dealing with different situations. Laing states that normally a good many of our actions may be mechanical and not completely against the grain of our being. However, in the particular schizoid way of being, this mask or false self-system does not serve to gratify or fulfil the self but is an adaptation for the compliance of others or what the schizoid imagines to be the others expectations or intentions (good or bad), a response to what people say they are (so an impersonator), and in this way life is meaningless, alien and impoverishing. There is a basic split of outward compliance and inner withholding of compliance. We may find a model child, an ideal husband, an industrious clerk, but gradually the façade usually becomes more and more stereotyped whereby bizarre characteristics develop. If all the individual's behaviour comes to be compulsively alienated from the secret self, so that it is

given over entirely to compulsive mimicry, impersonality, caricaturing, they may then try to strip themselves of all behaviour resulting in a catatonic withdrawal. Psychosis is sometimes simply the sudden removal of the veil of the false self-system, the individual declaring that the person (mother, father, husband, wife) has been trying to kill him or steal his soul (Laing, 1990).

Chapter 7. Self-consciousness.

The schizoid is frequently tormented by the compulsive nature of the awareness of his own processes, under this scrutinizing glare everything withers. With a constant dread of being turned to stone, consciousness is then a type of scanning radar. Being self-conscious then, heightens awareness to the potential dangers of being exposed to danger (by simply being visible to others). The psychotic conditions – gaze or scrutiny of the other can be experienced as an actual penetration into the core of the inner self. Here there is a conflict, the need to maintain an identity and relatedness whilst dealing with a threat to their identity and reality. The gatekeeper is the false self, offering only what other people regard them as being. They are not what anyone can see (Laing, 1990).

Laing associated utilisation of the false self with the fear of being invisible (regressive tendencies of fear of disappearing, with fear of the mother disappearing). Laing writes "it seems that the loss of the mother, at a certain stage, threatens the individual with loss of himself. The mother, however, is not simply a thing which the child can see, but a person who sees the child. Therefore, Laing suggests that a necessary component in the development of the self is the experience of oneself as a person under the loving eye of the mother. Failure of responsiveness on the mother's part to one or other aspect of the infants 'being' may have important consequences" (Laing, 1990, p. 116). **The schizoid individual is assuring himself that he exists by always being aware of himself – the need to be perceived – to have one's presence endorsed or confirmed by the other, in fact to be loved (Laing, 1990).**

Chapter 8. The case of Peter – a case study.

Chapter 9. Psychotic developments

Crossing the borderline into a psychotic condition can be abrupt and dramatic, but equally can be a transitioning over many years. As direct communication with others in a shared

world becomes more and more turned over to the false self-system, it is only through this medium that the self can communicate. These become like the walls of a prison that the true self cannot escape. Feelings of anxiety become more intense. The un-realness of perception and falsity of purpose culminates into feelings of deadness that permeate even the true self. This leads to a further withdrawal from the shared world into a direction of psychosis. An attempt to experience real alive feelings are met with intense pain or terror, although this may be attempted through self-harm activities, for example hair pulling, stubbing cigarettes out on the body, in order to feel something real. The individual whose false self-system has remained intact may present the appearance of complete normality, however, psychotic processes may be going on secretly and when trouble arises it is sudden and of no apparent reason. *Cures* may arise that consist of the patient once more playing at being sane. **The work involved in therapy is to try to make contact with the true original self, which we take to be still possible, whereby the patient can be nursed back to a feasible life (Laing, 1990).**

Chapter 10. The self and the false self in a schizophrenic.

The divorce of the self from the body is painful to be borne, the self desperately longing for help, however schizoid defences create a dilemma. There is a fear of being in the body as then there is no escape from attacks and danger. Yet, there are no advantages in being outside the body. Within the self-body split the centre fails to hold and this chaotic nonentity is not compatible with life (catatonic schizophrenia). Odd, bizarre and obscure actions create barriers for comprehending the schizophrenic. At the same time *the self* longs to be comprehended, to be known and accepted by someone. **Attempts by clinicians towards any engagement must necessarily proceed with great caution - don't try to get too near too soon**. **Laing offer's case material where a patient describes playing at schizophrenia, playing at being mad, in order to throw off those clinicians that are deemed dangerous and untrustworthy**. A patient described using *red herring* speech to throw them off the scent. Laing (1990) writes:

> *This provides striking confirmation of Jung's statement that the schizophrenic ceases to be schizophrenic when he meets someone by whom he feels understood. When this happens most of the bizarrerie which is taken as the signs of the disease simply evaporates (p. 165)*

It is the love of the physician and his ability to recognise the patients total being that helps to bring the fragments back to unity. Yet, this is just the threshold as one patient of Laing's (1990) described:

> *Loving is impossible at first because it turns you into a helpless little baby. The patient can't feel safe to do this until he is absolutely sure the doctor understands what is needed and will provide it (p. 167).*

Chapter 11. The ghost of the weed garden: a study of a chronic schizophrenic. (Laing, 1990).

A synopsis of all the chapters from Laing's *The Divided Self*, brought this image to my mind.

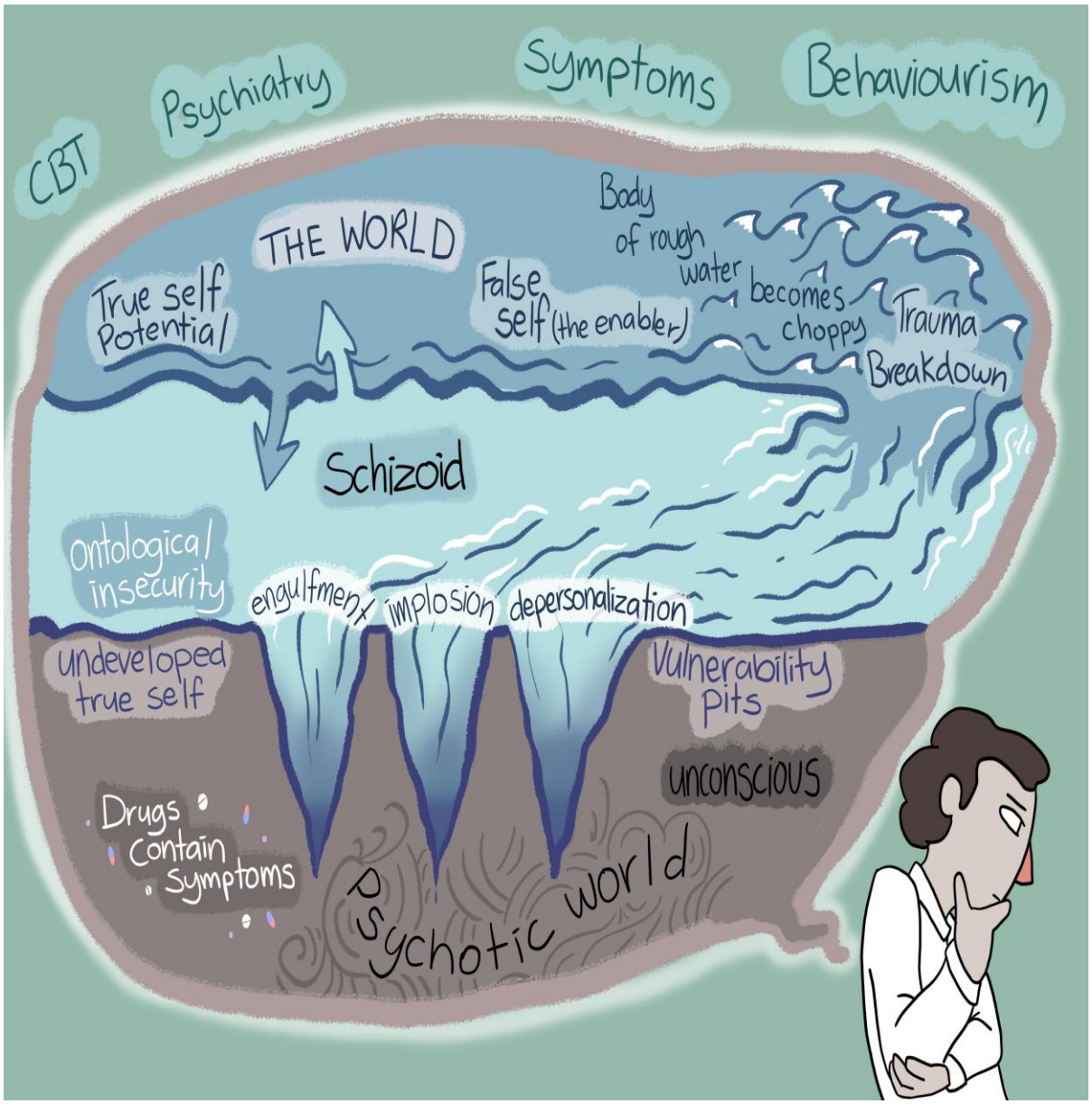

Figure 8. Possibilities in a schizoid world.

Hermeneutic circle.

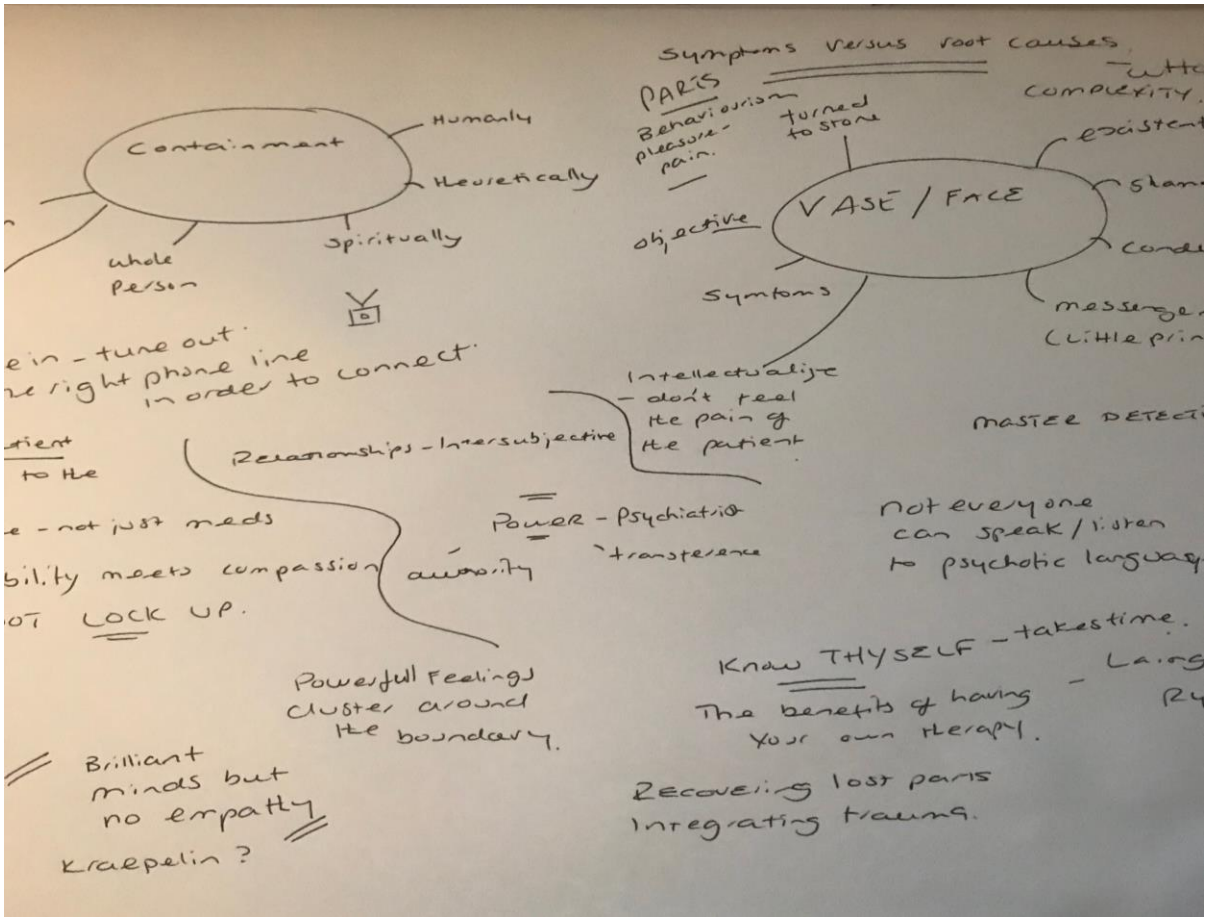

Figure 9. Themes from my data gathering.

With these themes in mind I re-entered the hermeneutic circle, ideas and words forming around them.

Chapter Summary.

Working through the hermeneutic process - from the parts to the whole, themes began to emerge. In this chapter I have provided a synopsis of these themes from each chapter of *The Divided Self.* I then re-entered the hermeneutic process with these themes in mind. Gradually ideas and words formed around the themes, the results of which I present in the next chapter.

Chapter 6

Finding

This chapter expands on the themes and patterns that emerged from my hermeneutic study and process. Firstly, I write of Laing's experience in mental health hospitals and institutions as a psychiatrist and his subsequent move to study psychoanalysis, this in order to offer a context for the further findings that follow. I then pull together the three most important aspects of Laing's history that I felt contributed to his ability to tune into psychotic and schizophrenic patients. I imagined these as *earth-wires*, flowing between Laing and his patients. Initially, I discuss how these *earth-wires* function or flow. This is a necessary step in order to highlight what Laing regarded as essential elements that a clinician possess in order to engage with a schizophrenic patient. I expand and further clarify these necessary elements utilising the concepts of *doer and done to*, *two-way street* and *third space* made known by intersubjectivity theorist, Jessica Benjamin (2012). I follow with, what I suggest, are some of the *earth-wire* resources Laing drew from and then consider some theories that may support Laing's therapeutic approach. Finally, I write concerning the *blocked signals* that may ensue when clinicians lose awareness that others have minds and treat them as physical objects.

"The Divided self is a study of schizoid and schizophrenic persons; its basic purpose is to make madness, and the process of going mad, comprehensible" (Laing, 1990 p. 9).

Laing wrote these words in the preface of *The Divided Self* at the age of 28, as a senior registrar for the NHS (the youngest to hold that rank in Britain at that time, Laing, 1985). Previously Laing had been training as a psychiatrist in the British Army, administering, ordering or assisting in a range of treatments for psychiatric patients, from insulin injections, electric shocks, lobotomies, induced comas to straitjackets and padded cells. During this training Laing began to question the benefits of those treatments, writing:

> *I was just beginning to suspect that insulin and electric shocks did more harm than good. In fact, I had begun to have to call into question my own sanity, because I was beginning to suspect that insulin and electric shocks, not to mention lobotomy and the whole environment of a psychiatric unit, were ways of destroying people and*

driving people crazy if they were not so before, and crazier if they were (Laing, 1985, p. 98).

Getting too close.

An incident with a *manic* patient who was raving in a padded cell was perhaps the impetus for Laing to consider other ways to help his patients. Laing, on one late-night shift, had ordered an injection if this patient did not quieten down. Laing had the cell opened and sat down for a while to listen, whereby the patient calmed down. Laing began to visit the patient nightly, *hanging out* with him, relaxing in his company without bothering to diagnose or to make sense of it. After some weeks this patient became calm and reflexive, eventually being discharged from the ward and the army (Laing, 1985).

Later, as a senior registrar in the NHS, Laing was warned against getting too close to his patients. His office, a newly set up interview room, had a desk and chair, with two armchairs for the patient and a possible other person. Instead of sitting in the chair behind the desk, Laing sat in the armchair next to the patient. Laing was called into his superiors office (who had heard of Laing altering the usual patient/psychiatrist set up) and offered advice, that although Laing was seen to be very interested in his patients, he was warned - “don’t get too close to them” (Laing, 1985, p. 142).

During a seminar with senior staff members of a psychiatric unit in London Laing was questioned regarding his approach.

Questioner: Dr Laing, I am told that you allow your schizophrenic patients to talk to you.

Dr Laing: Yes, I do.

Laing remarked that “you could have heard a pin drop” (Laing, 1985, p. 142)

The influence of *Big Pharma*?

Laing’s practice was seriously against the grain of psychiatric doctrine of his time. Psychiatric unit’s administered psychiatric drugs to inhibit and suppress verbalisation of the schizophrenic processes. Laing was going in the opposite direction, scrutinized as “fanning a

fire to life at the same time as trying to blow it out" (Laing, 1985, p. 143). At this time there was a surge in pharmaceutical drug use for mental health conditions, including psychosis and schizophrenia. For example, the drug chlorpromazine first appeared in 1952 as a tranquilliser reporting to control agitation and excitement. By 1956, chlorpromazine (also branded as Thorazine) was being widely prescribed by psychiatrists in Europe and North America for schizophrenia, perhaps reflecting the pharmaceutical company Smith Kline & French's persistent marketing campaigns (Haddad, Kirk & Green, 2016).

Figure 9: Thorazine advertisement, 1962.

Whilst Laing did not negate the need for drugs to help alleviate the pain of those in distress, he was concerned that the focus of treatment had tipped too far in favour of diagnosing a disease (that required medicating) over psychotherapeutic interventions and this was a serious problem. Laing argued that a human being can be seen from different points of view, as a complex physical-chemical system or a complex human being with a unique (existential phenomenological) experience of the world. We can either engage with an organism or a person, in the first instance we may be listening for symptoms to enable a diagnosis, and the second to get to know the person, their desires, fears, hopes or despair. Each focus determines our attention and the results attained (Laing, 1990).

Attending to underlying causes of mental health distress.

The Divided Self presented schizophrenia, not as a disease, but as a human being's way of coping with life as they find it. Which, given the *disease* of schizophrenia was/is based on a consensus of a cluster of symptoms, not biological evidence (there is still no biological marker for schizophrenia or psychosis (Harrington, 2019), Laing's statement still stands. The text offers one an opportunity to step into the world of a schizoid state of mind and comprehend the underlying mental state of observable behaviour and symptoms and a detailed account of a development into madness. Taking on board what one may learn from *The Divided Self*, a therapist may then approach a psychotic client with a field of reference. However, Laing stated that one can know all there is to know about the psychopathology of schizophrenia "without being able to understand one schizophrenic" (Laing, 1990, p. 33).

Engagement with a psychotic client, Laing (1990) believed, required the therapist to **"**enlist all the powers of **every aspect of themselves in the act of comprehension** (p.32). Further, when sitting with a schizophrenic patient, "**the therapist must have a plasticity to transpose himself into a strange and even alien view of the world. In this act, he draws on his own psychotic possibilities, without forgoing his sanity. Only thus can he arrive at an understanding of the patient's *existential position***" (p. 34). In reference to my research question, how did Laing tune into his psychotic patients, I regarded the two criteria, as pointed out by Laing above, to be the foundation of his approach.

As this study is about how Laing tuned into his patients, I focused on the dominant aspects of Laing's approach and the way I envisaged, he was able to apply himself to embody the

above criteria. Initially, I found studying Laing's biographies and autobiographies the most useful. I focused on three strands of Laing's history; his childhood and innate nature, his experiences as a psychiatrist and his psychoanalytic training. During his psychoanalytic training, and undergoing a training analysis, Laing was assessed by Charles Rycroft and found to be a schizoid type with intact defences (Clay, 1996, p.66). These three strands of Laing's self I imagined as *earth-wire's* as presented in this image below.

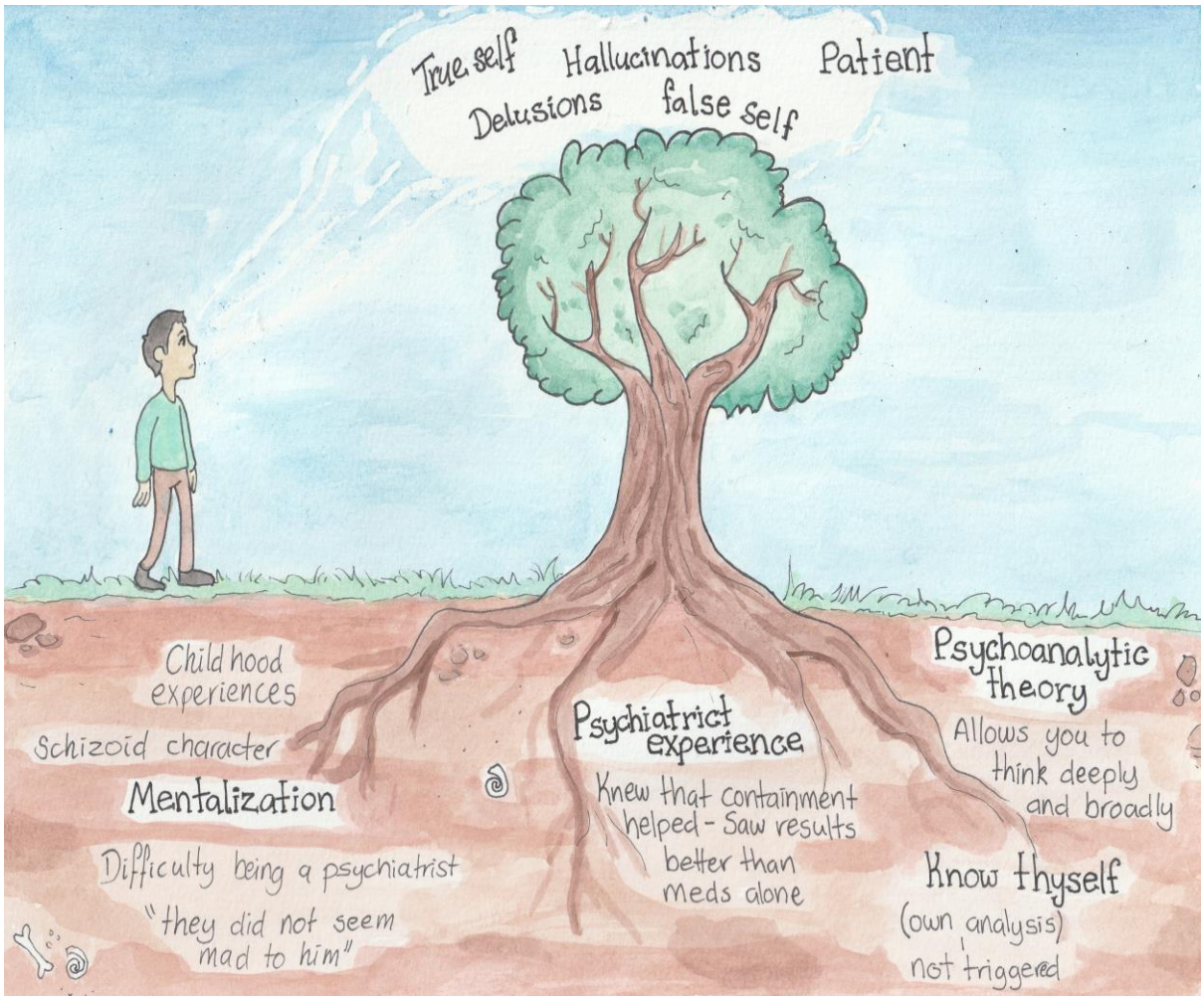

Figure 10. Laing's earth-wires.

How the signals flow on the wires.

The three *earth-wire's* flow in both directions, sending and receiving. They could, for example, be explained as two- way streets where information can flow back and forth, however in Laing's case I believe that they are more than this. In order to form a structure onto what I found around Laing's important ideas of engaging with patients, I have utilised the intersubjective theorist and psychotherapist Jessica Benjamin's (2012) conceptualisations of treatment approaches within the patient-clinician dyad. These

concepts offer insights into the mechanisms of different types of patient-clinician engagement. Benjamin termed these concepts; *doer and done to* (or one-way street), *the two-way street* and the *third space.*

Doer (Subject)----------> Done To (Object/Vase) scenario

Image removed due to copyright issues

(Or one-way street)

Laing (1990) wrote and spoke against a psychiatry profession that was more and more viewing patients as symptoms to be diagnosed. This type of interaction can be viewed as a *one- way street* type of engagement - listening and observing for symptoms of a disease, the patient feeling like a diagnosis rather than a human being. This creates an impasse, which is similar to Benjamin's (2012), concept of the *doer and done to* - a scenario where the patient feels *done to* rather than invited to join a co-created space. This type of engagement has the potential to re-ignite the patient's schizoid defences, against depersonalisation, engulfment and implosion, and is incompatible to forming healthy relationships. This could be mistaken as recovery, for example a quietening down of symptoms, that in reality are dangerous erosions of a capacity to relate. Laing warned against excommunicating the patient who is psychotic or schizophrenic, as they are already doing that themselves (Gilford, 2017).

From my own experience of working with those who have spent, sometimes decades in mental health institutions, I have heard stories of how they painfully felt non-engagement with clinicians. One mental health consumer, *Anne* [6] shared her experience relating to this topic (personal communication, 20th February, 2019):

> *...it was the connection with people that made you better...it's got to be...friendly to me…very difficult thing to climb out of being committed to a long term ward...wish I could have had it all sooner (psychodynamic psychotherapy). Ward 10 at Auckland hospital...I was 16 ½ years old. I didn't know anything, I didn't know what I was feeling.* ***Psychiatrist was hopeless...he barely asked questions...I felt nothing coming from him****.* ***I was lost in the system*** *(at another mental health facility in New*

[6] I have named this person Anne in order to maintain her anonymity.

Zealand)...was not seeing anyone professionally...then they realised I hadn't been seen by anyone, but I was attending the groups!

Being viewed as a diagnosis rather than a person has distressing consequences for the ontologically insecure person, as preserving identity is an effort to prevent losing the self (Laing, 1990).

Two-way traffic - Either I'm crazy or you are.

Clinician------>
<-------- Patient

Laing pointed out that an absolute prerequisite to working with psychotics is the ability to orientate oneself as a person in the other's scheme of things, rather than only to see the other as an object in one's own world (Laing, 1990). Thinking in terms of his world/my world is also <u>not</u> compatible to comprehending his *existential* existence (Laing, 1990). "To recognize that the object of our feelings, needs, actions, and thoughts is actually another subject, an equivalent centre of being, is the real difficulty" (Benjamin, 2012, p. 92). The recognition of another mind that can be felt with, yet has a distinct, separate centre of feeling and perception, is a crucial developmental attainment for clinicians (Benjamin, 2012). Laing (1990) emphasised the critical importance of this attainment that "one should be able to see that the concept and/or experience that a man may have of his being, may be very different from one's own concept or experience of his being" (p. 26). Further, that an absolute "prerequisite to working with psychotic patients is that the clinician re-orientates themselves to the patient's world-of-being, without prejudging who is right and who is wrong" (Laing,1990, p. 26). However, as Benjamin suggests "two subjects, mutually influencing each other, may each feel their perspective is right 'either I'm crazy or you are' and this can be confusing" (Benjamin, 2012, p. 95).

The Third space.

------ > you & me < ---------**"The therapist must have a plasticity to transpose himself into a strange and even alien view of the world...only thus can he arrive at an understanding of the patient's *existential position***" (Laing, 1990, p. 34).

So how does a practitioner grasp the *two-way street* directionality and not fall into the trap of the confusing *two-way street*? Benjamin (2012) asserts we need to move into a processing centre of the *third space*. The *third space* is an intersubjective mental space that facilitates a certain letting go of the self to take in another's point of view or reality (Benjamin, 2012). In Laing's terms "a plasticity to transpose oneself into a strange and alien view of the world" (Laing, 1990, p. 34). To sustain connectedness to the other's mind while accepting this separateness and difference requires a surrendering. Surrender implies freedom from any intent to control or coerce - surrender is not to someone but letting go into being with. Benjamin thinks in terms of the *third space* as a quality or experience of intersubjective relatedness, that has as its correlate in a certain kind of internal mental space. This is closely related to Donald Winnicott's idea of a transitional space or a space of potential (Benjamin, 2012). I felt this also correlated somewhat to Freud's free association method with his neurotic patients. In Freud's approach the analysand (patient) speaks freely and openly whilst the psychoanalyst surrenders themselves to an evenly suspended attentiveness, a meditative frame of mind more akin to Buddhism than psychiatry (Bollas, 2001).

As Laing stipulated, the way we attend to, the way we treat each one another is the therapy (The road to no town, 2018)[7]. Significantly, the consequences of building a professional-patient engagement from this *third space* is the greater possibility of gaining from a patient a history of *their-self*, whereby psychotic symptoms can become explicable, and not what a psychiatric history usually is in these circumstances a "history of the false-self system" (Laing, 1990, p. 148). As Laing asserts "the mad things said and done by the schizophrenic will remain essentially a closed book if one does not understand their existential context" (Laing, 1990, p. 17). Laing stated that the therapeutic task was to make contact with the true, original self of the individual. Which we must believe is still a possibility, even running the risk of translating the actively psychotic patient's language into one's own rather than an account in schizophrenese (Laing, 1990).

[7] I would argue that Laing's emphasis on the relational aspects of his therapeutic approach pre-dates by more than three decades Stolorow and Atwood's theory of intersubjectivity, 1996.

Earth-wire resources, Shamanism & Psychoanalysis, Know thyself, Mentalisation.

In a TV interview on *The Signature* series, Laing declared that he too had experienced mentally distressing states of being.

Image removed due to copyright issues.

I think it's true that some people blow it...they go over the hill...they go into the wilderness, lose their bearings...become completely dis-orientated...don't know who they are.

Now, I've been in a certain amount of that territory myself, without being labelled insane.

And I can sometimes, sometimes, when someone has gone over the hill and got lost over there, I can sometimes go out...and hunt for that person and find them...where they've got to, and meet them there, and say, do you want to come back (Gilford, 2016).

Figure 11. Laing's discloses his experience of psychotic territories

******

Dorothee von Grieff resided at Kingsley Hall (1968-1969) comments below on her experience of being a patient with R. D. Laing.

Image removed due to copyright issues.

Ronnie Laing was a shaman, he had an incredible gift just to listen, to be in the present, to tune into the other person's world and experience, and I had never met that before (Our daily read, 2012).

Figure 12. A first person's experience of Laing's therapeutic presence, as Shamanic.

Laing's willingness and courage to retrieve lost souls/stretch himself into the psychotic world of his patients, was acknowledged and admired by his patients. Their experience of him as having Shamanic like qualities I felt warranted investigation.

Shamanism and psychoanalysis.

I found features from Laing's past, (his ontological, childhood insecurities, schizoid nature, his disclosure of having been in mentally distressing territory, his ability to get so close to the schizophrenic experience in his writing), common to that of shamanic pre-initiation states found across cultures. These states include nervousness, extraordinary dreams, trance states, states of derangement and extreme distress. Innately, candidates are "disposed to extreme introversion, whose unique inner experiences affect a radical separation between him and his fellows" (Sandner, 1996, p. 20). Shamanic candidates have a lengthy training processing these pre-initiation states to a stage of finally demonstrating mastery over them - only then are they seen as functioning shamans (Merchant, 2011, p. 2). Put another way, encountering their own shadow during the process of initiation enables them to "penetrate the darkness of the soul and battle dis-ease" (Sandner, 1996, p. 23). Likewise, a psychoanalytic practitioner also undergoes a lengthy training to face their own shadowy aspects through their own analysis.

Shamans and psychoanalysts focus on the healing and growth of the psyche, building a connection with what may be termed a "separate space to which the psyche has access" (Sandner, 1996, p. 5). In shamanism this separate space is known as the world of spirits, in psychoanalysis the deep unconscious. I found common ground in the application of this knowledge. For example, in psychoanalysis we understand that unconscious material is being communicated through the mechanism of transference and countertransference. The patient transfers feelings and thoughts of a relationship from the past onto the analyst. The analyst, aware through his thoughts and feelings that something is taking place, is able, from his observing ego, hypothesize (think about this), able to *digest* this for the patient and if appropriate, offers an interpretation. This ability of acutely sensitive discernment is grown through the psychoanalytic training stage in undergoing several years of analysis. Likewise, in shamanic terms, having gained mastery over their own *psychic infection*, gains what may be termed, an *immunisation*. The sufferer can transmit their *disease* to a protected, immunised, healthy person, who is able to subdue the infection (Sandner, 1996).

The distinction of being able to discern what is the analysts and what is the patients, in terms of thoughts and feelings is an acquired skill and is necessary in order not to get caught up in what is being projected.

Make sure you stay in your lifeboat.

As Laing points out in this BBC radio interview, *In the Psychiatrists chair (*excerpt below), *being with* does not mean *joining* a psychotic patient. The clinician requires the ability to "transpose himself into a strange and even alien view of the world……without forgoing his sanity" (Laing, 1990, p. 34).

> **Interviewer**: One of the things I wondered was the extent to which - that old adage that senior physicians used to go on about...not getting too close to the patient in psychiatry…
>
> But the truth that was supposed to be at the heart of it was, that if you did enter into what you've called the *Gongaata of the spirit*[8]*,* it could destroy you, that in a sort of way you could be overwhelmed by that which you were there to try in some detached sense to cope.
>
> **Laing**: I've never been personally tempted to follow someone over the edge.
>
> **Interviewer**: You haven't?
>
> **Laing**: No, I don't like distracted and disordered and confused and bewildered... states of mind, I do not like them at all. I'm very sorry for someone who's trapped in a state of mind like that, but I've no desire to share it. You know the best way to get to a drowning man, to rescue him, is not to fall into the river or the sea oneself but to stay in the lifeboat (Clare, n.d.).

[8] Gongaata: meaning din, hubbub or clatter (English - Marathi dictionary) (https://www.shabdkosh.com/dictionary/english-marathi/gongaata/gongaata-meaning-in-marathi

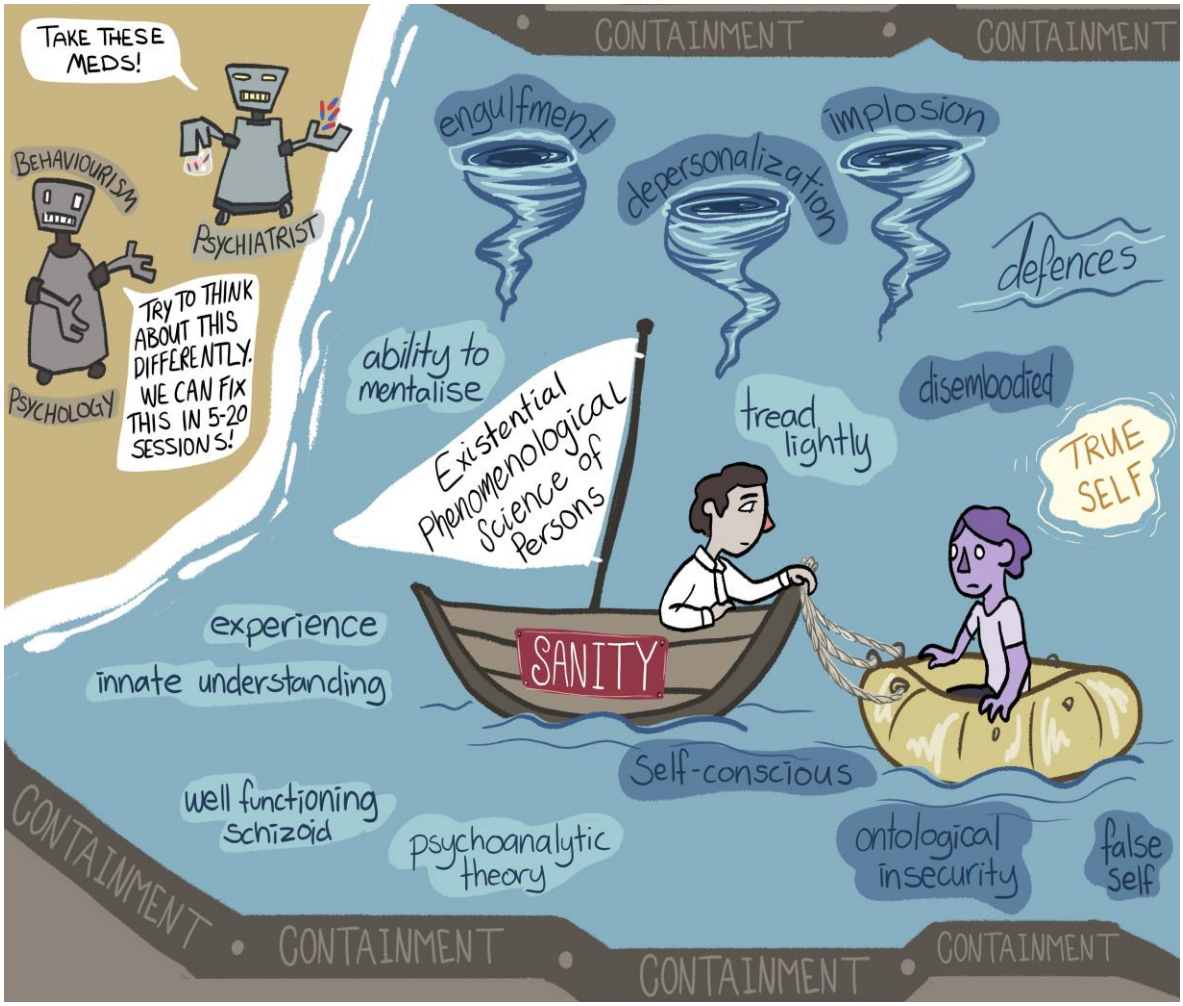

Figure 13. Stay in the lifeboat.[9]

Mirrors of experience.

".....enlist all the powers of every aspect of themselves in the act of comprehension" (Laing, 1990, p. 32).

Know Thyself - The core aspect of psychoanalytic and psychodynamic training.

Not an easy task for a clinician to be in confronting or bewildering waters of experience. However, having a frame of theoretical psychoanalytic reference externally, and internally through experience (and having worked through that experience in analysis), Laing could

[9] The Psychiatrist and Behavioural figures I have portrayed here are not aimed to represent the *people* who offer psychiatry and CBT, but rather I am trying to show a sort of programming of treatments in an overwhelmed mental health system that results in patients feeling like a diagnosis rather than a person and wanting to have a service that responds to the trauma that underpins their symptoms (Ara Oranga, 2018).I recognise the potential value of medication and behavioural sciences in the context of a multidisciplinary team approach to treating psychosis.

find his bearings, and this is a foothold for the patient. Laing attended a five day a week analysis for 4 years with Charles Rycroft at Tavistock, London. Attending to your own analysis is core to becoming a psychoanalyst and has a two-fold purpose; firstly, facilitating a deep understanding of one's unconscious mental life and secondly assists working through unconscious problems or difficulties you might have that would interfere with your ability to work effectively as a psychoanalyst. The core conviction for a requirement to undertake one's own analysis is that to understand the unconscious minds of others, you must first understand your own (Institute of psychoanalysis, n.d.). In growing a capacity for discernment, messages that come from the patient can be accepted as pieces of a puzzle that sit in a psychoanalytic theoretical framework. Theory offers mental maps that can be brought to the fore, offering a foothold for the clinician in whatever territory they find themselves in.

Mentalisation.

Laing, having to navigate a troubled childhood, diagnosed as schizoid with intact defences and admitting having been in psychotic territory without being termed insane, would have had, according to Bateman and Fonagy's (2007) criteria below an exceptional mentalizing capacity for tuning into psychotic and schizophrenic patients. One of Laing's patients offers evidence of this, relating:

> *Meeting you made me feel like a traveller who's been lost in a land where no one speaks his language. Worst of all, the traveller doesn't even know where he should be going. He feels completely lost and helpless and alone. Then, suddenly, he meets a stranger who can speak English. Even if the stranger doesn't know the way to go, it feels so much better to be able to share the problem with someone, to have him understand how badly you feel.*
>
> *If you are not alone, you don't feel hopeless anymore. Somehow it gives you life and a willingness to fight again (Laing, 1990, p. 165).*

According to Bateman and Fonagy (2007), the capacity to imagine what others are thinking and feeling from our own histories and capacity to imagine, is the concept mentalisation. Mentalisation describes the effort an individual makes to understand other people in terms of their thoughts, feelings, wishes, beliefs, desires, their (strange and alien) subjective world (Bateman & Fonagy, 2007). From my own clinical experience, I have found that the greater

the alignment of one's personal history to another's person's personal history, the greater the potential for a deeper empathetic relationship.

For example, if you had been in a car crash, slipped on ice, lost a loved one, were once a restaurant chef, a mechanic, an ambulance driver - anyone who has this in common with you will have deeper knowing (embodied, emotional, cognitive, empathetic) and resonance with you far more than those who do not share this particular history. If we transfer this to the psychotic patient, whose character foundations are schizoid, as Laing's was, there is a capacity to mentalise to a much greater degree than a non-schizoid clinician. Delving deeper into the concept of mentalisation, there are similarities to Donald Winnicott's notion of carer/infant mirroring (Fonagy et al, 2004, cited in Smith, 2014). According to Winnicott (1963a, cited in Smith, 2014), from our very earliest experiences, in the mother-infant bond, the *good enough* mother responds favourably to the infant's behaviour and feeling states in their absolute dependency. The mother, providing a reflective holding environment for the infant, sees themselves mirrored in the mother's eyes and this enables them to know that they exist (Smith, 2014). From a therapeutic relational perspective, if the analyst has the capacity to mentalize the patient's distress, the patient finds a mirroring response, they can find themselves recognised in the mind of the analyst. This sense of being located somewhere, a home for their mind/being, is essential to avoid psychic homelessness and the disorientation that accompanies it (Spezzano, 2012).

The myth.

As Bateman and Fonagy (2007) state, crucially, if we have the capacity to understand and mentalise a schizophrenic patient's behaviour in terms of the thoughts and feelings that give rise to it, this offers a sense of meaning - behaviour becomes meaningful. As I have already discussed, Laing disputed the myth that clinicians should not speak to schizophrenic patients and instead searched for meanings and clues to understand how his patients came to be so mentally distressed. In my search for theoretical foundations and research that underpin Laing's approach, the writings of Sigmund Freud, Carl Jung and Bruno Bettelheim offered clarity.

Exploring theoretical foundations for Laing's approach. Freud, Jung & Bettelheim.

Adapting Freud's psychoanalytic ideas.

Freud (1986) wrote that "it was discovered one day that the pathological symptoms of certain neurotic patients have a sense. On this discovery the psychoanalytic method of treatment was founded...the sense of dreams prepares the study of the neuroses....and dreams are a neurotic symptom" (p. 111). As Freud noted our ancestors and all the peoples of antiquity attached great significance to dreams and thought they could be used for practical purposes (Freud, 1986). Laing appeared to transpose this method to apply to his psychotic patients, that psychotic symptoms have sense, and the sense made of the psychotic dialogue prepares for the study of psychosis or the schizophrenic state (the study of what caused the psychotic/schizophrenic state to emerge), as schizophrenese is a psychotic symptom. This suggests that if we can decode psychotic communication, this can be used for practical purposes. Was there any evidence that psychotic communication had any practical basis? I found the research of Swiss psychiatrist Carl Jung suggested there is (Silverstein, 2014).

Jung's theory of complexes.

The Psychology of Dementia Praecox (1907), was the first published work on a psychodynamic conceptualization of schizophrenia. Carl Jung's writings on schizophrenia branched away from the entrenched ideas of the time, that psychotic symptoms were essentially meaningless emanations, and instead demonstrated the psychological significance of psychotic symptoms, including what they could reveal about conscious, unconscious and symbolic processes. Jung theorised that a weakness in the hierarchical order of the ego led to normally inhibited contents of the unconscious entering consciousness. Further, where the central control of the psyche had become so weak, it could neither promote the positive or inhibit negative acts, or vice versa, leading to a fragmentation of psychic functioning into multiple, active independent complexes (Silverstein, 2014). Jung came to his theory of complexes through the *word association test*.

Although first invented by Francis Galton as an instrument to test IQ, Carl Jung was the first to apply this test in clinical psychological studies. As a psychiatrist and researcher at the

Burgholzli Mental Hospital in Zurich, Jung was curious that certain words could delay a response (stimulus and response mechanisms) from his patients, which indicated to him a block in self-expression. Jung hypothesised that certain words could be *triggers* that carried feeling tones associated with these words. Jung called these feeling tones *complexes* (Jungian analysts of Washington association, n.d.).

These complexes, Jung believed, were like clusters of ideas cemented together and emotionally charged. In psychosis, Jung noted, symptoms such as delusions could be viewed as manifestations of complexes. Further, as more and more memories (old and new) become associated with these pathological complexes, more and more of experience is interpreted through this lens rather than the ego complex. In the extreme, the inhibitory function of the pathological complex can become so strong that it can create a disturbance of reality testing. Jung noted that weakness of the ego in schizophrenia was not generalised, as in intoxicated states, but rather limited to those aspects of mental functioning that were influenced by complexes. An implication of this is that there will be areas of preserved reality testing, and other aspects of psychic life in schizophrenia, despite the presence of symptoms (Silverstein, 2014).[10]

Therefore, if schizophrenic communication links to an emotional complex, listening may provide a way into comprehending the nature of the disturbance. For example, this interaction between Laing and his patient Julie. In her psychosis she called herself Mrs Taylor:

> **Laing**: what does this mean?
> **Julie:** I'm tailor-made, I'm a tailored maid; I was made, fed, clothed and tailored (Laing, 1990, p. 192).

The history of this patient was that in her family unit, Julie was not simply trying to preserve her existence, but trying to *achieve* existence. Her mother was prepared to accept a

[10] Neuroscience research has recently demonstrated the series of events that Jung had researched, for example; weakening of the ego, complex formations that compete for control in the psyche. The reader is directed to Silverstein, 2014 to further investigate.

compliant, “false self” daughter and “to love this shadow….tried to order this shadow to act as though it were a person, never recognising the real, disturbing, presence in the world of a daughter with her own possibilities” (Laing, 1990, p. 193). In describing herself as Mrs Taylor, in a concrete way, the patient was accurately describing her dilemma using her own terms of reference.

Another patient of Laing spoke in terms of their fragmentation: “Her other self she might call ‘her’ and this ‘her’ is still ‘me’, she is an ‘I’ looking for ‘me” (Laing, 1990, pp. 158-9). Laing asserts that fragments of the self generally seem to retain the sense of the ‘I’, the other self is the basis of an hallucination. “The hallucination is an as-if perception of a fragment of the disintegrated other self by a remnant retaining residual I-sense. This becomes more apparent in manifestly psychotic patients” (Laing, 1990, pp. 158-9). The task of therapy is to make contact with the original self of the patient (and believing this is possible) which needs help in being nursed back to a feasible life (Laing, 1990).

Dr. Bruno Bettelheim – dynamic processes of a disturbed mind.

Another psychoanalytic writer and holocaust survivor, Dr. Bruno Bettelheim, offered an account of the dynamic processes of a disturbed mind and a rationale for tuning into the patient’s dialogue.

The unconscious overwhelms the ego and such direct chaotic contact weakens it. This chaotic content needs to be externalised and projected. The patient has to externalise the inner processes if they are to gain any grasp, not to mention control of them. The patient must somehow distance themselves from the content of their unconscious and see it as something external, if they are to gain any mastery over it. As the analyst (working with the delusions and hallucinations of the patient - my interjection), listens and makes meaning out of the mirrors of the patient’s inner experience, and not reality, the patient understands them. If the patient is only drawn to the reality of a situation then important parts of his inner reality, that are trying to be communicated from the inner world, are lost, are felt to be unacceptable and are not worked through - and the true self connection is once again lost (Bettelheim, 1976).

Blocked signals.

What happens when a clinician can't mentalize?

Fonagy and Bateson (2007) state that we may not have the capacity, imagination or perception to mentalize another mind/person. "It is a profoundly social construct, in the sense that we are attentive to the mental states of those we are with, physically or psychologically. Equally we can temporarily lose awareness of them as 'minds' and even momentarily treat them as physical objects" (p. 3). In, *The Divided Self,* Laing offered an example of this objectifying stance, in a lecture given by Emil Kraepelin (1856-1926, pioneer psychiatrist, classifying mental dis-ease and founder of modern psychiatry) which I provide below. I would argue that Kraepelin's mis-attunement[11], or non-mentalisation, disabled his capacity to connect with his patient, let alone decipher the meaningful properties that the patient was trying to communicate.

In a lecture theatre, surrounded by his students, Emil Kraepelin interacted with a schizophrenic patient. The patient, described as a strongly built 18 year old male with pale complexion, sat on a stool. With his eyes shut the patient replied to Kraepelin's question; if he knew where he was? The patient replied, "You want to know that too? I tell you who is being measured and is measured and shall be measured. I know all that, and could tell you, but I do not want to" (Kraepelin, 1905, cited in Laing p. 29). Kraepelin asked the patient's name. The patient replied, "What does he shut? He shuts his eyes...Why do you give me no answer? Are you getting impudent again? You don't whore for me?" (Kraepelin, 1905, cited in Laing 199, p. 29)

Kraepelin concluded to his audience that, "although he (the patient) undoubtedly understood all the questions, he has not given us a single piece of useful information. His talk was...only a series of disconnected sentences having no relation whatsoever to the general situation" (Kraepelin, 1905, cited in Laing, 1990, p. 30). Laing countered Kraepelin's

[11] I felt it useful to expand on what this word fully conveys. The APA dictionary definition of mis-attunement is: 1. a lack of rapport between infant and parent or caregiver such that the infant's efforts at communication and expression are not responded to in a way that allows the infant to feel understood. 2. In psychoanalysis, a lack of empathy by a therapist or analyst toward a patient.

account, arguing that the patient is "resenting this form of interrogation which is being carried out before a lecture-room full of students" (p. 30) and not willing to prostitute himself for Kraepelin before a classroom of students. (Laing, 1990)

When Laing listened in for the experience of the patient, he found meaning could be made, whereas Kraepelin's focus blocked any of these signal's reception. Similarly, Eugen Bleuler (1857-1939, psychiatrist who coined the name schizophrenia) remarked that "...they (psychotic patients) were stranger to him than the birds in his garden" (Laing, 1990, p. 28). This has consequences, where the scientific objective *look* stands opposed to the empathic approach, one cannot move into an empathic mode. "To try to find understanding within that way of looking" Laing once remarked, "is like trying to buy a camel in a donkey market" (Thompson, 2015, p. 71).

Exacerbated by psychiatric training?

In trying to ascertain the basis for psychiatrists who may struggle to mentalize another's mental distress I found, perhaps, exacerbated by a psychiatrist's training. Freud (1986) stated that, in medical training you are accustomed to *see* things:

> *You see an anatomical preparation, the precipitate of a chemical reaction, the shortening of a muscle as a result of the stimulation of nerves. Later on, patients are demonstrated before your senses - the symptoms of their illness, the products of the pathological process and even in many cases the agent of the disease in isolation. Through medical training the emphasis is on the observable, the symptoms of illness, the pathological process…the medical teacher plays in the main part leader and interpreter who accompanies you through a museum, while you gain a direct contact with the objects exhibited and feel yourselves convinced of the existence of the new facts through your own perception (p. 44).*

Freud contrasted this to psychoanalysis where only interchanges between patient and analyst take place, and this cannot be demonstrated. Further, although a patient may be introduced to a psychiatric lecture and describe his symptoms, what concerns his most intimate mental life requires a special emotional attachment to the doctor. One cannot learn psychoanalysis by being lectured to, what is required is a study of one's own personality. Through the process of an analysis one not only experiences its effects but also the techniques of one's own analyst (Freud, 1986).

Chapter 7

Discussion

As I discussed in Chapter 2 of this study, Dr. R. D. Laing entered the psychiatric profession in the 1950's during a radical time of transition. Antipsychotics were being introduced as a treatment for schizophrenia, alongside an aggressive marketing campaign by pharmaceutical companies. Soon, using medication to suppress the symptoms of schizophrenia and psychosis became the treatment of choice. Laing found himself *at odds* with his profession. Although he was not against medication *per se*, his core approach was getting to know his patients, listening and speaking to them, attempting to find out how they found themselves in such distressed states of mind. Laing offered his findings in *The Divided Self,* the purpose of which was to make the process of going mad comprehensible to his colleagues and those affected by it.

In my research I discovered that Laing's capacity to tune into his psychotic and schizophrenic patients was drawn from many quarters. My results focused on three strands that I named his *earth wires*. The first strand was Laing's ability to mentalize the schizoid state of being (the foundational characteristics of those who develop schizophrenia). This capacity can only come from a history of complementary experiences to that of the patient or an innate knowing. Laing had both, he had been in psychotic-like territories without going insane and had been diagnosed as a schizoid type with intact defences. Laing could enlist his mentalizing capacity of the schizoid state in the act of trying to comprehend his patients. Laing's patients describe how this felt when he was with them:

> as a shaman who could tune into another's world
> like a stranger who could speak their language
> someone who they could share their problem
> could understand how badly you felt
> you are not alone
> you don't feel helpless anymore
> it gives you life and a willingness to fight again

The second earth wire held Laing's experiences as a psychiatrist in the British army and psychiatric wards, gaining first-hand knowledge of the treatments available to psychiatric patients and how this affected them. Laing administered, ordered or assisted in a range of treatments to alleviate the suffering of his patients. However, as time went on, he began to question the benefits of electric shocks, lobotomies, induced comas, insulin injections, straitjackets and padded cells and seemingly stumbled upon an alternative. After spending many nights sitting, listening and talking to a manic patient in a padded cell, without trying to diagnose him or do anything to him, the patient was able to be released from care a few months later. This strand encompasses the strength and conviction behind Laing's decision to develop this alternate way of treating schizophrenia and his move to train as a psychoanalyst.

The third earth wire is accredited to Laing's psychoanalytic training. This provided a theoretical structure and frame for the depth of his work with schizophrenic patients and his writings on the foundations and processes of madness. Laing also underwent the core process of becoming a psychoanalyst - the experience of being a patient yourself. Laing was inspired by Freud, stating that he was a hero and the greatest of psychopathologists. Freud undertook his own self-analysis, where he descended to an underworld of terrors, carrying "with him his theory as a medusa's head which turned these terrors to stone" (Laing, 1990, p. 25). The commitment to an analysis has been stated as "our greatest professional virtue" (Bollas, 1989 p. 255), the experience of which extolls the integrity of the profession. A core attainment from one's own analysis is discernment and an understanding of one's own difficulties. Further, where powerful feelings are created by patients, a psychoanalytic training analysis builds an ability to discriminate - when those feelings and anxieties and ideas come from your own unresolved problems and when they are linked to what is brought by the patient (Institute of Psychoanalysis, British Psychoanalytical Society, n.d.).

As Charles (2017) writes:

> *Evidence regarding our mirror neuron system...shows how profoundly and directly impacted we are by the thoughts and feelings of others. This evidence affirms the value and validity of the psychoanalytic practice of making use ...of thoughts and feelings that arise in the presence of another person, to inform our ideas regarding what is going on inside them (p. 58).*

Psychotherapist and author Nancy McWilliams (1994) doubt's the effectiveness of therapists who work with schizoid patients, unless they were schizoid themselves or have had in-depth analysis.

Although Laing's approach was deemed controversial, my findings suggest that the ways in which he was able to tune into and listened to his schizophrenic patients have deep, significant relevance. Recent feedback from consumers of mental health systems validate how vital this aspect is in the treatment of mental health patients. Instead of feeling like a diagnosis, consumers said they wanted to be:

> seen as a whole person
> encouraged and supported to... restore their sense of self
> listened to
> taken seriously and have their experiences validated

The Divided Self humanized the process of going mad and facilitated an awareness that underlying causes and a person's history need attending to. My research suggests that psychoanalytic training not only develops our discernment and a mentalizing capacity, but also forms the theoretical structure for mental health professionals to undertake this long term, complex and demanding work.

Although my findings suggest the absolute value of this core aspect of psychoanalytic training it is not an automatic requirement for psychiatrists (or psychologists) in New Zealand. The Royal Australian and New Zealand College of Psychiatrists (2019), at its most advanced level of talking therapies training, offers 2 years of weekly formal education covering four main modalities, dynamic psychotherapies included. The aim of which is to familiarise students with contemporary approaches, supervision and training options and help develop a more sophisticated understanding of psychological and developmental processes in their psychotherapy work (The Royal Australian and New Zealand College of Psychiatrists, n.d.).

As there is no requirement for psychiatrists to attend to the core element of psychodynamic training, the vital process of their own analysis, there is the possibility, I would suggest, they

could be put in a position of trying to work in a modality that they cannot master. There is a difference between knowing about psychoanalysis and being psychoanalysed, knowledge is not the same as experience. Wilfred Bion's concept (Bion, 1965, cited in Eigen, 1988) of the distinction between knowing (K) and being (O) seems to fit here. The patient and analyst are faced with the same goal, wanting to pass on from the wish to know, accept and be thyself, into becoming what these words represent - the gap between x (knowing) and y (being) **is the process** of undergoing your own analysis (Eigen, 1988).

Going through the process of an analysis gives you the experience that things take time to heal and this healing cannot be squeezed into a certain number of sessions - we are not machines. Psychologists who provide symptom based talking therapies in the form of Cognitive Behaviour Therapy (CBT) are generally put in a position to attain results in 5-20 sessions. Psychoanalysis is against these quick fix solutions as it:

> *….. recognises that things take a long time to change, that people take a long time to change at all. CBT has its advantages but has its limitations… psychoanalysis is more open-ended and tries to attend to the whole personality…..that takes much longer, and this is called for, especially for more intransigent problems..(Institute of Psychoanalysis, British Psychoanalytical Society, n.d.).*

Dr. David Bell, who has led a specialist mental health outpatient service for the treatment of adults for 15 years (The Fitzjohn's Unit, London) states that enduring and severe mental health problems usually have their **origin in early life**. These patients require a long-term *whole person* approach and continuity of care, not brief treatments that focus on symptoms. The current expectations in mental health settings require patients to recover in weeks and return to their communities (Bell, 2018).

Implications for practice.

My research suggests the importance of psychoanalytic and psychodynamic therapists working with schizophrenic patients and those experiencing disturbed mental states. Schizophrenic patients need a container that can contain without falling apart or resorting to suppressing/medicating symptoms. Psychoanalytic training provides a specialised theoretical knowledge that helps decipher the complex mechanisms involved in a patient-analyst interaction, for example projection, introjection, transference and

countertransference. This offers the analyst a foothold in whatever territory they find themselves in. This foothold offers grounding and stability for the analyst in their containing function. Secondly, the analyst undergoing an analysis (being a patient themselves) entails the experience of venturing to the edges of one's own psyche. Having gone through this experience, the analyst can offer to patients a depth of mentalisation and mirroring that cannot be taught or learned from books.

What about the environment/families?

A few years ago, I sat next to a psychiatrist at a film presentation given by The International Society for Psychological and Social approaches to psychosis (ISPS). The film was based on a true story of how an individual processed his schizophrenia. Before the film started, we introduced ourselves to each other, including what we did professionally. With hardly any words passing between us the psychiatrist stated to me that "we don't blame the parents", a little shocked at this declaration, I was not able to reply as the lights dimmed for the start of the film. The film told a story of a childhood trauma that was slowly brought to the light of day.

It is concerning that psychiatry might think of psychoanalysis and psychodynamic practitioners as "parent blamers". There has been some controversial press over the years that might account for this stereotype. For example, "the refrigerator mother" was a term first proposed by psychiatrist Leo Kanner in the 1940's, later popularised by the research of Dr. Bruno Bettelheim. Bettelheim proposed that mothers who withhold affection, were emotionally frigid, cold and detached and incapable of nurturing their children caused autism (Ennis-Cole, Durodoye & Harris, 2013.) As time passed, Bettelheim's theory was refuted, but the stigma of psychoanalytic research and indeed therapy as "parent blaming" may have a long reach.

During the writing of this dissertation I have thought much about what gets passed on in families, and the notion of intergenerational trauma. How might we account for the early trauma history of these patients? Would families not also benefit from exploring and processing their own past traumas and would they not welcome help to tune into their children in better ways if this had been disabled due to their own trauma?

Psychoanalytic & psychodynamic therapies available in district and community mental health?

Our mental health statistics are only getting worse (Office of the Chief Coroner of New Zealand, 2019) and we are into our second New Zealand mental health inquiry since 1996, and little progress was made after that one (He Ara Oranga, 2018, pp. 8-9). My wonderings are what savings could be made if we provided the long-term treatment necessary for the processing of the underlying causes of mental distress. My concern is that the government may pour their resources into increasing a workforce that specialises in short-term symptom-based talk therapies and not include a workforce that **specialises** in attending to underlying causes that offer long term solutions.

In the 2018 New Zealand Government inquiry into mental health and addiction, people complained that:

> ...the biomedical approach fails to see **the whole person...does not address their overall life circumstances or their personal histories, traumas and challenges.**
>
> Workers at all levels of the system **questioned the effectiveness of current clinical practice models**.

The inquiry responded:

> Although medication can often be necessary and life-saving, we also need comprehensive services that mean people's mental health can be looked after fully – this would involve **root causes of issues being explored**. (section 2.2.2).

Relating to trauma:

> Many submissions highlighted **trauma in childhood as the origin** of mental distress and the trigger for counterproductive coping mechanisms such as addiction. Health services responding to mental distress need to get better at acknowledging and **responding to the trauma that underpins 'symptoms'**, rather than merely offering ways to 'dull the pain'. (section 2.5.4).

Choice of therapies:

> **People want a choice of therapies.** A critical element to build and improve our mental health and addiction services is to develop a broader range of services to provide **more choice** for people seeking help. **We believe** one of the priorities must be to broaden **access to evidence-based talk therapies (**4.3.1). (Evidence-based usually refers to Cognitive Behaviour Therapy or CBT).

Patients with severe and complex needs:

> Psychologists and skilled nurse specialists may need to directly provide therapies for people with more **severe and complex needs** and will play an important role as members of multi-skilled and multicultural intervention teams (4.3.2).

As my research suggests, severe and distressed mental states require long-term treatment that attends to underlying causes, from practitioners who are trained in this approach. As Murray Jackson[12] (2001) writes:

> *Cognitive-behavioural work with psychotic patients...attempts ultimately to manipulate the patient in order to make him or her stop having delusions, without investigating the person who suffers the delusions or the dynamic reasons why he or she has found it necessary to prefer psychotic explanations to rational ones. At worst it could become a purely empirical and sterile exercise with disappointing long-term results. At best the enormous investment that has gone into understanding conscious mental processes could link up with established psychoanalytic knowledge to produce something original and valuable (p. 51).*

Although psychoanalytic and psychodynamic therapists could be part of a solution they are employed in very small numbers in the New Zealand Mental Health system. Currently there are only 19 psychotherapists (psychoanalytic/psychodynamic) employed across physical (4) and mental health (15) services. This compares to approximately 160 psychologists (approximately split 80/80 across physical and mental health), (V. Watt, personal communication, September 28, 2019).

Limitations.

A limitation of this study is only researching one theorist. However, studying one person in-depth (the individual person in all their uniqueness) is in line with a psychoanalytic process, which utilises the case study method of research. This was also necessary due to my desire to focus on the richness and depth of Laing's writing. Nevertheless, I am aware this is just one voice. I did consider at the start of this research, a range of psychotherapy authors who specialise in writing on this topic, such as Franco De Masi, Anne Alvarez, Ira Steinman and

[12] Murray Jackson was Emeritus Consultant Psychiatrist at the Maudsley Hospital, London and a psychoanalyst with long experience of the treatment of patients with psychosis (Jackson, 2001, p.9).

John Reed, however, I could not expand on their valuable contributions as this would have been outside the scope of this dissertation.

Also, I have reflected on the notion of idealisation. I have admired Laing for all the reasons I have written about and perhaps because of the similarity of his approach to the one I received in my lived experience. I am not imagining Laing as an omnipotent hero, as he had his own issues, and did not pretend to have all the answers, instead, listening in order to understand. But I do regard him as an important figure head with theories that are worthy of far more investigation. Alvarez (2006) suggests that idealisation of this sort offers, what she terms, a *potent security,* enables us to develop a sense of live agency and growth in our work.

Direction for future research.

Laing believed that an existential-phenomenological foundation for a science of persons was a necessary research approach for "the understanding of a person's experience of his world and himself. The mad things said and done by the schizophrenic will remain essentially a closed book if one does not understand their existential context" (Laing, 1990, p. 17). As a research method, De Masi (2015) stresses the importance of psychoanalysis, as there is a focus on the unconscious functions of the mind as its primary instrument and object of study. Its practice contributes an important perspective on both psychopathology and human development in general. De Masi (2015) states:

> *In my opinion, deeper investigation into the field of more complex psychopathologies might represent a possible development direction for our discipline, since they provide opportunities for exploring unusual dimensions of the mind and intimate connections between emotional development and environment (p. 141)*

Why should we research psychopathology from a psychoanalytic and psychodynamic perspective?

Modern day psychiatry was founded on Emil Kraepelin's work in the early 20th century. His core belief was that the brain held supremacy over any other human structure and so searched for biological factors rather than the mechanisms of disturbed mental states. This led to a psychiatry without a psychology. With the hope of later discovering a biological

foundation for his work (which never eventuated), he focused on observing many thousands of cases, in an attempt to delineate the form and content of psychosis. His research method was to collate through an index card system a condensed version of information gathered on each case. Kraepelin's research method has a familiarity to the contemporary interpretive method of thematic analysis, as he collected larger or smaller group's clinical characteristics into subtypes to define them more precisely. By examining the numbers, Kraepelin gained criteria for two main categories of disorder, dementia praecox (later named schizophrenia) and manic-depressive psychosis. Kraepelin later conceded that his research methods carried a strong subjective rather than objective element in their procedures but could not spare the time to substantiate his opinions, hoping that his students would eventually fill the gaps. Contemporary scientific researchers would view Kraepelin's method and results as unacceptably flawed (Shepherd, 1995).

The foundations for the diagnosis of schizophrenia and psychosis are based on Kraepelin's methods of a classification of symptoms, for a disease that is yet to be found. Freud noted that psychiatrists, "in their favourable moments had doubts themselves whether their descriptive hypotheses deserved the name of science, as nothing is known of the origin, the mechanism or the mutual relations of the symptoms of which these clinical entities are composed" (Freud, 1986, p. 45). Kraepelin acknowledged during his career there was a need to study mental disorders from a psychological perspective, research that inquired into influences and causes. He stated that there was a great importance in researching the "original mental make-up of the individual, his intellectual development, his temperamental disposition and the qualities of his will, which to some extent, however, can be altered by his conditions of life" (Kraepelin, 1922a cited in Shepherd, 1995, p. 177).

The current focus on behavioural research to evidence cognitive treatments "can prevent us hearing our patients and as a society make us deaf to their and our problems" (Lowenthal, 2006, p. 49). The 2018 New Zealand Government Inquiry into mental health and addiction began their research from a pluralistic paradigm, gathering subjective data from many spheres of society. However, if these experiences are then analysed and processed through a dualistic paradigm, have we gained any ground? The data derived from this government research *could* be explored from a dualistic and pluralistic paradigm. As Bollas (2008) writes,

> Each theory sees something that the other theories do not see...what we gain from the eyes is different from what we take in from the ears. What we perceive of reality through the olfactory sense is different from what we take in from touch... (p. 11).

Bollas (2008) continues, that to follow one theory to the exclusion of others "is as absurd as saying that one must become an advocate of the ear, or an eye-guy, or a touch person, or a sniffer" (p. 11).

Psychoanalytic and psychodynamic therapy is well placed to research the underlying causes of mental distress. This research would offer multiple benefits; generating important knowledge of the aetiology of mental distress, how it emerges and to understand the mitigating environmental factors. Additionally, the data gathered from this type of research would provide government agencies with a targeted approach to their social welfare initiatives.

In addition, it is also apparent that effective psychotherapy can provide economic benefits "after working through difficult issues and gaining insight into their concerns many people use fewer Health Service resources in terms of fewer trips to Accident and Emergency departments, lower reliance on medication and visits to GPs" (Mitchell & Brownescombe Heller, 1999, cited in Milton, 2006, p. 70).

Further research into Laing's approach, theories and therapeutic community.

I would like to develop the avenues of all the plethora of ideas that this study has opened up for me. In particular, to research further Laing's theories of the process of going mad and the role of the therapeutic community. Laing's genius was recognised by many in and out of the establishments that he worked in. His writing on the process of going mad, resonated with the general public, becoming a bestseller that has never gone out of print. However, there is little research into his approach or his work on the process of going mad, or his therapeutic community, Kingsley Hall.

As Wilfred Trotter wrote "if mankind is to profit freely from the small and sporadic crop of the heroically gifted it produces it will have to cultivate the delicate art of handling ideas". On the genius Trotter adds "Let us hope that he will also find an intellectual

environment where even his most revolutionary ideas will be planted in a nourishing soil and bathed in a genial air" (Trotter, 1946, p. 31).

Further research into those who experienced disturbed mental states and were able to survive and thrive.

Recently there was a disclosure by a psychotherapist of a prolonged episode of severe mental distress. This was treated for many years in various psychiatric wards to no avail. What did work was a privately funded, consistent, depth approach that enabled a processing of the underlying causes of this person's psychotic symptoms (Nutters Club, 2019). I would suggest that researching those individuals that are willing to disclose their journey from insanity to wellness may offer insight into a better working model of treatment.

Final reflection.

My final reflection can be aptly summed up by the words of R. D. Laing in an excerpt from one of his many interviews:

> Interviewer: Perhaps what is most astonishing from the story of your therapy, is the fact that it was controversial at all.
>
> Laing: that's the saddest thing about it (Giford, 2017).

Musings.

At the beginning of my research study I wondered why Laing's work had not been expanded upon, several times comments have been made to me that perhaps Laing's work was not originally studied because he was a difficult man to get alone with.

A scenario and image formed in my mind, of a large group of people viewing Van Gogh's Sunflowers, budding artists amongst them. Behind them are teachers and researchers of art, commenting that, as they did not get along with Van Gogh, they would exclude him from the pool of artists that can be researched and studied by students.

My hope is that as decades have passed since Laing's association with professional establishments, who may have had clouded judgements, fresh eyes may instead reconsider the immensely important contribution Laing offered for our understanding not only of the schizoid state, but the process of going mad.

References

Alvarez, Z. (2006). *Live company: Psychoanalytic psychotherapy with autistic, borderline, deprived and abused children.* New York, NY: Routledge.

Austgard, K. (2012). Doing it the Gadamerian way: Using philosophical hermeneutics as a methodological approach in nursing science. *Scandinavian Journal of Caring Sciences*: *Methods and Methodologies*, 26(4), 829-834. https://doi.org/10.1111/j.1471-6712.2012.00993.x

Austgard, K. (2008). What characterises nursing care? A hermeneutical philosophical inquiry. *Scandinavian Journal of Caring Sciences,* 22 (2) 314-319*.* https://doi.org/10.1111/j.1471-6712.2007.00526.x

Bateman, A. W., & Fonagy, P. (2007). *Mentalization-based treatment for borderline personality disorder: A practical guide.* New York, NY: Oxford university press.

Bell, D., & Novakovic, A. (2013). *Living on the Border: Psychotic Processes in the individual, the Couple and the Group.* London, England: Karnac Books.

Bell, D. (2018). Introduction: against the tide. In R. Meyerowitz & D. Bell (Eds.), *Turning the tide, the psychoanalytic approach of the Fitzjohns Unit to patients with complex needs (1-20)*. London, England: Karnac Books.

Benjamin, J. (2012). Beyond Doer and Done to, an intersubjective view of thirdness. In L. Lewis & A. Harris (Eds.), *Relational psychoanalysis, Vol. 4., expansion of theory* (91-130). New York, NY: Routledge.

Bettelheim, B. (1989). *Freud and man's soul*. London, England: Penguin Group.

Bettelheim, B. (1976). *The uses of enchantment, the meaning and importance of fairy tales.* London, England: Thames and Hudson Ltd.

Bollas, C. (2001). Freudian Intersubjectivity: Commentary on paper by Julie Gerhardt and Annie Sweetnam. *Psychoanalytic Dialogues*, 11(1), 93-105.

Bollas, C. (1989). *The Shadow of the object, Psychoanalysis of the unthought known*. New York, NY: Columbia University Press.

Bollas, C. (2008). *The Freudian moment.* London, England: Karnac Books.

Bolognini, S. (2006). *Like wind, Like wave: Fables from the land of the repressed.* New York: NY: Other Press.

Brabban, A., Byrne, R., Longden, E., & Morrison, A.P. (2017). The importance of human

relationships, ethics and recovery-orientated values in the delivery of CBT for people with psychosis. *Psychosis*, 9(2),157-166. https://doi.org/10.1080/17522439.2016.1259648

California Institute of Integral Studies (n.d). *About the certificate in psychedelic-assisted therapies and research.* Retrieved September 4, 2019, from https://www.ciis.edu/research-centers/center-for-psychedelic-therapies-and-research/about-the-certificate-in-psychedelic-assisted-therapies-and-research

Calaprice, A. (2002). *Dear Professor Einstein: Albert Einstein's Letters to and from Children*. New York, NY: Prometheus Books.

Charles, M. (2017). Working with psychosis: contextualising and integrating fragments of meaning. In D. L. Downing & J, Mills (Eds.), *Outpatient Treatment of Psychosis, psychodynamic approaches to evidence-based practice (pp. 55-78)*. London, England: Karnac Books.

Clay, J. (1996). *R. D. Laing, A divided self.* London, England: Hodder and Stoughton.

Clare, A. (n.d.). *BBC Sounds, in the psychiatrist's chair with R. D. Laing*. Retrieved September 6, 2019 from https://www.bbc.co.uk/sounds/play/b064yk5p

Crotty, M. (1996). *Phenomenology and Nursing Research*. Melbourne, Australia: Churchill Livingstone.

De Masi, F. (2009). *Vulnerability to Psychosis: A Psychoanalytic study of the nature and therapy of the psychotic state*. London, England: Karnac Books.

De Masi, F. (2015). *Working with difficult patients, from neurosis to psychosis.* New York, NY: Routledge.

Downing, D.L., & Mills, J. (2017). *Outpatient Treatment of Psychosis, psychodynamic approaches to evidence-based practice*. London, England: Karnac Books.

Eigen, M. (1998). *The psychoanalytic mystic*. London, England: Free Association Books Ltd.

Elettrico. (2020). *Einstein and the Dark Universe*. Retrieved from https://search.creativecommons.org/photos/bfe89335-be3d-44a4-bb70-065001efd20a

Ennis-Cole, D., Durodoye, B.A., & Harris, H. L. (2013). The Impact of Culture on Autism Diagnosis and Treatment: Considerations for Counsellors and Other Professionals. *The Family Journal,* 21(3) 279–287. https://doi.org/10.1177/1066480713476834

Freud, S. (1964). *2. New introductory lectures on psychoanalysis*. London, England: Penguin books Ltd.

Freud, S. (1986). *1. Introductory lectures on psychoanalysis*. Middlesex, England: Penguin books Ltd.

Gadamer, H. (2013). *Truth and Method*. London, England: Bloomsbury publishing.

Gilford, S. (2016, June 12). *R. D. Laing 1* [Video file]. Retrieved from https://www.youtube.com/watch?v=k0ZvZAG_XRg&t=378s

Gilford, S. (2017, April 9). *R. D. Laing pt 2* [Video file]. Retrieved from https://www.youtube.com/watch?v=ETV3Gkw391I

Grant, M., Giddings, L. S. (2002) Making sense of methodologies: A paradigm framework for the novice researcher. *Contemporary Nurse*, 13(1) 10-28.

Haddad, P., Kirk, R., & Green, R. (2016.) Chlorpromazine, the first antipsychotic medication: history, controversy and legacy. *British Association of Psychopharmacology.* Retrieved from https://www.bap.org.uk/articles/chlorpromazine-the-first-antipsychotic/

Harrington, A. (2019). *Mind Fixers.* New York, NY: W. W. Norton & Company, Inc.

He Ara Oranga. (2018). *Report of the Governmental Inquiry into Mental Health and Addiction.* Wellington, New Zealand: Ministry of Health. Retrieved from https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/chapter-2-what-we-heard-the-voices-of-the-people/2-2-a-new-approach-wellbeing-and-community/

Institute of psychoanalysis, British psychoanalytical society. (n.d.). *Personal training analysis.* Retrieved September 5, 2019 from https://psychoanalysis.org.uk/what-is-involved-in-the-training/personal-training-analysis

Jackson, M. (2001). Psychoanalysis and the treatment of psychosis. In P. Williams (Eds.), *A language for psychosis* (pp. 37-53). London, England: Whurr Publishers Ltd.

Jung, C. (1989). *Memories, Dreams and Reflections.* New York, NY: Random House Inc.

Jungian analysts of Washington association. (n.d.). *Carl Gustav Jung (1875-1961*). Retrieved September 5, 2019 from https://www.jungiananalysts.org/jung_bio.html

Laing, R. D. (1985). *Wisdom, madness & folly, the making of a psychiatrist*. London, England: Macmillan London Limited.

Laing, R. D. (1990). *The divided self*. London, England: Penguin Books.

Loewenthal, D., & Winter, D. (2006). Questioning psychotherapeutic "evidence" (and research). In D. Loewenthal & D. Winter (Eds.), *What is psychotherapeutic research?* (p. 49). London, England: H. Karnac (Books) Ltd.

McWilliams, N. (1994). *Psychoanalytic diagnosis, understanding personality structure in the clinical process.* New York, NY: The Guildford Press.

Merchant, J. (2011.) *Shamans and Analysts: New Insights on the Wounded Healer*. New

York, NY: Routledge.

Milton, M. (2006). Evidence-based practice: issues for psychotherapy. In D. Loewenthal & D. Winter (Eds.), *What is psychotherapeutic research?* (p. 65 & 70). London, England: H. Karnac (Books) Ltd.

Multidisciplinary Association for Psychedelic Studies (n.d.). *A Phase 3 Program of MDMA-Assisted Psychotherapy for the Treatment of Severe Posttraumatic Stress Disorder (PTSD)*. Retrieved September 4, 2019 from https://maps.org/research/mdma/ptsd/phase3

National Health Service. (2019). *Overview, Cognitive behaviour therapy*. Retrieved from https://www.nhs.uk/conditions/cognitive-behavioural-therapy-cbt/

Nutters Club (2019, August 19). *Lynn Charlton: From suicidal, institutionalised youth to Psychotherapist* [Video file]. Retrieved from https://www.newstalkzb.co.nz/on-air/nutters-club/lynn-charlton-from-suicidal-institutionalised-youth-to-psychotherapist-part-1/

Office of the Chief Coroner (2019). *Chief Coroner releases provisional annual suicide figures*. Retrieved from https://coronialservices.justice.govt.nz/assets/Documents/Publications/Media-Release-August-2020.pdf

Our daily read. (2012). *The residents of R D Laing's Kinglsey Hall – in pictures*. Retrieved from http://www.ourdailyread.com/2012/09/the-residents-of-rd-laings-kingsley-hall-in-pictures/

Pind, J. L. (2012). Figure and ground at 100. *The Psychologist*, 25(1), 90-91. Retrieved from https://thepsychologist.bps.org.uk/volume-25/edition-1/looking-back-figure-and-ground-100

Perez-Alvarez, M. (2018). Psychology as a Science of Subject and Comportment, beyond the Mind and Behaviour*. Integrative Psychological and Behaviour Science,* vol. 52(1) 25-51. https://doi.org/10.1007/s12124-017-9408-4

Quinodoz, J. (2008*). Listening to Hanna Segal, her contribution to psychoanalysis*. Oxon, England: Routledge.

Read, J., Mosher, L. R., & Bentall, R. P. (2004). *Models of madness, psychological, social and biological approaches to schizophrenia.* New York, NY: Brunner-Routledge.

Sandner, D. F., & Wong, S H. (2012). *The sacred heritage: The influence of Shamanism on analytical psychology*. New York, NY: Routledge.

Shepherd, M. (1995). The two faces of Emil Kraepelin. *British Journal of Psychiatry* (1995), 167(2), 174-183. https://doi-org.ezproxy.aut.ac.nz/10.1192/bjp.167.2.174

Silverstein, S. (2014). Jung's views on causes and treatments of schizophrenia in light of

current trends in cognitive neuroscience and psychotherapy research. *The Journal of Analytical Psychology,* 59(1), 98-129. https://doi.org/10.1111/1468-5922.12057

Smith, J. D. (2014). Focusing on reflections: mentalization and mirroring in brief dynamic therapy. *British Journal of Psychotherapy,* 30(2), 212-228. https://doi.org/10.1111/bjp.12078

Spezzano, C. (2012). A home for the mind. In L. Lewis & A Harris (Eds.), *Relational psychoanalysis, Vol. 4., expansion of theory* (221-235). New York, NY: Routledge.

Sriraman, B., & English, L. (2010). *Theories of mathematics education*. New York, NY: Springer Heidelberg Bordrecht.

Stolorow, R. D., & Atwood, G. E. (1996) The Intersubjective Perspective. *The psychoanalytic review,* 83:181-194.

The official website for R. D. Laing (n.d.). *R D Laing MB, Ch.B., DPM - a timeline.* Retrieved September 4, 2019, from https://www.rdlaingofficial.com/r-d-laing-a-timeline/

The road to no town (2018, August 24). Anti-psychiatry pioneer and psychiatrist explains how patients SHOULD be treated - Common Sense?! ([Video file]. Retrieved from https://www.youtube.com/watch?v=V2pJC2a4tOs

The Royal Australian and New Zealand College of Psychiatrists. (n.d.). *Guide to psychotherapy training.* Retrieved September 5, 2019, from https://www.ranzcp.org/files/prefellowship/2012-fellowship-program/guide-for-psychotherapy-training.aspx

Thompson, M. G. (2015). T*he* legacy *of R. D. Laing, an appraisal of his contemporary relevance*. New York, NY: Routledge.

Thorozine advertisement (n.d.). *You can't tell me anything new about Thorozine.* Retrieved September 6, 2019, from http://www.whale.to/a/chlorpromazine_ads.html

Tinning, N. (n.d.). *The Science Museum, brought to life, exploring the history of medicine.* Retrieved September 4, 2019, from http://broughttolife.sciencemuseum.org.uk/broughttolife/techniques/antipsychiatry

Trotter, W. (1946). *The collective papers of Wilfred Trotter*. London, England: Oxford medical publications.

Turner, E. (2012). *Communitas, the anthropology of collective joy*. New York, NY: Pavlgrave Macmilllan.

Van Manen, M. (2014). *Phenomenology of practice, meaning-giving methods in phenomenological research and writing*. California, USA: Left Coast Press, Inc.

Wikipedia (n.d). *Rubins Vase*. Retrieved June 23rd, 2020, from https://en.wikipedia.org/wiki/Rubin_vase

Willis, J. W. (2007). *Foundations of Qualitative Research: Interpretive and Critical Approaches*. London, England: Sage Publications Ltd.

Winnicott, D. (1960) The Theory of the Parent-Infant Relationship. *The international journal of psychoanalysis,* vol. 41:585-595. Retrieved from http://icpla.edu/wp-content/uploads/2012/10/Winnicott-D.-The-Theory-of-the-Parent-Infant-Relationship-IJPA-Vol.-41-pps.-585-595.pdf