Wisdom, Madness and Folly

The Making of a Psychiatrist

R. D. Laing

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Photograph of the late Joe Schorstein
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None the less, he knew that the tale he had to tell could not be one of a final victory. It could only be the record of what had had to be done, and what assuredly would have to be done again in the never-ending fight against terror, and its relentless onslaughts, despite their personal afflictions, by all who, while unable to be saints, but refusing to bow down to pestilences, strive their utmost to be healers.

Albert Camus
La Peste

Introduction

In the last ten years or so, my destiny has taken me to many parts of the world where I have met old friends whom I have never met before. These are people who knew me from my books, and from reports of an experiment begun in 1964 in Kingsley Hall, a community centre in London, where several of us lived with a number of very disturbed 'psychotic' people who would otherwise have been in mental hospitals or psychiatric units and treated accordingly. Among us there were no staff, no patients, no locked doors, no psychiatric treatment to stop or change states of mind.

We declared a free-for-all: freedom to think, see, feel in any way whatever; freedom of biorhythm (autorhythm) for all of us. On the other hand, transgressive conduct for whatever reason, of whatever kind is objectionable. On this or any other issue we took our chances together.

Since this is in many respects the exact opposite of the usual psychiatric approach, it has come in for a lot of criticism, controversy, and misunderstanding.* I am often asked how I, as a psychiatrist, came to a point of view, right or wrong, about psychiatry that is so different from, and sometimes so at odds with, a great deal of the psychiatry in which I was trained.

This memoir is a response to such questions. It covers the first thirty years of my life, from 1927 to 1957. I am not trying to justify myself, or prove that I am right. I have tried to depict aspects of my world, and of my reactions to it. There is nothing

* There are, however, a number of places in Europe and America which now put this approach into play.

here about my sex or family life, little about friends and social life, almost nothing about theory, books, articles, scientific details. What is here are the sorts of things that 'struck' me on the road to seeing and responding to the suffering with which psychiatry is involved in a different way from the usual. This difference is not about scientific facts. As far as I am aware, I have never said that a scientific, clinical, medical fact is not exactly what it is: a scientific, clinical, medical fact. But one can see the same facts differently. One can construe them differently. So, here, I am trying to describe different points of view, and to show how I came to mine. No facts are in dispute. I believe that to give serious consideration to the issues that arise from seeing the same differently itself contributes to lessening some of the fear, pain, madness and folly in the world.

As a young psychiatrist in general hospitals and psychiatric hospitals, I administered locked wards and ordered drugs, injections, padded cells and straitjackets, electric shocks, deep insulin comas and the rest. I was uneasy about lobotomies but not sure why. Usually all this treatment was against the will of its recipients. I went around in a white coat, with stethoscope, tendon hammer and ophthalmoscope sticking out of my pockets, like any other doctor. Like them, I examined patients clinically. I had samples of blood, urine, spinal fluid sent for laboratory analysis, ordered electroencephalograms and so on.

It looked the same as the rest of medicine, but it was different. I was puzzled, and uneasy. Hardly any of my psychiatric colleagues seemed puzzled or uneasy. This made me even more puzzled and uneasy.

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Psychiatry Today

Psychiatry today is a set of institutions within the network of medical institutions that extends over much of the world – Europe, the USA, the USSR, China, Australia, New Zealand, parts of South America, Africa, India, etc. In its theory, practice, functions, position and power, it is an integral part of these larger institutions. As medical students and young doctors, all prospective psychiatrists have to be steeped in medicine-as-a-whole before they can become psychiatrists. This medical training distinguishes psychiatrists from non-medical mental-health professionals. Many doctors are not psychiatrists, but there are no psychiatrists who are not doctors. One may cease to be a psychiatrist without ceasing to be a doctor. If one ceases to be a doctor, one ceases to be a psychiatrist.

The word 'psychiatry' was coined to refer to the institution of a discipline within medicine. Etymologically, the word means psychological healing in the sense of the science and art of healing the psyche, mind, soul, person. But psychiatry is in fact a branch of medicine. Medical psychiatry is one approach to the art of psychological healing. A mental healer may be a psychiatrist. A psychiatrist may or may not be a mental healer. A mental healer may be a priest, or a shaman. In cultures which are still not technologically developed, or destroyed, I have met several 'primitive' priests, shamans, medicine men who have medical qualifications. But this is very rare.

The art of non-medical psychiatric mental healing has

nothing to do with psychiatry, at present, though in future there may be more cross-fertilization.*

As a medical student (1945–51) I encountered no such rift within medical psychiatry itself. I was aware of psychiatry as a division of medicine, with several subdivisions itself: there were, as there are, different 'schools' or orientations within psychiatry. It took me some time to figure out the medical politics of these orientations – the biologic–organic, the dynamic, the social, the existential and so forth – and it took me several years to realize the extent to which 'psychiatry' as a whole is different from the rest of medicine. In some medical schools 'psychiatry' is taught to medical students virtually as neurology. Psychiatry is really neuropsychiatry, neuropsychiatry is really neuroscience. Psychiatry, neuropsychiatry and neurology are branches, basically, of biology (including genetics, biophysics and biochemistry) applied to medicine.

The term 'medicine' itself is tricky. It is sometimes used for the whole medical profession, for medicine-in-general, along with general surgery, obstetrics and gynaecology, public health, paediatrics, geriatrics, psycho-social medicine, neurology, dermatology, and specialties within specialties – neurosurgery, cardiac surgery, thanatology. As a branch of modern Western medicine, within the international medical community, psychiatry is often ranked alongside surgery, medicine, obstetrics and gynaecology as a major division of medicine-in-general, although in some places it is considered a division of a division, a branch of a branch (general medicine) of medicine in the overall sense. Psychiatry itself has subdivisions, from child psychiatry to psychogeriatrics, and addresses itself in different ways to different domains – biologic, social, for example.

Psychiatry has many functions. Some of these are the same as those of other fields of Western medicine, but psychiatry is unique in several respects. It is the only branch of medicine that treats people physically in the absence of any known physical

* The term 'anti-psychiatry' was coined by the psychiatrist David Cooper because he felt that psychiatry as the theory and practice of medical psychiatry was and is predominantly repressive, anti-psychiatric in the sense of the science and art of mental healing. Quite a few medical psychiatrists agree with him.

pathology. It is the only branch of medicine that 'treats' conduct, alone, in the absence of symptoms and signs of illness of the usual kind. It is the only branch of medicine that treats people against their will, in any way it likes, if it deems it necessary. It is the only branch of medicine that imprisons patients, if judged necessary.

What I seemed to be engaged in was a concerted effort to stop undesired states of mind and conduct, and to keep undesired people in such undesired states of mind and conduct away from people outside, who did not want them around. Italian psychiatrists have recently almost entirely given up offering this service. Can our society, as it exists, do without it? What alternative will emerge? Crisis intervention? But supposing an intolerable impasse remains? If a violinist in an orchestra is out of tune and does not hear it, and does not believe it, and will not retire, and insists on taking his seat and playing at all rehearsals and concerts and ruining the music, what can be done? If all persuasion fails, is there anything else to do than to have him or her removed, by physical force, against his or her will, and *kept away* for as long as he or she persists in spoiling the fun for everyone else, call him or her ill or not?

It is not easy. What do we do when we don't know what to do? I want that guy out of sight, out of sound, out of mind. I want to get on with the music. Fair enough? But how? What would we do without psychiatrists? If not psychiatrists, the police? The police are not rushing to volunteer to 'fill the gap'.

The situation keeps cropping up in our society, when, no matter how liked, esteemed or loved, some people become insufferable to others. No one they know wants to live with them. They are not breaking the law, but they arouse in those around them such urgent feelings of pity, worry, fear, disgust, anger, exasperation, concern, that something has to be done. A social worker or psychiatrist is 'brought in'. He or she is there to exercise discretion and responsibility in deciding what is to happen. The first, decisive, crunch decision is: should *this* person, or *that* person, be taken away, locked up, and observed for a while? Then comes the second decision: should this person be kept in

for a further period of observation, maybe 'treated'? In Italy, where psychiatrists refuse to make these decisions, they are trying to develop the art of helping 'the group' to resolve the 'crisis' within itself. What are the ordinary limits of ordinary people? The 'need' for this removal, seclusion and treatment service is not manufactured by psychiatrists. There is a consumer demand. As long as there is, some group will be appointed to meet it. Such intervention may not always be controlled by doctors. It is difficult to imagine our society without such a service, run under the control of the medical profession or not.

There he sits. In a deserted office in inner London at ten o'clock on a Friday night. He does not move. He does not speak. He has been sitting like that for twelve hours. No one knows why. No one knows who he is. Hospital or prison? The police don't want him. Hospital it has to be. Hospital it is.

The offender or intruder is taken away to a locked ward. He is observed. He does not move. He does not speak. If he does not soon, he will be given an electric shock, or two, or more. He will remain in 'involuntary custody' as long as he does not snap out of it one way or another. To authorize this procedure a psychiatrist (or two) signs a form, authorizing it to be done. As things are, how can it be otherwise?

If we wish some group to have the power to do to people whatever may be necessary to stop, start, or change them, there is no group in a better position to do so than psychiatrists. We should not blame psychiatrists because we give them such depth of power, especially when, to be exercised as expected, it *must* be exercised *routinely*.

One may be in hospital at one's own behest. Otherwise one is 'in' because the company one keeps does not find one congenial.

Not all psychiatric wards are 'locked', but everywhere in the developed world there is a psychiatric ward somewhere not too far away to which to send those who 'have to be locked up': for observation in the first place, then for a repertoire of possibilities, depending on the local psychiatric orientation – drugs,

straitjackets, padded cells, tube feeds, injections, electroshocks, comas, lobotomies; maybe for behaviour therapy, or reconditioning of one kind or another.

All micro-social crises, the heartbreak and the catastrophes that so often lead to someone becoming a psychiatric patient in a mental institution, all go on outside these institutions. Even when a psychiatrist is called 'in' to such a situation, often he is expected to regard what he sees as a *fait accompli*; often he does, and it is. He gives his official seal, as it were, to the proceedings.

During my first six years of professional practice as a psychiatrist I hardly saw a patient outside institutions, whether mental hospitals, psychiatric units, out-patient clinics, or other wards or prisons. How many of these people got to those places in the first place was something of a mystery. What was going on *before* I, as a psychiatrist, appeared on the scene, whether on a 'home visit', or, much more usually, in my office or on the ward? One takes a 'history' from the patient, relatives, or friends to find out. I realized, often, that it would take something like a major detective investigation to find out. Working entirely 'in' institutions, I began to find it strange how people appeared in them, already metamorphosed into patients, voluntarily or involuntarily, self-'referred' or referred by a referring doctor or social worker. Whence came they, out of that world out there, where patients were people before they were patients? And whither go they to become what or whom again when they disappear? They are in-patients and out-patients because of what they were like before they were patients: whatever were they like when they were not yet patients?

Mental hospitals and psychiatric units admit, routinely, every day of the week, people who are sent 'in' for non-criminal conduct, but for conduct which their nearest and dearest relatives, friends, colleagues and neighbours find insufferable. This is our society's only resolution to this unlivable impasse. If they refuse to go away, or can't or won't fend for themselves, it is our only way to keep people out of the company that can't stand them. The staff of those places to which such unpopular people

are sent are paid minimal wages to take care of them. It is not surprising that the ordinary human beings who are the staff feel no more need for such company than anyone else has done. Who wants to get especially close to such rejected people who end up as patients? Psychiatrists and nurses seldom have to be reprimanded for getting too close to them and never for not keeping a safe distance.

This state of affairs seems inevitable in those psychiatric institutions that are prisons for people whom the world out there can't stand and wants secluded and excluded for non-criminal offences. To say that a locked ward functions as a prison for non-criminal transgressors is not to say it should not be so. Our society may continue to 'need' some such prisons for unacceptable persons. As our society functions at present such places are indispensable. This is not the fault of psychiatrists, nor necessarily the fault of anyone.

Psychiatrists never tire of telling us that there is an unbridgeable gulf between some people and the rest of us. Karl Jaspers called it an abyss of difference. Manfred Bleuler calls it a total difference. No human bond can span it. Some people are 'strange, puzzling, inconceivable, uncanny, incapable of empathy, sinister, frightening; it is impossible to approach them as equals', in Manfred Bleuler's words. Both he and Jaspers are talking about schizophrenics – over one in ten of us according to orthodox psychiatry.

These are extraordinary statements to have to be made, and not only on behalf of psychiatrists. They express feelings many people share. In the face of this, Harry Stack Sullivan, the American psychiatrist, felt impelled to announce that such people were, more than anything else, 'simply human'.

Carl Rogers tells me that Martin Buber told him once that schizophrenics are not capable of an I–Thou relationship. That sums up the psychiatric position, and that is the position from which I dissent. It is simply not a generalization I can make to match my own personal experience of such people. Psychiatrists say I am kidding myself, or that I am one of them anyway, or that I am trying to make out that these people do not need treatment. They do indeed 'need treatment'. Whatever treat-

ment they get, first and last, 'we' should not forget to treat 'them', however strange 'they' are to 'us', as 'simply human' like ourselves.

There are many people who have been psychotic – in their own estimation as well as in that of psychiatrists – who want people to know what it is like to be completely out of the ordinary, commonsense, shared world, and into some other hell-world of sheer horror, terror and torture. There is no doubt that there are enormous differences between states of mind, between different 'realities'. I am not trying to gloss over or to minimize these differences. The question is: what sort of difference does this sort of difference make? What sort of difference does it make to 'us'? What sort of difference do we take the difference between us to be?

Without doubt there is loss of personal contact, lack of rapport, and so on. Why? Some psychoanalysts and psychotherapists strain to understand schizophrenese. There are schools which decode its signs and symptoms.

In some ways psychoanalytic systems of 'interpretation', which try to make sense out of psychotic symptomatology, in making out that the patient means something totally different – if he or she means anything – from what he or she seems to mean, only widen the gulf. It is no surprise that there is no evidence that individual psychotherapy, based on such systems of proving to the patient that he or she is incapable of saying anything that in itself makes sense, seems to work.

Karl Jaspers maintained that there was 'no greater difference' in 'the psychic life' of human beings than that between the normal person and the psychotic. A corollary to this doctrine is that this difference is genetic and constitutional. It must be. This psychiatric doctrine of the abyss of difference between us and them takes us to the brink of another sort of abyss. How do 'we' treat 'them'? The Nazi regime in Germany in the late thirties took this doctrine to its logical conclusion. They should not be allowed to breed, and there was no point, really, in keeping them alive. They started their cleaning and tidying up of Germany by killing 50,000 mental-hospital patients until they stopped under protest from the Churches and others. But

there was no general outcry against the theory and practice. They then switched the same exterminating teams over to the Jews and the gypsies.

A real Aryan Nazi would be psychotic to call himself a Jew. The Jewish parents of a lady schizophrenic patient of mine got out of Germany and settled in the Mid-West of the USA, where they passed themselves off as good German Lutherans. She was diagnosed schizophrenic when she began to have delusions that she was Jewish.

The attribution to the other of an incapacity to form a human bond was and is *the* basis for the diagnosis of schizophrenia. Both this attribution and the causal theory to account for it are crushed into the diagnosis. He or she is cut off (schizophrenic in a descriptive sense) and this is so *because* he or she is suffering from a mental illness, namely, schizophrenia, in the causal sense.

In my first book, *The Divided Self*, I tried to show the situation here. The attribution (the patient is autistic) is made by a person, in the role of diagnosing psychiatrist, about a person, in the role of patient-to-be-diagnosed. It is made across a gulf *between* them. The sense of a human bond with that patient may well be absent in the psychiatrist who diagnoses the patient as incapable of any such bond with anyone. Many psychiatrists have become very angry with me for pointing this out. Some enhanced understanding of what is going on between psychiatrist and patient does not preclude a scientific explanation of what is going on in the patient alone, and such a scientific explanation does not need to be a way to cut off a cut-off person from the possibility of human reunion, communion and renewal.

I have never idealized mental suffering, or romanticized despair, dissolution, torture or terror. I have never said that parents or families or society 'cause' mental illness, genetically or environmentally. I have never denied the existence of patterns of mind and conduct that are excruciating. I have never called myself an anti-psychiatrist, and have disclaimed the term from when first my friend and colleague, David Cooper, introduced

it. However, I agree with the anti-psychiatric thesis that by and large psychiatry functions to exclude and repress those elements society wants excluded and repressed. If society requires such exclusion then exclusion it will get, with or without the aid of psychiatry. Many psychiatrists want psychiatry to bow out of this function. In Italy, as I have mentioned, some have done so; more would like to do so in other countries, but it is not easy. Such a complete change of policy requires as complete a change of outlook, and that is rare.

Thus society expects psychiatry to perform two very special functions. To lock certain people up; and to stop and, if possible, change certain states of mind and types of conduct in the name of curing mental illnesses.

Within two years of carrying out my duties as a clinical psychiatrist, I came to the painful realization that I would not like to be treated the way my own patients had to be treated. I would not like to be locked up in a psychiatric ward under observation. I could not believe that the drugs, the comas, the electric shocks I was expected to prescribe and administer were the great recent advances in psychiatry I was trained to believe they were. But maybe I had got it all wrong – I had to admit that if I were like many of my patients, there would be nothing else for it. The psychiatrists who were doing what I was supposed to learn to copy did not seem to be uncomfortable about what they were doing.

I knew what a psychiatrist like me was supposed to conclude about my patient's state of mind if he were to tell me my treatment was destroying him. But I agreed with him. Was I at the fuzzy beginnings of a clinical paranoid psychosis? Over thirty years later I am trying to put words to the unease I felt then and still feel about some aspects of the field of my profession.

There are hundreds of thousands of people in every country in the civilized world who lapse into wretched and crippling and crippled states of mind. If they get too much for us we turn them over to a psychiatric service they are not at liberty to refuse, and which is not at liberty to refuse them. Their wretched minds