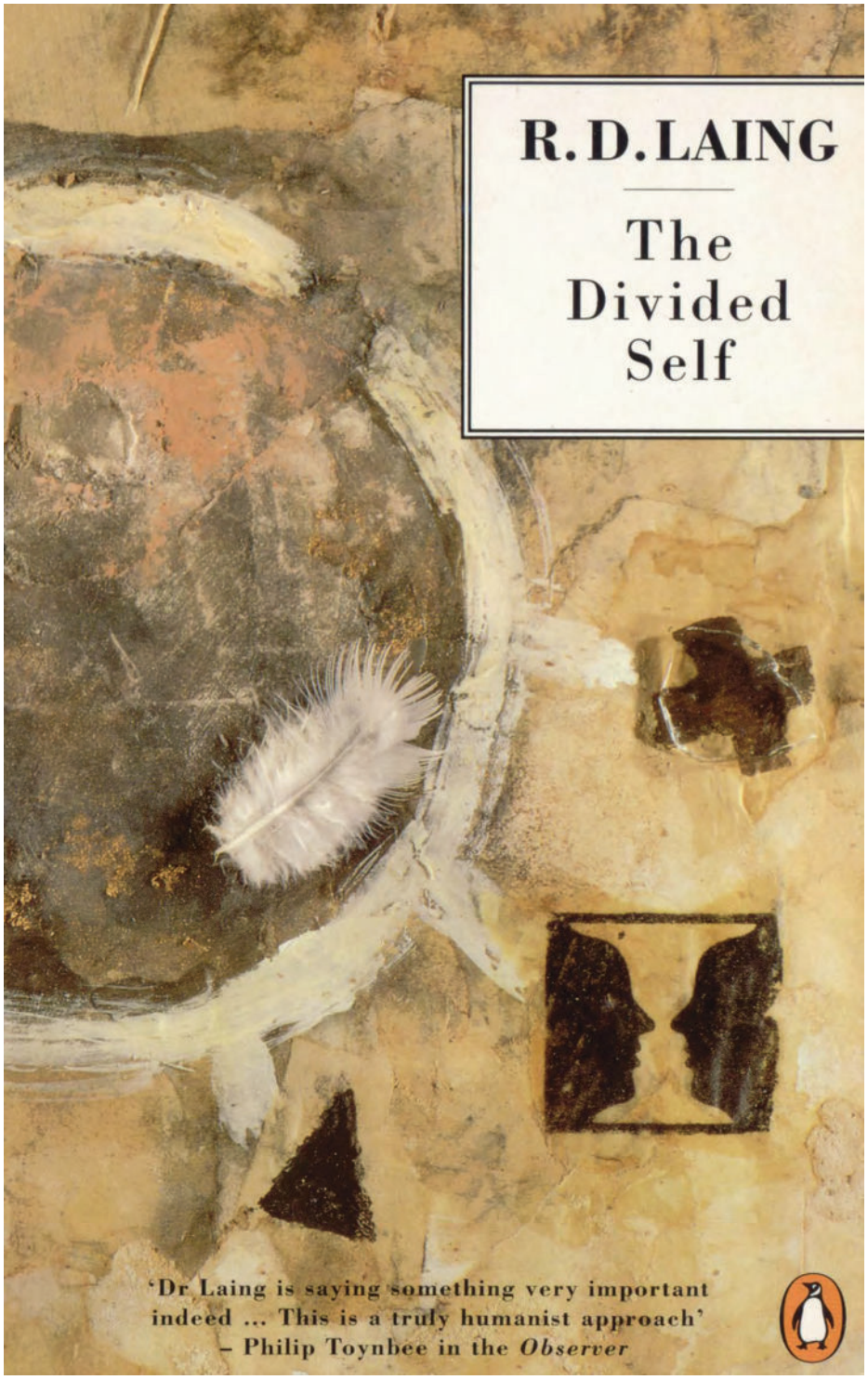
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THE DIVIDED SELF

R. D. Laing, one of the best-known psychiatrists of modern times, was born in Glasgow in 1927 and graduated from Glasgow University as a doctor of medicine. In the 1960s he developed the argument that there may be a benefit in allowing acute mental and emotional turmoil in depth to go on and have its way, and that the outcome of such turmoil could have a positive value. He was the first to put such a stand to the test by establishing, with others, residences where persons could live and be free to let happen what will when the acute psychosis is given free rein, or where, at the very least, they receive no treatment they do not want. This work with the Philadelphia Association since 1964, together with his focus on disturbed and disturbing types of interaction in institutions, groups and families, has been both influential and continually controversial.

R. D. Laing's writings range from books on social theory to verse, as well as numerous articles and reviews in scientific journals and the popular press. His publications are: *The Divided Self, Self and Others, Interpersonal Perception* (with H. Phillipson and A. Robin Lee), *Reason and Violence* (introduced by Jean-Paul Sartre), *Sanity, Madness and the Family* (with A. Esterson), *The Politics of Experience* and *The Bird of Paradise, Knots, The Politics of the Family, The Facts of Life, Do You Love Me?, Conversations with Children, Sonnets, The Voice of Experience* and *Wisdom, Madness and Folly*.

R. D. Laing died in 1989. Anthony Clare, writing in the *Guardian,* said of him: 'His major achievement was that he dragged the isolated and neglected inner world of the severely psychotic individual out of the back ward of the large gloomy mental hospital and on to the front pages of influential newspapers, journals and literary magazines . . . Everyone in contemporary psychiatry owes something to R. D. Laing.'

R. D. Laing

The Divided Self

An Existential Study in Sanity and Madness

Penguin Books

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To my mother and father

Contents

Preface to the Original Edition

This is the first of a series of studies in existential psychology and psychiatry, in which it is proposed to present original contributions to this field by a number of authors.

The present book is a study of schizoid and schizophrenic persons; its basic purpose is to make madness, and the process of going mad, comprehensible. Readers will judge variously the success or failure of this aim. I would ask, however, that the book should not be judged in terms of what it does not attempt to do. Specifically, no attempt is made to present a comprehensive theory of schizophrenia. No attempt is made to explore constitutional and organic aspects. No attempt is made to describe my own relationship with these patients, or my own method of therapy.

A further purpose is to give in plain English an account, in *existential terms,* of some forms of madness. In this I believe it to be the first of its kind. Most readers will find a few terms strangely used in the first few chapters. I have, however, given careful thought to any such usage, and have not employed it unless I felt compelled by the sense to do so.

Here again, a brief statement about what I have not tried to do may avoid misunderstanding. The reader versed in existential and phenomenological literature will quickly see that this study is not a direct application of any established existential philosophy. There are important points of divergence from the work of Kierkegaard, Jaspers, Heidegger, Sartre, Binswanger, and Tillich, for instance.

To discuss points of convergence and divergence in any detail would have taken me away from the immediate task. Such a

discussion belongs to another place. It is to the existential tradition, however, that I acknowledge my main intellectual indebtedness.

I wish to express here my gratitude to the patients and their parents about whom I have written in the following pages. All of those to whom I have referred at any length have given their willing consent to this publication. Names, places, and all identifying details have been changed, but the reader can be assured that he is not reading fiction.

I wish to register my gratitude to Dr Angus MacNiven and Professor T. Ferguson Rodger for the facilities they provided for the clinical basis for this study and the encouragement they gave me.

The clinical work upon which these studies are based was all completed before 1956, that is, before I became an assistant physician at the Tavistock Clinic, when Dr J. D. Sutherland generously made secretarial help available in the preparation of the final manuscript. Since the book was completed in 1957 it has been read by many people, and I have received much encouragement and helpful criticism from more individuals than I can conveniently list. I would like to thank particularly Dr Karl Abenheimer, Mrs Marion Milner, Professor T. Ferguson Rodger, Professor J. Romano, Dr Charles Rycroft, Dr J. Schorstein, Dr J. D. Sutherland, and Dr D. W. Winnicott for their constructive 'reactions' to the MS.

R. D. LAING

Preface to the Pelican Edition

One cannot say everything at once. I wrote this book when I was twenty-eight. I wanted to convey above all that it was far more possible than is generally supposed to understand people diagnosed as psychotic. Although this entailed understanding the social context, especially the power situation within the family, today I feel that, even in focusing upon and attempting to delineate a certain type of schizoid existence, I was already partially falling into the trap I was seeking to avoid. I am still writing in this book too much about Them, and too little of Us.

Freud insisted that our civilization is a repressive one. There is a conflict between the demands of conformity and the demands of our instinctive energies, explicitly sexual. Freud could see no easy resolution of this antagonism, and he came to believe that in our time the possibility of simple natural love between human beings had already been abolished.

Our civilization represses not only 'the instincts', not only sexuality, 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.

In the context of our present pervasive madness that we call normality, sanity, freedom, all our frames of reference are ambiguous and equivocal.

A man who prefers to be dead rather than Red is normal. A man

* *See* recently, Herbert Marcuse, *One-Dimensional Man,* Beacon Press, 1964.

who says he has lost his soul is mad. A man who says that men are machines may be a great scientist. A man who says he *is* a machine is 'depersonalized' in psychiatric jargon. A man who says that Negroes are an inferior race may be widely respected. A man who says his whiteness is a form of cancer is certifiable.

A little girl of seventeen in a mental hospital told me she was terrified because the Atom Bomb was inside her. That is a delusion. The statesmen of the world who boast and threaten that they have Doomsday weapons are far more dangerous, and far more estranged from 'reality' than many of the people on whom the label 'psychotic' is affixed.

Psychiatry could be, and some psychiatrists are, on the side of transcendence, of genuine freedom, and of true human growth. But psychiatry can so easily be a technique of brainwashing, of inducing behaviour that is adjusted, by (preferably) non-injurious torture. In the best places, where straitjackets are abolished, doors are unlocked, leucotomies largely forgone, these can be replaced by more subtle lobotomies and tranquillizers that place the bars of Bedlam and the locked doors *inside* the patient. Thus I would wish to emphasize that our 'normal' 'adjusted' state is too often the abdication of ecstasy, the betrayal of our true potentialities, that many of us are only too successful in acquiring a false self to adapt to false realities.

But let it stand. This was the work of an old young man. If I am older, I am now also younger.

London September 1964

Acknowledgements

Thanks are due to the author and to Grune & Stratton for permission to quote from *Meaning and Content of Sexual Perversions,* by Medard Boss; to George Allen & Unwin in respect of *The Phenomenology of Mind,* by Hegel, translated by J. B. Baillie; to Baillière, Tindall & Cox in respect of *Lectures on Clinical Psychiatry,* by E. Kraepelin; to The Hogarth Press and the Institute of Psycho-Analysis in respect of *Beyond the Pleasure Principle,* by Sigmund Freud, from *The Complete Psychological Works of Sigmund Freud,* Vol. XVIII; to Rider & Co., London, in respect of *The Analysis of Dreams,* by Medard Boss, and *The Psychology of Imagination,* by Jean-Paul Sartre; and to Martin Secker & Warburg in respect of *The Opposing Self,* by Lionel Trilling.

The author wishes to thank Dr M. L. Hayward and Dr J. E. Taylor for their kind permission to quote at some length in Chapter 10 from their paper 'A Schizophrenic Patient Describes the Action of Intensive Psychotherapy', which appeared in the *Psychiatric Quarterly,* 30, 211-66.

Je donne une œuvre subjective ici, œuvre cependant qui tend de toutes ses forces vers L'objectivité.

E. MINKOWSKI

Part 1

1 The existential-phenomenological foundations for a science of persons

The term schizoid refers to an individual the totality of whose experience is split in two main ways: in the first place, there is a rent in his relation with his world and, in the second, there is a disruption of his relation with himself. Such a person is not able to experience himself 'together with' others or 'at home in' the world, but, on the contrary, he experiences himself in despairing aloneness and isolation; moreover, he does not experience himself as a complete person but rather as 'split' in various ways, perhaps as a mind more or less tenuously linked to a body, as two or more selves, and so on.

This book attempts an existential-phenomenological account of some schizoid and schizophrenic persons. Before beginning this account, however, it is necessary to compare this approach to that of formal clinical psychiatry and psychopathology.

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. In describing one way of going mad, I shall try to show that there is a comprehensible transition from the sane schizoid way of being-in-the-world to a psychotic way of being-in-the-world. Although retaining the terms *schizoid* and *schizophrenic* for the sane and psychotic positions respectively, I shall not, of course, be using these terms in their usual clinical psychiatric frame of reference, but phenomenologically and existentially.

The clinical focus is narrowed down to cover only some of the

ways there are of being schizoid or of going schizophrenic from a schizoid starting-point. However, the account of the issues lived out by the individuals studied in the following pages is intended to demonstrate that \hese issues cannot be grasped through the methods of clinical psychiatry and psychopathology as they stand today but, on the contrary, require the existential-phenomenological method to demonstrate their true human relevance and significance.

In this volume I have gone as directly as possible to the patients themselves and kept to a minimum the discussion of the historical, theoretical, and practical issues raised particularly *vis-à-vis* psychiatry and psycho-analysis. The particular form of human tragedy we are faced with here has never been presented with sufficient clarity and distinctness. I felt, therefore, that the sheer descriptive task had to come before all other considerations. This chapter is thus designed to give only the briefest statement of the basic orientation of this book necessary to avoid the most disastrous misunderstandings. It faces in two directions: on the one hand, it is directed to psychiatrists who are very familiar with the type of 'case' but may be unused to seeing the 'case' *qua person* as described here; on the other hand, it is addressed to those who are familiar with or sympathetic to such persons but who have not encountered them as 'clinical material'. It is inevitable that it will be somewhat unsatisfactory to both.

As a psychiatrist, I run into a major difficulty at the outset: how can I go straight to the patients if the psychiatric words at my disposal keep the patient at a distance from me? How can one demonstrate the general human relevance and significance of the patient's condition if the words one has to use are specifically designed to isolate and circumscribe the meaning of the patient's life to a particular clinical entity ? Dissatisfaction with psychiatric and psychoanalytic words is fairly widespread, not least among those who most employ them. It is widely felt that these words of psychiatry and psycho-analysis somehow fail to express what one 'really means'. But it is a form of self-deception to suppose that one can say one thing and think another.

It will be convenient, therefore, to start by looking at some of the

words in use. The thought *is* the language, as Wittgenstein has put it. A technical vocabulary is merely a language within a language. A consideration of this technical vocabulary will be at the same time an attempt to discover the reality which the words disclose or conceal.

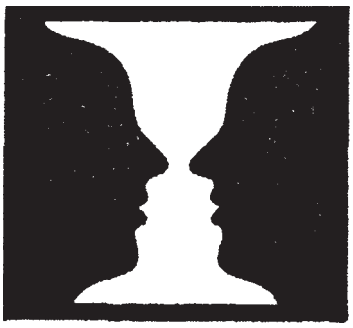
The most serious objection to the technical vocabulary currently used to describe psychiatric patients is that it consists of words which split man up verbally in a way which is analogous to the existential splits we have to describe here. But we cannot give an adequate account of the existential splits unless we can begin from the concept of a unitary whole, and no such concept exists, nor can any such concept be expressed within the current language system of psychiatry or psycho-analysis.

The words of the current technical vocabulary either refer to man in isolation from the other and the world, that is, as an entity not *essentially* 'in relation to' the other and in a world, or they refer to falsely substantialized aspects of this isolated entity. Such words are: mind and body, psyche and soma, psychological and physical, personality, the self, the organism. All these terms are abstracta. Instead of the original bond of *I* and *You,* we take a single man in isolation and conceptualize his various aspects into 'the ego', 'the superego', and 'the id'. The other becomes either an internal or external object or a fusion of both. How can we speak in any way adequately of the relationship between me and you in terms of the interaction of one mental apparatus with another? How, even, can one say what it means to hide something from oneself or to deceive oneself in terms of barriers between one part of a mental apparatus and another? This difficulty faces not only classical Freudian metapsychology but equally any theory that begins with man or a part of man abstracted from his relation with the other in his world. We all know from our personal experience that we can be ourselves only in and through our world and there is a sense in which 'our' world will die with us although 'the' world will go on without us. Only existential thought has attempted to match the original experience of oneself in relationship to others in one's world by a term that adequately reflects this totality. Thus, existentially, the concretum is seen as a man's *existence,* his *being-in-the-world.* Unless we begin with the concept of man in relation

to other men and from the beginning 'in' a world, and unless we realize that man does not exist without 'his' world nor can his world exist without him, we are condemned to start our study of schizoid and schizophrenic people with a verbal and conceptual splitting that matches the split up of the totality of the schizoid being-in-the-world. Moreover, the secondary verbal and conceptual task of reintegrating the various bits and pieces will parallel the despairing efforts of the schizophrenic to put his disintegrated self and world together again. In short, we have an already shattered Humpty Dumpty who cannot be put together again by any number of hyphenated or compound words: psycho-physical, psycho-somatic, psycho-biological, psycho-pathological, psycho-social, etc., etc.

If this is so, it may be that a look at how such schizoid theory originates would be highly relevant to the understanding of schizoid experience. In the following section, I shall use a phenomenological method to try to answer this question.

Man's *being* (I shall use 'being' subsequently to denote simply *all that a man is)* 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 person or thing. Now, even the same thing, seen from different points of view, gives rise to two entirely different descriptions, and the descriptions give rise to two entirely different theories, and the theories result in two entirely different sets of action. The initial way we see a thing determines all our subsequent dealings with it. Let us consider an equivocal or ambiguous figure:



In this figure, there is one thing on the paper which can be seen as a vase or as two faces turned towards each other. There are not two things on the paper: there is one thing there, but, depending on how it strikes us, we can see two different objects. The relation of the parts to the whole in the one object is quite different from the relation of the parts to the whole in the other. If we describe one of the faces seen we would describe, from top to bottom, a forehead, a nose, an upper lip, a mouth, a chin, and a neck. Although we have described the same line, which, if seen differently, can be the one side of a vase, we have not described the side of a vase but the outline of a face.

Now, if you are sitting opposite me, I can see you as another person like myself; without *you* changing or doing anything differently, I can now see you as a complex physical-chemical system, perhaps with its own idiosyncrasies but chemical none the less for that; seen in this way, you are no longer a person but an organism. Expressed in the language of existential phenomenology, the other, as seen as a person or as seen as an organism, is the object of different intentional acts. There is no dualism in the sense of the coexistence of two different essences or substances there in the object, psyche and soma; there are two different experiential Gestalts: person and organism.

One's *relationship* to an organism is different from one's relation to a person. One's description of the other as organism is as different from one's description of the other as person as the description of side of vase is from profile of face; similarly, one's theory of the other as organism is remote from any theory of the other as person. One acts towards an organism differently from the way one acts towards a person. The science of persons is the study of human beings that begins from a relationship with the other as person and proceeds to an account of the other still as person.

For example, if one is listening to another person talking, one may either *(a)* be studying verbal behaviour in terms of neural processes and the whole apparatus of vocalizing, or *(b)* be trying to understand what he is saying. In the latter case, an explanation of verbal behaviour in terms of the general nexus of organic changes that must necessarily be going on as a *conditio sine qua non* of his verbalization, is no contribution to a possible understanding of

what the individual is saying. Conversely, an understanding of what the individual is saying does not contribute to a knowledge of how his brain cells are metabolizing oxygen. That is, an understanding of what he is saying is no substitute for an explanation of the relevant organismic processes, and vice versa. Again, there is no question here or anywhere of a mind-body dualism. The two accounts, in this case personal and organismic, taken up in respect to speech or any other observable human activity, are each the outcome of one's initial intentional act; each intentional act leads in its own direction and yields its own results. One chooses the point of view or intentional act within the overall context of what one is 'after' with the other. Man as seen as an organism or man as seen as a person discloses different aspects of the human reality to the investigator. Both are quite possible methodologically but one must be alert to the possible occasion for confusion.

The other as person is seen by me as responsible, as capable of choice, in short, as a self-acting agent. Seen as an organism, all that goes on in that organism can be conceptualized at any level of complexity - atomic, molecular, cellular, systemic, or organismic. Whereas behaviour seen as personal is seen in terms of that person's experience and of his intentions, behaviour seen organismically can only be seen as the contraction or relaxation of certain muscles, etc. Instead of the experience of sequence, one is concerned with a sequence of processes. In man seen as an organism, therefore, there is no place for his desires, fears, hope or despair as such. The ultimates of our explanations are not his intentions to his world but quanta of energy in an energy system.

Seen as an organism, man cannot be anything else but a complex of things, of *its,* and the processes that ultimately comprise an organism are *it*-processes. There is a common illusion that one somehow increases one's understanding of a person if one can translate a personal understanding of him into the impersonal terms of a sequence or system of *it*-processes. Even in the absence of theoretical justifications, there remains a tendency to translate our personal experience of the other as a person into an account of him that is depersonalized. We do this in some measure whether we use a machine analogy or a biological analogy in our 'explanation'. It should be noted that I am not here objecting to the use of

mechanical or biological analogies as such, nor indeed to the intentional act of seeing man as a complex machine or as an animal. My thesis is limited to the contention that the theory of man as person loses its way if it falls into an account of man as a machine or man as an organismic system of it-processes. The converse is also true (see Brierley, 1951).

It seems extraordinary that whereas the physical and biological sciences of it-processes have generally won the day against tendencies to personalize the world of things or to read human intentions into the animal world, an authentic science of persons has hardly got started by reason of the inveterate tendency to depersonalize or reify persons.

In the following pages, we shall be concerned specifically with people who experience themselves as automata, as robots, as bits of machinery, or even as animals. Such persons are rightly regarded as crazy. Yet why do we not regard a theory that seeks to transmute persons into automata or animals as equally crazy ? The experience of oneself and others as persons is primary and self-validating. It exists prior to the scientific or philosophical difficulties about how such experience is possible or how it is to be explained.

Indeed, it is difficult to explain the persistence in all our thinking of elements of what MacMurray has called the 'biological analogy': 'We should expect,' writes MacMurray (1957), 'that the emergence of a scientific psychology would be paralleled by a transition from an organic to a personal... conception of unity' (p. 37), that we should be able to *think* of the individual man as well as to experience him neither as a thing nor as an organism but as a person and that we should have a way of expressing that form of unity which is specifically personal. The task in the following pages is, therefore, the formidable one of trying to give an account of a quite specifically personal form of depersonalization and disintegration at a time when the discovery of 'the logical form through which the unity of the personal can be coherently conceived' (ibid.) is still a task for the future.

There are, of course, many descriptions of depersonalization and splitting in psychopathology. However, no psychopathological theory is entirely able to surmount the distortion of the person imposed by its own premisses even though it may seek to

deny these very premisses. A psychopathology worthy of its name must presuppose a 'psyche' (mental apparatus or endopsychic structure). It must presuppose that the objectification, with or without reification imposed by thinking in terms of a fictional 'thing' or system, is an adequate conceptual correlate of the other as a person in action with others. Moreover, it must presuppose that its conceptual model has a way of functioning analogous to the way that an organism functions in health and a way of functioning analogous to an organism's way of functioning when physically diseased. However pregnant with partial analogies such comparisons are, psychopathology by the very nature of its basic approach precludes the possibility of understanding a patient's disorganization as a failure to achieve a specifically personal form of unity. It is like trying to make ice by boiling water. The very existence of psychopathology perpetuates the very dualism that most psychopathologists wish to avoid and that is clearly false. Yet this dualism cannot be avoided within the psychopathological frame of references except by falling into a monism that reduces one term to the other, and is simply another twist to a spiral of falsity.

It may be maintained that one cannot be scientific without retaining one's 'objectivity'. A genuine science of personal existence must attempt to be as unbiased as possible. Physics and the other sciences of things must accord the science of persons the right to be unbiased in a way that is true to its own field of study. If it is held that to be unbiased one should be 'objective' in the sense of depersonalizing the person who is the 'object' of our study, any temptation to do this under the impression that one is thereby being scientific must be rigorously resisted. Depersonalization in a theory that is intended to be a theory of persons is as false as schizoid depersonalization of others and is no less ultimately an intentional act. Although conducted in the name of science, such reification yields false 'knowledge'. It is just as pathetic a fallacy as the false personalization of things.

It is unfortunate that personal and subjective are words so abused as to have no power to convey any genuine act of seeing the other as person (if we mean this we have to revert to 'objective'), but imply immediately that one is merging one's own feelings and attitudes into one's study of the other in such a way as to

distort our perception of him. In contrast to the reputable 'objective' or 'scientific', we have the disreputable 'subjective', 'intuitive', or, worst of all, 'mystical'. It is interesting, for example, that one frequently encounters 'merely' before subjective, whereas it is almost inconceivable to speak of anyone being 'merely' objective.

The greatest psychopathologist has been Freud. Freud was a hero. He descended to the 'Underworld' and met there stark terrors. He carried with him his theory as a Medusa's head which turned these terrors to stone. We who follow Freud have the benefit of the knowledge he brought back with him and conveyed to us. He survived. We must see if we now can survive without using a theory that is in some measure an instrument of defence.

THE RELATIONSHIP TO THE PATIENT AS PERSON OR AS THING

In existential phenomenology the existence in question may be one's own or that of the other. When the other is a patient, existential phenomenology becomes the attempt to reconstruct the patient's way of being himself in his world, although, in the therapeutic relationship, the focus may be on the patient's way of being-with-me.

Patients present themselves to a psychiatrist with complaints that may be anywhere in the range between the most apparently localized difficulty ('I have a reluctance for jumping from a plane'), to the most diffuse difficulty possible ('I can't say why I've come really. I suppose it is just me that's not right'). However, no matter how circumscribed or diffuse the initial complaint may be, one knows that the patient is bringing into the treatment situation, whether intentionally or unintentionally, his existence, his whole being-in-his-world. One knows also that every aspect of his being is related in some way to every other aspect, although the manner in which these aspects are articulated may be by no means clear. It is the task of existential phenomenology to articulate what the other's 'world' is and his way of being in it. Right at the start, my own idea of the scope or extension of a man's being may not coincide with his, nor for that matter with that of other psychiatrists. I, for instance, regard any particular man as finite, as one who has had a

beginning and who will have an end. He has been born, and he is going to die. In the meantime, he has a body that roots him to this time and this place. These statements I believe to be applicable to each and every particular man. I do not expect to re-verify them each time I meet another person. Indeed, they cannot be proved or falsified. I have had a patient whose notion of the horizons of his own being extended beyond birth and death: 'in fact' and not just 'in imagination' he said he was not essentially bound to one time and one place. I did not regard him as psychotic, nor could I prove him wrong, even if I cared to. Nevertheless, it is of considerable practical importance 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. In these cases, one has to be able 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, i.e. within the total system of one's own reference. One must be able to effect this reorientation without prejudging who is right and who is wrong. The ability to do this is an absolute and obvious prerequisite in working with psychotics.

There is another aspect of man's being which is the crucial one in psychotherapy as contrasted with other treatments. This is that each and every man is at the same time separate from his fellows and related to them. Such separateness and relatedness are mutually necessary postulates. Personal relatedness can exist only between beings who are separate but who are not isolates. We are not isolates and we are not parts of the same physical body. Here we have the paradox, the potentially tragic paradox, that our relatedness to others is an essential aspect of our *being,* as is our separateness, but any particular person is not a necessary part of our being.

Psychotherapy is an activity in which that aspect of the patient's being, his relatedness to others, is used for therapeutic ends. The therapist acts on the principle that, since relatedness is potentially present in everyone, then he may not be wasting his time in sitting for hours with a silent catatonic who gives every evidence that he does not recognize his existence.

2 The existential-phenomenological foundations for the understanding of psychosis

There is a further characteristic of the current psychiatric jargon. It speaks of psychosis as a social or biological *failure* of adjustment, or *mal*-adaptation of a particularly radical kind, of *loss* of contact with reality, of *lack* of insight. As van den Berg (1955) has said, this jargon is a veritable 'vocabulary of denigration'. The denigration is not moralistic, at least in a nineteenth-century sense; in fact, in many ways this language is the outcome of efforts to avoid thinking in terms of freedom, choice, responsibility. But it implies a certain standard way of being human to which the psychotic cannot measure up. I do not, in fact, object to all the implications in this 'vocabulary of denigration'. Indeed, I feel we should be more frank about the judgements we implicitly make when we call someone psychotic. When I certify someone insane, I am not equivocating when I write that he is of unsound mind, may be dangerous to himself and others, and requires care and attention in a mental hospital. However, at the same time, I am also aware that, in my opinion, there are other people who are regarded as sane, whose minds are as radically unsound, who may be equally or more dangerous to themselves and others and whom society does not regard as psychotic and fit persons to be in a madhouse. I am aware that the man who is said to be deluded may be in his delusion telling me the truth, and this in no equivocal or metaphorical sense, but quite literally, and that the cracked mind of the schizophrenic may *let in* light which does not enter the intact minds of many sane people whose minds are closed. Ezekiel, in Jaspers's opinion, was a schizophrenic.

I must confess here to a certain personal difficulty I have in being

a psychiatrist, which lies behind a great deal of this book. This is that except in the case of chronic schizophrenics I have difficulty in actually discovering the 'signs and symptoms' of psychosis in persons I am myself interviewing. I used to think that this was some deficiency on my part, that I was not clever enough to get at hallucinations and delusions and so on. If I compared my experience with psychotics with the accounts given of psychosis in the standard textbooks, I found that the authors were not giving a description of the way these people behaved with me. Maybe they were right and I was wrong. Then I thought that maybe they were wrong. But this is just as untenable. The following seems to be a statement of fact:

The standard texts contain the descriptions of the behaviour of people in a behavioural field that includes the psychiatrist. The behaviour of the patient is to some extent a function of the behaviour of the psychiatrist in the same behavioural field. The standard psychiatric patient is a function of the standard psychiatrist, and of the standard mental hospital. The figured base, as it were, which underscores all Bleuler's great description of schizophrenics is his remark that when all is said and done they were stranger to him than the birds in his garden.

Bleuler, we know, approached his patients as a non-psychiatric clinician would approach a clinical case, with respect, courtesy, consideration, and scientific curiosity. The patient, however, is diseased in a medical sense, and it is a matter of diagnosing his condition, by observing the signs of his disease. This approach is regarded as so self-evidently justifiable by so many psychiatrists that they may find it difficult to know what I am getting at. There are now, of course, many other schools of thought, but this is still the most extensive one in this country. It certainly is the approach that is taken for granted by non-medical people. I am speaking here all the time of psychotic patients (i.e. as most people immediately say to themselves, *not* you or me). Psychiatrists still hang on to it in practice even though they pay lip-service to incompatible views, outlook, and manner. Now, there is so much that is good and worth while in this, so much also that is *safe* in it, that anyone has a right to examine most closely any view that a clinical professional attitude of this kind may not be all that is required, or

may even be misplaced in certain circumstances. The difficulty consists not simply in noticing evidence of the patient's feelings as they reveal themselves in his behaviour. The good medical clinician will allow for the fact that if his patient is anxious, his blood pressure may be somewhat higher than usual, his pulse may be rather faster than normal, and so on. The crux of the matter is that when one examines 'a heart', or even the whole man as an organism, one is not interested in the nature of one's own personal feelings about him; whatever these may be are irrelevant, discounted. One maintains a more or less standard professional outlook and manner.

That the classical clinical psychiatric attitude has not changed in principle since Kraepelin can be seen by comparing the following with the similar attitude of any recent British textbook of psychiatry (e.g. Mayer-Gross, Slater and Roth).

Here is Kraepelin's (1905) account to a lecture-room of his students of a patient showing the signs of catatonic excitement:

> The patient I will show you today has almost to be carried into the rooms, as he walks in a straddling fashion on the outside of his feet. On coming in, he throws off his slippers, sings a hymn loudly, and then cries twice (in English),' My father, my real father!' He is eighteen years old, and a pupil of the Oberrealschule (higher-grade modern-side school), tall, and rather strongly built, but with a pale complexion, on which there is very often a transient flush. The patient sits with his eyes shut, and pays no attention to his surroundings. He does not look up even when he is spoken to, but he answers beginning in a low voice, and gradually screaming louder and louder. When asked where he is, he says, '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.' When asked his name, he screams, 'What is your name? What does he shut? He shuts his eyes. What does he hear? He does not understand; he understands not. How? Who? Where? When ? What does he mean? When I tell him to look he does not look properly. You there, just look! What is it? What is the matter? Attend; he attends not. I say, what is it, then? Why do you give me no answer? Are you getting impudent again? How can you be so impudent? I'm coming! I'll show you! You don't whore for me. You mustn't be smart either; you're an impudent, lousy fellow, such an impudent, lousy fellow I've never met with. Is he beginning again? You understand nothing

at all, nothing at all; nothing at all does he understand. If you follow now, he won't follow, will not follow. Are you getting still more impudent? Are you getting impudent still more? How they attend, they do attend,' and so on. At the end, he scolds in quite inarticulate sounds.

Kraepelin notes here among other things the patient's 'inaccessibility':

> Although he 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 whatever to the general situation* (1905, pp. 79-80, italics my own).

Now there is no question that this patient is showing the 'signs' of catatonic excitement. The construction we put on this behaviour will, however, depend on the relationship we establish with the patient, and we are indebted to Kraepelin's vivid description which enables the patient to come, it seems, alive to us across fifty years and through his pages as though he were before us. What does this patient seem to be doing? Surely he is carrying on a dialogue between his own parodied version of Kraepelin, and his own defiant rebelling self. '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 I could tell you, but I do not want to.' This seems to be plain enough talk. Presumably he deeply resents this form of interrogation which is being carried out before a lecture-room of students. He probably does not see what it has to do with the things that must be deeply distressing him. But these things would not be 'useful information' to Kraepelin except as further 'signs' of a 'disease'.

Kraepelin asks him his name. The patient replies by an exasperated outburst in which he is now saying what he feels is the attitude implicit in Kraepelin's approach to him: What is your name? 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? (i.e. he feels that Kraepelin is objecting because he is not prepared to prostitute himself before the whole classroom of students), and so on ... such an impudent, shameless, miserable, lousy fellow I've never met with ... etc.

Now it seems clear that this patient's behaviour can be seen in

at least two ways, analogous to the ways of seeing vase or face. One may see his behaviour as 'signs' of a 'disease'; one may see his behaviour as expressive of his existence. The existential-phenomenological construction is an inference about the way the other is feeling and acting. What is the boy's experience of Kraepelin? He seems to be tormented and desperate. What is he 'about' in speaking and acting in this way ? He is objecting to being measured and tested. He wants to be heard.

INTERPRETATION AS A FUNCTION OF THE RELATIONSHIP WITH THE PATIENT

The clinical psychiatrist, wishing to be more 'scientific' or 'objective', may propose to confine himself to the 'objectively' observable behaviour of the patient before him. The simplest reply to this is that it is impossible. To see 'signs' of 'disease' is not to see neutrally. Nor is it neutral to see a smile as contractions of the circumoral muscles (Merleau-Ponty, 1953). We cannot help but see the person in one way or other and place our constructions or interpretations on 'his' behaviour, as soon as we are in a relationship with him. This is so, even in the negative instance where we are drawn up or baffled by an absence of reciprocity on the part of the patient, where we feel there is *no one there* who is responding to our approaches. This is very near the heart of our problem.

The difficulties facing us here are somewhat analogous to the difficulties facing the expositor of hieroglyphics, an analogy Freud was fond of drawing; they are, if anything, greater. The theory of the interpretation or deciphering of hieroglyphics and other ancient texts has been carried further forward and made more explicit by Dilthey in the last century than the theory of the interpretation of psychotic 'hieroglyphic' speech and actions. It may help to clarify our position if we compare our problem with that of the historian as expounded by Dilthey.* In both cases, the essential task is one of interpretation.

* The immediate source for the Dilthey quotations in the following passage is Bultmann's 'The problem of hermeneutics' {*Essays,* 1955, pp. 234-61).

Ancient documents can be subjected to a formal analysis in terms of structure and style, linguistic traits, and characteristic idiosyncrasies of syntax, etc. Clinical psychiatry attempts an analogous formal analysis of the patient's speech and behaviour. This formalism, historical or clinical, is clearly very limited in scope. Beyond this formal analysis, it may be possible to shed light on the text through a knowledge of the nexus of socio-historical conditions from which it arose. Similarly, we usually wish to extend as far as we can our formal and static analysis of isolated clinical 'signs' to an understanding of their place in the person's life history. This involves the introduction of dynamic-genetic hypotheses. However, historical information, *per se,* about ancient texts or about patients, will help us to understand them better only if we can bring to bear what is often called sympathy, or, more intensively, *em*pathy.

When Dilthey, therefore, 'characterizes *the relationship between the author and the expositor* as the conditioning factor for the possibility of the comprehension of the text, he has, in fact, laid bare the presupposition of all interpretation which has comprehension as its basis' (Bultmann, op. cit.).

> We explain [writes Dilthey] by means of purely intellectual processes, but we understand by means of the cooperation of all the powers of the mind in comprehension. In understanding we start from the connection of the given, living whole, in order to make the past comprehensible in terms of it.

Now, our view of the other depends on our willingness to enlist all the powers of every aspect of ourselves in the act of comprehension. It seems also that we require to orientate ourselves to this person in such a way as to leave open to us the *possibility* of understanding him. The art of understanding those aspects of an individual's being which we can observe, as expressive of his mode of being-in-the-world, requires us to relate his actions to *his* way of experiencing the situation he is in with us. Similarly it is in terms of his present that we have to understand his past, and not exclusively the other way round. This again is true even in the negative instances when it may be apparent through his behaviour that he is denying the existence of any situation he may be in with

us, for instance, when we feel ourselves treated as though we did not exist, or as existing only in terms of the patient's own wishes or anxieties. It is not a question here of affixing predetermined meanings to this behaviour in a rigid way. If we look at his actions as 'signs' of a 'disease', we are already imposing our categories of thought on to the patient, in a manner analogous to the way we may regard him as treating us; and we shall be doing the same if we imagine that we can 'explain' his present as a mechanical resultant of an immutable 'past'.

If one is adopting such an attitude towards a patient, it is hardly possible at the same time to understand what he may be trying to communicate to us. To consider again the instance of listening to someone speaking, if I am sitting opposite you and speaking to you, you may be trying (i) to assess any abnormalities in my speech, or (ii) to explain what I am saying in terms of how you are imagining my brain cells to be metabolizing oxygen, or (iii) to discover why, in terms of past history and socio-economic background, I should be saying these things at this time. Not one of the answers that you may or may not be able to supply to these questions will in itself supply you with a simple understanding of what I am getting at.

It is just possible to have a thorough knowledge of what has been discovered about the hereditary or familial incidence of manic-depressive psychosis or schizophrenia, to have a facility in recognizing schizoid 'ego distortion' and schizophrenic ego defects, plus the various 'disorders' of thought, memory, perceptions, etc., to know, in fact, just about everything that can be known about the psychopathology of schizophrenia or of schizophrenia as a disease without being able to understand one single schizophrenic. Such data are all ways of *not* understanding him. To look and to listen to a patient and to see 'signs' of schizophrenia (as a 'disease') and to look and to listen to him simply as a human being are to see and to hear in as radically different ways as when one sees, first the vase, then the faces in the ambiguous picture.

Of course, as Dilthey says, the expositor of a text has a right to presume that despite the passage of time, and the wide divergence of world view between him and the ancient author, he stands in a not entirely different context of living experience from the original

writer. He exists, in the world, like the other, as a permanent object in time and place, with others like himself. *It is just this presupposition that one cannot make with the psychotic.* In this respect, there may be a greater difficulty in understanding the psychotic in whose presence we are here and now, than there is in understanding the writer of a hieroglyphic dead for thousands of years. Yet the distinction is not an essential one. The psychotic, after all, as Harry Stack Sullivan has said, is more than anything else 'simply human'. The personalities of doctor and psychotic, no less than the personalities of expositor and author, do not stand opposed to each other as two external facts that do not meet and cannot be compared. Like the expositor, the therapist must have the plasticity to transpose himself into another 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.*

I think it is clear that by 'understanding' I do not mean a purely intellectual process. For understanding one might say love. But no word has been more prostituted. What is necessary, though not enough, is a capacity to know how the patient is experiencing himself and the world, including oneself. If one cannot understand him, one is hardly in a position to begin to 'love' him in any effective way. We are commanded to love our neighbour. One cannot, however, love this particular neighbour for himself without knowing who he is. One can only love his abstract humanity. One cannot love a conglomeration of 'signs of schizophrenia'. No one *has* schizophrenia, like having a cold. The patient has not 'got' schizophrenia. He is schizophrenic. The schizophrenic has to be known without being destroyed. He will have to discover that this is possible. The therapist's hate as well as his love is, therefore, in the highest degree relevant. What the schizophrenic is to us determines very considerably what we are to him, and hence his actions. Many of the textbook 'signs' of schizophrenia vary from hospital to hospital and seem largely a function of nursing. Some psychiatrists observe certain schizophrenic 'signs' much less than others.*

* There is now an extensive literature to support this view. See, for example, 'In the Mental Hospital' (articles from *The Lancet,* 1955-6).

I think, therefore, that the following statement by Frieda Fromm-Reichmann is indeed true, however disturbing it is:

> . . . psychiatrists can take it for granted now that in principle a workable doctor-patient relationship can be established with the schizophrenic patient. If and when this seems impossible, it is due to the doctor's personality difficulties, not to the patient's psychopathology (1952, p. 91).

Of course, as with Kraepelin's catatonic young man, the individual reacts and feels towards oneself only partially in terms of the person one takes oneself to be and partially in terms of his phantasy of what one is. One tries to make the patient see that his way of acting towards oneself implies a phantasy of one kind or another, which, most likely, he does not fully recognize (of which he is unconscious), but which, nevertheless, is a necessary postulate if one is to make any sense of this way of conducting himself.

When two sane persons are together one expects that *A* will recognize *B* to be more or less the person *B* takes himself to be, and vice versa. That is, for my part, I expect that my own definition of myself should, by and large, be endorsed by the other person, assuming that I am not deliberately impersonating someone else, being hypocritical, lying, and so on.* Within the context of mutual sanity there is, however, quite a wide margin for conflict, error, misconception, in short, for a disjunction of one kind or another between the person one is in one's own eyes (one's being-for-oneself) and the person one is in the eyes of the other (one's being-for-the-other), and, conversely, between who or what he is for me and who or what he is for himself; finally, between what one imagines to be his picture of oneself and his attitude and intentions towards oneself, and the picture, attitude, and intentions he has in actuality towards oneself, and vice versa.

That is to say, when two sane persons meet, there appears to be a reciprocal recognition of each other's identity. In this mutual recognition there are the following basic elements:

(a) I recognize the other to be the person he takes himself to be.
(b) He recognizes me to be the person I take myself to be.

* There is the story of the patient in a lie-detector who was asked if he was Napoleon. He replied, 'No'. The lie-detector recorded that he was lying.

Each has his own autonomous sense of identity and his own definition of who and what he is. You are expected to be able to recognize me. That is, I am accustomed to expect that the person you take me to be, and the identity that I reckon myself to have, will coincide by and large: let us say simply 'by and large', since there is obviously room for considerable discrepancies.

However, if there are discrepancies of a sufficiently radical kind remaining after attempts to align them have failed, there is no alternative but that one of us must be insane. I have no difficulty in regarding another person as psychotic, if for instance:

he says he is Napoleon, whereas I say he is not;

or if he says I am Napoleon, whereas I say I am not;

or if he thinks that I wish to seduce him, whereas I think that I have given him no grounds in actuality for supposing that such is my intention;

or if he thinks that I am afraid he will murder me, whereas I am not afraid of this, and have given him no reason to think that I am.

I suggest, therefore, that *sanity or psychosis is tested by the degree of conjunction or disjunction between two persons where the one is sane by common consent.*

The critical test of whether or not a patient is psychotic is a lack of congruity, an incongruity, a clash, between him and me.

The 'psychotic' is the name we have for the other person in a disjunctive relationship of a particular kind. It is only because of this interpersonal disjunction that we start to examine his urine, and look for anomalies in the graphs of the electrical activity of his brain.

It is worth while at this point to probe a little farther into what is the nature of the barrier or disjunction between the sane and the psychotic.

If, for instance, a man tells us he is 'an unreal man', and if he is not lying, or joking, or equivocating in some subtle way, there is no doubt that he will be regarded as deluded. But, existentially, what does this delusion mean? Indeed, he is not joking or pretending. On the contrary, he goes on to say that he has been pre-