CHAPTER 6

RD LAING'S CONCEPTUALISATION OF THE PSYCHIATRIC SUBJECT

> I am not fond of the word psychological. There is no such thing as the psychological. Let us say that one can improve the biography of the person (Jean-Paul Sartre in Laing, 1965a: 120).

In his memoirs Ronald David Laing (1985) recalls how he struggled with psychiatric treatment regimes for psychiatric patients: insulin injections, padded cells, locked wards, ECT, and codes of practice that involved not talking to patients. Laing could not accept such dehumanising practices in the name of psychiatry. He tried to understand how psychiatrists justified such treatment of psychotic people. Laing found treatment was justified on the basis that people who experience psychosis are considered different. This difference, as outlined in chapter two, Laing (1985: 7) attributed to Jasper's claim, that there was 'no greater difference' in the psychic life of human beings than 'that between the normal person and the psychotic'.

In an analysis of this 'difference', Laing (1985: 7) asks, 'what sort of difference do we take the difference between us to be?' Laing notes the difference associated with psychiatric problems was considered to be due to biology. But Laing notes:

> 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' (Laing, 1985: 7)?

Laing came to the conclusion 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 recent advances in psychiatry that I was led to believe they were… I knew what a psychiatrist like me was supposed to conclude about my patients' state of mind if he were to tell me my treatment was destroying him. But I agreed with him (Laing, 1985: 9).

Laing recognised the conceptualisation of patients as 'different' to have implications in terms of interpersonal relations in psychiatry. It meant that the doctor's opinion is considered legitimate, while the patient's is not. There are two aspects of the doctor-patient relationship that Laing considered significant in the process of diagnosis. Firstly, he considered the (ever-present) imbalance of power to be important. He considered the term 'patient' to refer to the power imbalance of those subject to psychiatric practices. Secondly, he considered diagnosis to occur in and through a relational process, and not a mechanical, objective, neutral one, as is claimed.

For example, Laing suggested diagnosis of schizophrenia is made on the basis that the person with schizophrenia is considered 'autistic', that is, incapable of forming a human bond. Laing argues that this lack of willingness to bond is as much a product of the disinclination of the practitioner to bond with the patient as the patient with the practitioner. A psychiatrist, states Laing, makes a diagnosis:

> In the role of a diagnosing psychiatrist, about a person, in the role of patient-to-be-diagnosed. It is made across a gulf *between* them. The sense of human bond with that patient may well be absent in the psychiatrist who diagnoses the patient as incapable of any such bond with anyone (Laing, 1985: 9).

The failure of the psychiatrist to see his own role in the construction of such 'autism' means for Laing (1965a: 33) that 'we are already'

(speaking as a psychiatrist), 'behaving in a manner analogous to the way we regard him as treating us'. It is this power differential, Laing claims, that has made what is acceptable for one, pathological in another.

Laing points out that if the practitioner is unwilling to enter into a relationship, why should the diagnosed be? Nonetheless, failing to be willing to enter into the one-sided relationship with the practitioner lands the patient as no longer person, with the diagnosis of mental illness. Nonetheless, Laing (1965: 34) highlights the importance of the interpersonal in the doctor-patient relationship: 'what the schizophrenic is to us determines very considerably what we are to him, and hence his actions'.

In an attempt to bridge the 'abyss of difference', and respond to psychiatry's failure to understand the patient, the central concern of this thesis, Laing's attempt to address the limitations of biological psychiatry will be examined. Laing developed a number of different accounts of psychiatric problems over the course of his career. The first two will be analysed here in an attempt to consider an alternative to the current paradigm of psychiatry. 'Ontological insecurity' was Laing's first alternative conception of psychiatric problems based on a 'science of person'. Here psychosis or a split sense of self was seen as due to the failure to achieve a sense of ontological security.

The section: From the Case Study to the History of the Subject is an example of how taking a biography facilitates understanding. This example also shows how ontological insecurity is the product of a person's interpersonal relationships. Interpersonal relationships become the focus of his next conceptualisation of problems for the psychiatric subject. Each of these accounts involves a different conceptualisation of psychiatric problems with implications for the conceptualisation of the subject. These conceptualisations will be considered through a detailed analysis of Laing's work. This close reading is important as it provides a counterbalance to the psychiatric paradigm. It also lays the foundation for an alternative conceptualisation of the subject that takes into account the social and the personal which come together in the concept of a narrative subject in the following chapter.

1) Ontological Insecurity

Laing (1965a) first attempted an alternative conceptualisation of the problems people were experiencing in *The Divided Self*. Here he described the split nature of schizoid and schizophrenic conditions as 'ontological insecurity': the terminology of existential-phenomenology. [1] Laing's (1965a) aim in *The Divided Self*, was to 'make madness, and the process of going mad, comprehensible'. Ratna (1994) considered *The Divided Self* to make three contributions to understanding schizophrenia. Firstly, that schizophrenese, the so-called language of

schizophrenia, was made understandable. Secondly, that the fragmented personality of the schizophrenic was made understandable. Thirdly, that ambivalence, a diagnostic sign that characterises schizophrenia, was clarified.

Laing described ambivalence as the deep need for, and fear of, love. For a person experiencing schizophrenia, ambivalence results in withdrawal from relationships. Laing understood the need to be loved and understood is, at the same time also a source of terror that the same love will overwhelm: 'The critical test of whether or not a patient is psychotic is the lack of congruity, and incongruity, a clash between him and me' (Laing, 1965a: 129).

Laing identified the terminology in psychiatry as central to the failure to understand psychiatric conditions. Laing argued the reason a person's behaviour is read as symptomatic of a pathological problem, is because the scientific discourses do not provide other terms within which to conceptualise the interrelationship of the mind on the body. Clinical terms, he (Laing, 1965a: 18) said: 'isolate and circumscribe the meaning of the patient's life to a particular clinical entity'.

Laing considered the terms utilised to conceptualise psychiatric problems as dualist: mind and body, self and other. These terms, he thought, failed to conceptualise the interaction of the mind on the body,

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[1] Laing was well versed with existential-phenomenology and translated Sartre's works in *Reason and Violence* with David Cooper (Laing & Cooper, 1971).

the other on the self. In other words, discourses available to articulate mental health problems are either biological or phenomenological, without adequate conceptualisation of the interaction of the two in a social context. Psychiatric concepts, he suggested, precluded an alternative conceptualisation of the issues because of the monism that reduces one term to another.

For example, biological approaches to a problem prevent phenomenological and/or social ones. The language of psychopathology:

> precludes the possibility of understanding patients disorganisation as a failure to achieve a specifically personal form of unity... (which) perpetuates the very dualism that most psychopathologists wish to avoid and is clearly false. Yet this dualism cannot be avoided within the psychopathological frame of reference except by falling into a monism that reduces one term to another, and is simply another twist to the spiral of falsity (Laing, 1965a: 24).

Laing's analysis highlighted the limitations of pathology as a way to understanding the experience of the psychiatric subject. [2]

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[2] These issues about the importance of the subjective experience of the schizophrenic are the same kinds of issues more recently being debated in philosophy. In *Philosophical Perspectives on Psychiatric Diagnostic Classification,* Sadler, Wiggins and Schwartz (1994) take the issues of the subjectivity of diagnosis as a promising area of development for psychiatry. Bolton and Hill (1997), Graham and Stephens (1994), and Sadler, Wiggins and Schwartz (1994), collectively argue for the role of meaning to be considered in 'psychopathology'. Bolten and Hill (1997), in particular, argue that intentional purposes are central to representational processes, and that the subjective nature of these processes need to be made central to the conceptualisation of mental health and illness.

Mishara (1994: 130) argues that the DSM's claim to be phenomenologically 'descriptive' is wrong as 'it harbours an array of concealed theoretical assumptions

Laing goes on to argue that Kraepelin's view of psychosis was only one way of perceiving schizophrenic behaviour. To challenge this view, Laing, attempted to 'reconstruct the patient's way of being himself in his world' (Laing, 1965a: 25). To this end, Laing reinterpreted Kraepelin's precedent-setting study, thereby undermining the very foundation of psychiatric concepts and practice. To do this Laing first outlined Kraeplin's quote from a person in a catatonic state:

> 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 (Laing, 1965a: 29-30).

Kraepelin's judgement of this scenario is that:

> 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 (Laing, 1965a: 30).

In contrast, Laing reinterpreted the quote as suggesting that the person resented being used as a sign of disease. Laing's interpretation was that the person was responding to an experience of being subject to an interrogation. Consequently Laing suggested that the person: 'feels, that Kraepelin is objecting because he is not prepared to prostitute himself before the whole classroom of students' (Laing, 1965a: 30). Laing interpreted the patient's response as a send up of the interrogator.

> Kraepelin asks him his name. The patient replies by an exasperated outburst in which he is now saying what he feels is the attitude

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about the nature of mental disorder and its classification'. Stephens and Graham (1994) argue that hearing voices is a product of a subject's disturbed sense of self rather than an auditory hallucination. This is remarkably close to what Laing was saying as will be demonstrated.

> implicit in Kraepelin's approach to him: What is his name? What does he shut? He shuts his eyes… Why do you give me no answer? Are you getting imprudent again? You don't whore for me (Laing, 1965a: 30)?

Laing argued that the same behaviour can be seen either as signs of disease (as Kraepelin did), or in an existential-phenomenological way as representing the frustration of his relationship with Kraepelin. Laing's approach was to recognise that the person was tormented and desperately objecting to being treated as an object to be classified and that 'he wants to be heard', not classified (Laing, 1965a: 31). Laing protested 'we will find no intelligibility in behaviour if we see it as an essential phase in an essentially inhuman process' (Laing, 1965a: 25). Using existentialist-phenomenology, Laing reconceptualised the problems experienced by people requiring psychiatric services as an internalisation of interpersonal experience, rather than biology.

In Laing's framework of understanding, ontological insecurity is a product of a person's relatedness to and separateness from others, which is central to the construction of one's sense of self. Laing identified interpersonal relationships as central to mental health problems. He argued that relatedness and separateness are 'an essential part of our being' (Laing, 1965a: 26). Laing defined ontological security as a place of 'being' secure. This security offers a state of autonomy and separateness in relation to others. However, as this sense of autonomy is developed in relationship to others, this places the role of interpersonal relations as central to the development of ontological security.

Laing explains, interpersonal relationships are central to the concept of self, because a sense of self is established in the pattern of relationships at a micro level.

> A lack of a sense of autonomy implies that one feels one's being to be bound up in the other, or that the other is bound up in oneself, in a sense that transgresses the actual possibilities within the structure of human relatedness. It means that a feeling that one is in a position of ontological dependency on the other (i.e. dependent on the other for one's very being), is substituted for a sense of relatedness and attachment to him based on genuine mutuality. Utter detachment and isolation are regarded as the only alternative to a clam—or vampire like attachment in which the other person's life-blood is necessary for one's own survival, and yet is a threat to one's survival. Therefore the polarity is between complete isolation or complete merging of identity rather than between separateness and relatedness. The individual oscillates perpetually between the two extremes, each equally unfeasible (Laing, 1965a: 53).

The ontologically insecure person does not feel connected to the body, and 'is preoccupied with preserving rather than gratifying himself: the ordinary circumstances of living threaten his low threshold of security' (Laing, 1965a: 42).

The ontologically insecure person experiences others as a source of anxiety because of the fear that relationships with others will lead to 'engulfment', 'implosion', 'petrification' and 'depersonalisation' (Laing, 1965a: 43-47). For example, engulfment refers to the ontologically insecure person's sense of a threat to identity in any relationship. 'Being loved, or simply being seen' can mean being destroyed (Laing, 1965a: 44). Isolation is an attempt to preserve identity 'to prevent himself losing his self' (Laing, 1965a: 42-43). As security is not found, separateness is not achieved. The person experiences him/herself as ontologically insecure, which involves a compensatory mechanism of

splitting into a mind and body, or of separation of the self into a 'false' embodied self, in contrast with the 'true' disembodied self.

> This split will be seen as an attempt to deal with the basic underlying insecurity. In some cases it may be a means of effectively living with it or even an attempt to transcend it (Laing, 1965a: 65).

The absence of the true self from the body means the body is observed by the disembodied self, which becomes hypervigilant, and develops complex relationships with the body, which are unique to the individual.

> Instead of being the core of his true self, the body is felt as the core of a false self, which a detached, disembodied, 'inner', 'true' self looks on at with tenderness, amusement or hatred (Laing, 1965a: 69).

The person split in such a manner has a complex relationship to the 'inter-personal' relationships of the split sense of self within.

> In all this there is an attempt to create relationships to persons and things within the individual without recourse to the outer world of persons and things at all. The individual is developing a microcosm within himself: but, of course, this autistic, private, intra-individual 'world' is not a feasible substitute (Laing, 1965a: 74).

In other words, Laing (1965a: 43) is saying, not that the person is loosing contact with reality, but that their reality is a reality 'he can no longer share with other people'.

The schizoid state is a person's way of dealing with a threatening situation, from which there is otherwise no escape. This psychic escape is by way of detaching from the body. But this split creates some problems: 'His false self does not serve as a vehicle for the fulfillment or gratification of the self. The actions of the false self do not, however, 'gratify' the 'inner self'' (1965a: 96). Laing describes the schizoid

individual disembodied self as an attempt to preserve the self, but this involves a paradox:

> The tragic paradox is that the more the self is defended in this way, the more it is destroyed. The apparent eventual destruction and dissolution of these schizophrenic conditions is accomplished not by external attacks from the enemy (actual or supposed), from without, but by the devastation caused by the inner defensive manoeuvres themselves (Laing, 1965a: 77).

The false-self system is not straightforward. The false self of the schizoid is compliant to the will of others:

> It is felt as alien; the unrealness, meaninglessness, purposelessness which permeate its perceptions, thoughts, feelings, and actions and its overall deadness are not simply productions of secondary defences but are a direct consequence of the basic dynamic structure of the individual's being (Laing, 1965a: 96).

It is the self that others want him/her to be. These persons experience themselves as denied the right to their own subjective life by saying: 'I was merely a puppet of her reality' (Laing, 1965a: 97). The false self is not an attempt to be good, but a 'negative conformity' to another's will, 'prompted by the dread of what might happen if one were to be oneself in actuality' (Laing, 1965a: 97). Such compliance means that one's self is denied outward expression and concealed within the imaginary.

But this false self marks the split between the inner and outer life. This outer compliance is an attempt to 'preserve himself from total extinction' (Laing, 1965a: 97). What explains this split Laing suggests, is fear and hatred. Fear is the response to forced compliance by an other, and hatred is then directed toward the self, thereby endangering life. 'However, the anxiety to which the self is subject precludes the

possibility of a direct revelation of its hatred, except… in psychosis' (Laing, 1965a: 99-100).

In this context of hatred driven inward, the false self is a characterisation of the behaviour despised in the other, but denied as part of the self through the notion of the divided false self. This, according to Laing, is in order to protect or deaden the vulnerable, frightened self. Laing identifies the paradox at the heart of the false self-system: where the "inner' secret self hates the characterisation of the false self', the inner self fears the intrusion of the false self, but, in actuality, 'the inner self is not more true than the outer' (Laing, 1965a: 102-103). In David's case the:

> inner secret self turned into a most controlling manipulating agency, which used to be his false self very much like the puppet he felt he had been for his mother. That is, the shadow of his mother had fallen across his inner self as well as his outer self [Laing, 1965: 103).

What had been the compliance of the false self, becomes an attack by the use of a mocking caricature of the other. The false-self system then 'is a way of not being oneself which seems to offer security' and 'does tend to occur with particular insistence and compulsiveness on the basis of the schizoid false-self system' (Laing, 1965a: 104).

Laing (1965a: 105) explains schizophrenic behaviour as a 'patchwork of other people's peculiarities made more peculiar by the incongruity of the setting in which they are reproduced'. He likens these patchwork fragments to pieces of shrapnel that:

> get embedded in the individual's behaviour as pieces of shrapnel in the body. While maintaining an apparently happy smooth

> relationships with the world, the individual is forever picking at those alien fragments which (as he experiences it) are unaccountably extruding from him. These behavioural fragments fill the subject with disgust and horror… this little 'introjected' action fragment or particle cannot be attacked without violence to the subject's own being (Laing, 1965: 105).

Laing (1965a: 105) describes the experience of schizophrenia as one where behaviour is completely consumed by 'compulsive mimicry, impersonating, caricaturing'. Catatonia is described as an attempt to avoid this behaviour.

Laing (1965a: 106-119) identified self-consciousness to be central to ontological insecurity. He stated that on one hand, there is a need to be seen to be reassured of existence, but on the other hand, being seen is also experienced as a dangerous threat to identity, resulting in the false-self system. Being somebody else, or absent from the body, or incognito, are defenses in schizoid and schizophrenic conditions. Laing (1965a: 111) argues that though such defence mechanisms offer an 'avenue of escape' from ontological insecurity, the result is a 'source of weakness' and cost a coherent sense of self.

People with schizoid and schizophrenic conditions even more so, remain 'compulsively preoccupied with the sustained observation of one's own mental and/or bodily processes' (Laing, 1965a: 112). That is:

> he turns the living spontaneity of his being into something dead and lifeless by inspecting it. This he does to others as well and fears their doing it to him (petrification) (Laing, 1965a: 112).

Hypervigilance is an attempt to lessen the danger of being in 'someone else's power and control' (Laing, 1965a: 113). The self is not embodied,

though because despite 'his longing to be known', 'this is also what is most dreaded' (Laing, 1965a: 114).

Laing (1965a: 115-119) discusses the role of the other in the construction of the self by drawing from Freud's (1920) discussion of a little boy playing with a reel and string, his image in a mirror, and his mother's disappearance. The loss of the mother is associated with the loss of the sense of the self as the self is constructed as a person as in the eye of the mother. His game of making his self/image disappear in the mirror, is a crucial phase of developing self identity which is to an extent confused with the image of the mother as 'other'. Laing goes on to argue that when a person experiencing schizoid schizophrenia feels threatened that the other may 'go away or die or not reciprocate one's feelings for him', the person seeks another to mirror him/herself to 'turn his self, a quasi-duality with an overall unity, into two selves, i.e. an actual duality' (Laing, 1965a: 117).

For a child, the caretaker is the source of his/her identity. Laing maintains that the identification of the self with the caretaker, is what informs the characteristics of the 'observing self' (Laing, 1965a: 117). This understanding recognises the role of interpersonal relationships in the development of schizoid or schizophrenic conditions. But the implications of this claim are serious, as what happens is the child internalises the destructive observer.

> It may be that the child becomes possessed by the alien and destructive presence of the observer who has turned bad in his

> absence, occupying the place of the observing self, of the boy himself outside the mirror (Laing, 1965a: 117).

Through this understanding Laing (1965a: 117) explains that the extraordinarily critical observing self 'has now a persecuting observer in the very core of his being'. The child becomes an object to himself by observing him/herself as other.

> He retains his awareness of himself as an object in the eyes of another by observing himself as the other: he lends the other his eyes in order that he may continue to be seen; he then becomes an object in his own eyes. But the part of himself who looks into him and sees him, has developed persecutory features he has come to feel the real person outside him to have (Laing, 1965a: 117).

Laing (1965a: 117) suggests that 'the child becomes possessed by the alien and destructive presence of the observer', which references an 'alien' observer whereby the child, 'then becomes an object in his own eyes'. The consequence is that 'the part of himself who looks into him and sees him, has developed the persecutory features he has come to feel the real person outside him to have' (Laing, 1965a: 117). The absence of the mother for the young child is associated with fear of the absence of the consciousness of his/her own being: 'not to be conscious of oneself, therefore, may be equated with nonentity' (Laing, 1965a: 119).

What Laing suggests then is that if in the developmental phase the environment provides security, the person develops a sense of 'being'; but if this security is not provided, the person achieves this sense of being that is not otherwise available, through a 'special strategy' of remaining self-conscious.

> The schizoid individual is assuring himself that he exists by always being aware of himself. Yet he is persecuted by his own insight and lucidity (Laing, 1965a: 119).

Laing argues that providing ontological security later in life is an opportunity for this developmental phase to be achieved. However this is not to overestimate the success or underestimate the difficulty of reversing problems that arise early in life.

Laing outlines the problem central to the schizoid and schizophrenic's conditions as the internalised other, which has a profound effect on the self. Laing uses this idea to identify the central role of interpersonal or intersubjective relationships in the construction of the self. Problematic conceptions of the self, he suggests, can be understood as the result of problematic interpersonal relationships. This theme he goes on to develop further and is discussed in the next section.

Beforehand, the case study of Peter in chapter eight of *The Divided Self* (Laing, 1965a: 129-133) provides an example of how one person coped with his split sense of self. That is, he felt he had to stop being the false self he felt others wanted him to be and to be the nobody he thought he really was. He described himself as 'on the fringe of being' (Laing, 1965a: 125). This, Laing (1965a: 120) supposed, was because 'he had been treated as though he wasn't there'. The lack of responsiveness from those around him meant he saw himself as 'not *seen*' (Laing, 1965a: 126). Compliance with others' wishes in the false-self system meant that he began to hate others and himself. His lack of being handled early on had left him with a:

> compulsive preoccupation (which he felt as extremely unpleasant) with being touchable, smellable, etc., to others was a desperate attempt to retain that very dimension of a living body: that it has a being-for-others (Laing, 1965a: 131).

This 'being-for-others' he had to pump up as a:

> dimension of his experience that had not become established in a primary sense out of the original infantile situation, and the gap was filled, not by any later development of a feeling of being loved and respected as a person, but by a feeling that practically all love was disguised persecution, since it aimed to turn him into a thing of the other (Laing, 1965a: 131).

Laing (1965a) goes on in the third part of *The Divided Self* to discuss the concept of the divided sense of self in relation to psychotic conditions. Laing provides examples of his notion of the split self in someone experiencing psychosis to provide insights into the acute phenomenology of the split self. For someone experiencing psychosis, the dissociation from the body means that:

> the body is conceived not only as operating to comply with and placate others, but as being in the actual possession of others. The individual is beginning to be in a position to feel not only that his perceptions are false because he is continually looking at things through other people's eyes, but that they are playing a trick on him because people are looking at the world through his eyes (Laing, 1965a: 144).

The person at this point experiences a lack of realness in life. There is an enviable hatred toward those who do experience life, as their experience of life is empty, dry and unfulfilled. Despite the envy there is also fear of life, as this threatens the self, so simultaneously there is an attempt to acquire and destroy the real. Laing (1965a: 144) proposed that acquiring life through these experiences, is by the magical means of touching, copying and imitating and stealing, or of experiencing terror.

Laing (1965a: 147) describes the experience of the person living with psychosis to be one where 'everything he approaches becomes dead'. This leaves two equally psychotic options available: 'He may decide to be himself despite everything', or 'He may attempt to murder his self' (Laing, 1965a: 147). Importantly, statements considered delusional in psychiatry, Laing (1965a: 149) argues, contain 'existential truth'–'they are to be understood as statements that are literally true within the terms of reference of the individual who makes them'.

For instance, committing suicide for the schizophrenic would not result in the death of self, as the self is not located in the body but in the soul and is therefore immortal. One way the schizophrenic tries to preserve his self is to deny his being. 'The schizophrenic feels he has killed his 'self' and this appears to be in order to avoid being killed. He is dead, in order to remain alive' (Laing, 1965a: 150). A person feels compelled to kill themselves, according to Laing, from anxiety and guilt.

For Marie, a girl who 'presented unequivocally the clinical picture of dementia praecox or schizophrenia simplex', to suddenly transform, would be explained by psychiatry according to Laing (1965a: 156), as 'an arrest in the process of the progressive schizophrenic deterioration probably on an organic basis'. But:

> from an existential point of view, one could say that she had stopped trying to murder herself. She saw that her life had become a systemic attempt to destroy her own identity and to become a nobody… she attempted to reduce herself to vanishing point by never doing anything specific. She acted as though it was possible not to put herself into her actions. The effort to dissociate herself from her actions comprised everything she did. By these means she sought to become nobody (Laing, 1965a: 156).

Laing goes on to discuss how the split sense of self, impacts on perception, and how this '*other self*' is the basis of hallucinations. The thinking of the other self, Laing explains, has the quality of a perception:

> since it is received by the experiencing self neither as a product of its imagination nor as belonging to it. That is, the *other self* is the basis of an hallucination' (Laing, 1965a: 158).

It is from this other source that the individual says 'he has been murdered, or that 'he' has murdered his 'self' (Laing, 1965a: 158).

> What may happen is that the place and function of the inner phantom 'self' becomes almost completely taken over by archetypal agencies which appear to be in complete control and dominate all aspects of the individual's being (Laing, 1965a: 158).

Laing describes the split self as the 'kernal' of psychosis. Laing (1965a: 158) conceives the task of therapy is to 'make contact with the original self'.

> However, when the centre fails to hold, neither self-experience nor body-experience can retain identity, integrity, cohesiveness, or vitality, and the individual becomes precipitated in to a condition the end result of which we suggested could best be described as a state of 'chaotic nonentity' (Laing, 1965a: 162).

Laing explains that the structure of the perceptual experience of a person with schizophrenia makes dialogue difficult to follow. This is made more difficult, Laing argues, by the person with schizophrenia who plays at being psychotic, to protect the self. Despite longing to be loved, 'any form of understanding *threatens* his whole defensive system' (Laing, 1965a: 163). Hiding the self is to keep it 'safe from being smothered or engulfed by love, as much as from destruction from hatred' (Laing, 1965a: 164). The schizophrenic plays at being mad 'to

avoid at all costs the possibility of being held *responsible* for a single coherent idea, or intention' (Laing, 1965a: 164).

However, Laing found, like Jung:

> 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' (Laing, 1965a: 165).

Until then:

> Everything the patient *is* is felt to be 'not-me'. He rejects all that he is, as a mere mirror of an alien reality… 'He can't be real'… This false self system is the breeding ground of paranoid fears since it follows easily that the false-self system, which has spread to include everything and is disavowed by the self… as an alien presence or person in possession of the individual (Laing, 1965a: 168).

The self becomes alien, enemy territory, controlled by a hostile agent. The self exists in a vacuum that becomes a torture chamber. It is not that the 'I' does not exist but that it has no body, no 'me', no identity. One of Laing's patients expressed:

> I only felt real because of the reactions I could produce in you. If I had scratched you and you didn't feel it, then I'd be really dead. I could only be good if you saw it in me. It was only when I looked at myself through your eyes that I could see anything good. Otherwise, I only saw myself a starving, annoying brat whom everyone hated and I hated myself for being that way. I wanted to tear out my stomach for being so hungry (Laing, 1965a: 174).

Laing (1965a: 176) describes the schizophrenic as having two motives for 'promoting a state of death-in-life'. First is the primary guilt of having no right to life in the first place, and second of being entitled at most to a 'dead life' (Laing, 1965a: 176). An example was Joan. Her parents wanted her to be a boy, and since she could not be she said 'I tried to die by being catatonic. When I was catatonic, I tried to be dead and grey and motionless. I thought my mother would like that' (Laing,

1965a: 176). What is being demonstrated in this analysis is in contrast with the biological conception of the subject utilised in acute psychiatric services.

The biological conception leaves the capacity of the person to identify the internalisation of the meaning and significance of behaviour for themselves unrecognised. This failure also leaves these needs unmet. Laing (1965a) in *The Divided Self* has demonstrated that even for the most disturbed person, behaviour has a meaning, a context and a history, which has been internalised. The person him/herself has the capacity to identify and express these meanings and significance given a safe context and the opportunity to do so. What is required is an unconditionally loving and nonjudgemental commitment to understand that person's perspective.

From the Case Study to the History of the Subject

These case studies mark an intersection between Laing's first analysis of psychotic symptoms to do with ontological insecurity and Laing's next analysis of the important role of the intersubjective in producing symptoms. The implication of Laing's existential-ontology of psychotic symptoms presented here from *The Divided Self* (Laing, 1965a) is that the appropriate approach for physicians to take to 'mental health' problems, is a biography. He argues, psychotic symptoms though ontological or internal, are existential, in that they are rooted in the

social context of (discourse with) a family. Laing argues importantly that:

> it is only when one is able to gather from the individual himself the history of his self, and *not what a psychiatric history in these circumstances usually is, the history of the false-self system,* that his psychosis becomes explicable [Laing, 1965: 148).

To this end, the role of narrative in understanding the historical nature of the self is explored further here and in the next chapter.

Laing (1965a: 178-205) demonstrated the role of biography in providing understanding in the last chapter of *The Divided Self,* a case study of Julie. This study brings out the interchange between these two levels of analysis, that is, how the interpersonal context is internalised. Julie was a person who had been diagnosed with chronic schizophrenia. She described her trouble as one of not being 'a real person', of 'being empty' and 'worthless' (Laing, 1965a: 178-179). In response to this, Laing took a 'clinical biography', not case notes for a medical history of pathology, but an account of her history as a subject.

In Julie's case, both parents colluded to deny the validity of their daughter's complaints against them. Julie's mother and the other adults in her life praised behaviour as 'good', which Laing considered as 'existentially dead'.[3] This, Laing (1965a: 187) explained, led to a lack of 'genuine self-action' that 'seems never to have become established to

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[3] This is a reference to Laing's knowledge of philosophy. He was also a first rate athlete, pianist, dramatist, poet and by all accounts, comedian (Laing, 1994; 1968; 1976; 1982; 1985; Mullan, 1995).

any extent, but instead all action is in almost total compliance and conformity with outside directives'.

Julie's total lack of disobedience, is evidence for Laing (1965a: 187), that Julie was 'too terror stricken to become a person'. Laing (1965a: 187) explains that what this resulted in for Julie was that though her actions had been trained by her mother, 'she' was not 'in' them'. What this meant for Julie was that she could not be 'herself neither in her mother's presence nor in her absence' (Laing, 1965a: 186). Denied the control of presence and absence, Laing (1965a: 186) argues she never developed a sense that she did not need the presence of another to have a sense of her own existence. 'If an individual needs another in order to be himself, it presupposes a failure to fully achieve autonomy' (Laing, 1965a: 186). Laing held that this ontologically insecure situation explains why Julie was not able to attain the autonomy necessary to have a mind of her own.

Laing identified Julie's schizophrenic cryptic statements as indicative of her accounts of her problem. She called herself 'Taylor' to refer to how she felt 'tailor-made' by her mother (Laing, 1965a: 192). Julie did not have anyone in her life that acknowledged her. Her problem with her parents was not to win an argument, but to 'achieve existence' (Laing, 1965a: 193). As she was not allowed existence, she could not develop what one might call 'the ability of common sense' (Laing, 1965a: 193). For instance, 'when her mother said she was bad, Julie felt this as

murder. It was the negation of any autonomous point of view on her part' (Laing, 1965a: 193).

Laing discusses the 'praecox feeling' that earlier psychiatrists wrote about, a feeling of inaccessibility to the person, sometimes referred to as autism, mentioned earlier. Laing describes being with Julie as similar to being with 'different personalities in operation at the one time' (Laing, 1965a: 196). Laing (1965a: 196) understood the way Julie spoke 'to be the result of a number of quasi-autonomous partial systems striving to give expression to themselves out of the same mouth at the same time'. This understanding made her expression comprehensible.

Laing goes on to say Julie's state of disintegration was not static:

> She would sometimes marvelously come together again and display a most pathetic realisation of her plight. But she was terrified of these moments of integration, for various reasons. Among others, because she had to sustain in them intense anxiety; and because the process of disintegration appeared to be remembered and dreaded as an experience so awful that there was refuge for her in her unintegration, unrealness and deadness (Laing, 1965a: 196-197).

Laing describes each of the fragments of her personality as acting independently of and as unaware of the others. Identification of these made Julie's behaviour explicable.

> The absence of a total experience of her being as a whole meant that she lacked the unified experience on which to base a clear idea of the 'boundary' of her being... Rather *each system seemed to have a boundary of its own* (Laing, 1965a: 197).

Each system seemed to be structured differently, and autonomously. All these systems were perceived as not her but as operating outside her. That is to say, she was 'hallucinated'.

The fragmented personality and the experience of hallucination and delusion Laing identified as understandable when the historical, social and inter-personal settings were defined. Voices and hallucinations considered products of biologically induced delusions in psychiatry, are here deemed by Laing as fragments of the self that are not recognised as such because the fundamental conception of the self as split and abstracted from the body. Laing's account validates a person's experience of these 'voices', and 'vision', as experiences of a different person, the embodied person, which is not identified by the disembodied 'true' self as self. Laing's (1965a: 178-205) work offers an understandable and meaningful account of the process whereby hallucinations, such as the experience of 'voices', arise.

Laing (1965a: 198) described the implications of being split to mean that one has a tendency to 'become what one perceives' whether that is the 'rain', a 'chair', and the 'wall'. As Julie stated 'I could be that wall. It's a terrible thing for a girl to be a wall' (Laing, 1965a: 198). Laing explains, for Julie:

> all perception seemed to threaten mergence and all sense of being perceived by the other threatened her similarly. This meant that she was living in a world of constant persecution and felt herself to be doing to others what she dreaded as happening to her (Laing, 1965a: 198).

This in turn, contributed to her confusion.

> Almost every act of perception appeared to involve a confusion of self with not self. The ground was prepared for this confusion by the fact that, since large aspects of her person were partially outside her 'self' it was easy to confuse those split-off aspects of her being with other people (Laing, 1965a: 198).

For Laing (1965a: 198), that meant, to be in a relationship with her was complex as 'if she likes me, she is like me, she is me'. Laing called all the personalities that constructed Julie an 'intra-personal group'. This group in Julie's case was dominated by what Laing called 'a bad internal mother'. 'She was basically an internal female persecutor who contained in concentrated form all the bad that Julie ascribed to her mother' (Laing, 1965a: 200).

She also had a system which called Julie 'her little sister', and another system that was the compliant little girl. Her 'inner' self had diminished into 'pure possibility'. Yet there were times when Julie's own 'pathetically scared' person spoke. For example:

> I was born under a black sun. I wasn't born, I was crushed out. It's not one of those things you get over like that. I wasn't mothered, I was smothered. She wasn't a mother. I'm choosy who I have for a mother. Stop it. Stop it. She's killing me. She's cutting out my tongue. I'm rotten, base. I'm wicked. I'm wasted time (Laing, 1965a: 200).

Laing understood Julie through piecing together the partial systems of Julie's personality through her biography. When she talks about her mother as a black sun, he identifies the reference as her destructive mother. The interruption to which she cries 'Stop it, stop it', is from this bad mother (Laing, 1965a: 200). This is then followed by a referring back to her conversation with Laing: 'She's killing me. She then goes on to degrade herself as her bad mother would' (Laing, 1965a: 200).
Once when Laing interrupted the bad internal mother's response to Julie's accusations about her, she stopped and answered from her perspective:

> Julie's frightened of being killed by herself for saying these things... that's my conscience killing me. I've been frightened of my mother all my life and always will be. Do you think I can live (Laing, 1965a: 201)?

Julie's insanity, Laing argues, consists in the lack of integration of her being. Her schizophrenia, Laing (1965a: 202) argues, is in her reference to herself as in the third person, and the interruption by another (for example, 'I'm a good girl'). The self that was left consisted of cryptic statements; Laing described these as the psychotic remains of the inner self of schizoid states. Laing (1965a: 205) saw her language as 'an expression of the way she experienced being-in-her-world'.

This analysis highlights the inadequacies of the current conception of the subject in mental health in biological terms and points to the crucial role of the intersubjective in the internal construction of the self. This existential-phenomenological understanding of symptoms has evaded acute psychiatry, and marks the transition into the next analysis Laing offers. Laing goes on to explore the role of the intersubjective in his next account of the subject. Recognising the role of intersubjective relationships in the break down of mental health is important as it calls attention to the need to focus on the interpersonal as the means by which to restore well-being, a topic that is taken up in chapters seven and eight.

A significant feature of Laing's account of family life for those experiencing what has been labelled schizophrenia, is that access to discourses other than their own family discourse is lacking. This is a significant feature of the case studies in his next series of studies. Laing

identified that understanding a person was facilitated by recognising the possibilities, or lack of them, for developing a self-concept in the context of the family. That is, understanding a person is facilitated through an examination of a person's life 'in her own interpersonal microcosms' (Laing, 1965a: 180). Laing states 'it is just as important to discover the way the people in the individual's world have regarded her behaviour as it is to have a history of her behaviour itself' (Laing, 1965a: 182).

This next approach is not an attempt to blame the mother, as has been implied by Mitchell (1975). On the contrary, Laing (1965a: 190) recognises the importance of the entirety of the family context: 'father or other significant adults may play a decisive role in the child's life, either in direct relation with the child or, indirectly through the effects on the mother'. Laing in his first analysis identified the important role of the dynamics of the family as a whole, rather than to the mother in particular in precipitating problems labelled as mental illness. Neither does this discount the influence of the broader social and socio-economic factors. These, Laing (1965a: 182) agrees, 'profoundly influence the nature of the family and hence the patient'. His intention was to identify the important role of inter-personal relationships on the structure of the internal world of someone experiencing psychosis. This was an attempt by Laing to humanise the way psychiatrists' treat their clients.

2) The Intersubjective: The Primacy of the Interpersonal

In *The Divided Self,* Laing (1965a) identified the intrapersonal world of the psychiatric subject as crucial to understanding the individual's relationship to the world. Then Laing moved the focus from the individual to the social context where he considered the role of the intersubjective as central to psychiatric problems. In Laing's first analysis, the focus was (interpersonal relationships) from the point of view of the subject, in the second analysis; Laing focused directly on the role of interpersonal relationships to explain a person's 'mental health problems'.

Laing argues that science does not account for the subjective meanings that humans apply and the intersubjective nature of the relationships between persons. Science can only deal with objects, not the subjective interaction of persons. For Laing, the self is intersubjective, dependent on others' reflections for its own self-consciousness. Laing (1968: 83) in *The Politics of Experience* states: 'There are no basic emotions, instincts, or personality, outside of the relationships a person has within one or other social context'.

This approach developed when Laing was working at Glasgow's Gartnavel Royal Mental Hospital with patients who had been there since the turn of the century. He describes the scene as like a scene from Homer, where there are ghosts across 'their oceanic abyss, across our rivers of fear' (Laing, 1985: 112). Laing gained the confidence of one old lady, who prior to this had ranted and raved up and down the ward.

Now, she sat beside Laing, and Laing (1985: 113) asked her to fill him in on the other patient's actions: 'she took me on. She became my mentor'.

Laing sat in the day room of that ward for one or two hours every day for several months with more than fifty patients. He states: 'it began to dawn on me that the autism of each patient, although autistic, was interwoven with that of the others' (Laing, 1985: 114). Once recognising this he wanted to see what would happen if he had 'a few patients together with the same nurses day after day in less distressing surroundings' (Laing, 1985: 114).

Laing tried an experiment with eleven of the most withdrawn people in the ward, who had been there for over four years. He allocated two nurses to work nine a.m. to five p.m. Monday to Friday, in a separate room, which was nicely decorated, comfortably furnished and well equipped with materials for activities. Laing met the nurses once a week to talk about the patients and made informal visits. This is what happened.

> On the first day, the eleven completely withdrawn patients had to be shepherded from the ward across to the day room. The second day, at half past eight in the morning, I had one of the most moving experiences of my life on that ward. There they all were clustered around the locked door, just waiting to get out and over there with the two nurses and me. And they hopped and skipped and twiddled around and what not on their way over. So much for being 'completely withdrawn' [Laing, 1985: 115-116].

It was here that Laing (1985: 115) became aware of the exquisite sensitivity of these people to 'nuances that some people never notice'. In the room, the patients now wore ordinary clothes, make-up and had

coiffured their hair. Within eighteen months, all eleven patients had left hospital. Within another year, they were all back. Laing (1985: 117) asks 'had they found more companionship 'inside' than they could find 'outside'?' Laing discussed the split between experience and behaviour as the essence of psychopathology.

> Violence attempts to constrain the other's freedom, to force him to act in the way we desire, but with ultimate lack of concern... We are effectively destroying ourselves by violence masquerading as love (Laing, 1965: 50).

Laing saw further evidence for the powerful role of the intersubjective in his work. A particularly striking example was when he worked at the Glasgow University Department of Psychiatry. There he met a fourteen-year-old boy who on returning from school found his mother having died in a pool of blood from an haemoptysis. She had had tuberculosis. His father, for the next three months accused the boy of the mother's death by exhausting her, by his life, from conception. The boy then found his father had hanged himself. Within six months he was in the Glasgow University Department of Psychiatry.

He was incontinent of urine and faeces, self absorbed, silent or stuttering incoherent sounds, and had peculiar ways of walking and gesturing. At times he was hyper-alert, other times he would 'flutter'. He was diagnosed catatonic schizophrenic. Laing said:

> He was broken up, shattered to pieces by what had happened. He was staggering. He had been through a literally staggering experience. He was staggered. He had been struck—not quite dumb. He could utter sounds, but nothing coherent came out of his mouth.

> Just scraps, shreds, drive, a sudden bellow, a moan, a laugh (Laing, 1985: 139).

Laing saw him every day for six weeks. Writing his clinical notes, he became aware of how the clinical picture of acute catatonic schizophrenia had transformed during the interview into the 'clinical picture of a quiet guy sitting in a chair talking about calculus' (Laing, 1985: 139).

He was astonished at 'how extraordinary that interview was and how extraordinary that I could take it so blandly for granted' (Laing, 1985: 139). He noted that, if this miraculous transformation had happened anywhere else it would have been 'heralded as a medico-psychiatric, biochemical, scientific breakthrough of the first order' (Laing, 1985: 139-140). Laing thought if he left this fourteen-year-old in a mental hospital, he would only get worse. So he took him home to his wife and three children. His incontinence stopped immediately, as did his shaking. He spoke coherently, and in three months was together enough for foster care. He visited Laing fifteen years later. He was married, with two children, had a job, and was studying psychology.

What these examples demonstrate is the powerful role of the history of interpersonal relationships and in the restoration of the self. These themes are present in *The Self and Others* (Laing, 1961), revised as *Self and Others* (Laing, 1971b), *Interpersonal Perception* (Laing, 1966) and *Sanity, Madness and the Family* (Laing, 1965b), Knots (1970), and some parts of *The Politics of the Family* (Laing, 1971a). Laing's stated aim was to outline the role that others have in constructing the self. Laing

argued that the interdependence of persons could be seen, in the subjective reliance on others for recognition. This means that intersubjective relationships have the potential to construct or destruct others.

> I shall try to depict persons within a social system or 'nexus' of persons, in order to try to understand some of the ways in which each affects each person's experience of himself and of how interactions take form. Each contributes to the other's fulfillment or destruction (Laing, 1971b: 9).

Kirsner (1976) has pointed out how Laing's influences changed in this period. He no longer relied on existential-phenomenology, but drew from the work of psychoanalysts such as Klein and Winnicot. Goffman's work on asylums was also influential as well as communication theorists such as Bateson and other colleagues whose work centered on the 'double bind', research into schizophrenia. Bateson (1973) states that:

> According to our thesis, the term 'ego functioning' is precisely the process of discriminating communication modes either within the self or between the self and others (in Kirsner, 1976: 173).

Bateson (1973) explained the problems of schizophrenia as occurring in the conflict between three areas of communications: those sent, those received and those experienced internally. Bateson attributed these problems to learning in the family of origin. These contradictory communications are then re-enacted in the psychiatric hospital where the interests of the staff take precedence over those of the patient, which are claimed to be in the interests of the latter (in Kirsner, 1976).

In *Self and Others*, Laing (1971b) discusses 'unconscious experience' as a contradiction in terms on the grounds that experience informs

conscious life. Laing argues that it is not useful to explain problems produced by 'experience' through reference to mechanisms such as the unconscious, as it only further obscures problems. In *Self and Others* (1971b), the ways in which conflicting attributions by others, place the person concerned in a false position is examined. Contradictory communications, Laing argues, have the potential to drive people crazy. This is especially the case if it is a conflict that cannot be resolved. They tend to undermine a person's confidence in their own emotional reactions and perceptions of reality (Searles in Laing, 1971b: 139). This means that the false self is confirmed at the expense of the true self. This collusion is:

> Always clinched when self finds in the other that other who will 'confirm' self in the false self that is trying to make real and vice versa. The ground is then set for prolonged mutual evasion of truth and true fulfillment. Each has found an other to endorse his own false notion of himself and to give this appearance a semblance of reality (Laing, 1971b: 111).

In the next book on this theme, *Interpersonal Perception,* Laing (1966) identifies the significant role of others in the construction of self-identity. This is claimed to be in contrast to Freud's focus on egoism, which excludes, according to Laing, the concept of you. Laing writes:

> Some philosophers, some psychologists, and more sociologists have recognised the significance of the fact that social life is not made up of a myriad of I's and me's only, but of you, he, she, we and them, and also that the experience of you or her or them or us may indeed be as primary and compelling (or more so) as the experience of 'me' (Laing, 1966: 3).

He goes on to say: 'psychoanalytic theory has no concepts for the dyad as such, nor indeed for any social system generated by more than one person at a time' (Laing, 1966: 6). Laing argues that the id, ego and

superego are internal objects, and that the way they relate to each other is unexplained, leaving interpersonal relationships and their impact on self-identity untheorised.

Laing used the concept of meta-perspectives: 'my view of the other's (your, his, her, their) view of me', and meta-identity: 'how I think you see me', to conceptualise the theoretical construction of self-identity as a product of both of these views (Laing, 1966: 7). Laing argues that behaviour needs to be seen in context as a function of the behaviour of the other. He argues that:

> The failure to see the behaviour of one person as a function of the behaviour of the other has led to some extraordinary perceptual and conceptual aberrations that are still with us. For instance, in a sequence of moves in a social interaction between person (a) and person (b)… is in turn explained as an *intra*personal sequence (process) due to *intra*psychic pathology (Laing, 1966: 8).

Laing, as is evident above, identifies one's behaviour as a response to another's. In recognising the impact of one person on another, Laing is developing an account of subjectivity as a product of intersubjectivity. Laing argued that in relationship there is 'no isolated individual person… The other is at one and the same time a threat and necessary to self's identity' (Laing, 1966: 27). The impact of the experience of someone else's behaviour occurs through interpretation. Laing explains that the person's present interpretations are based on past learning within the family context. As Laing understands, the experience of mental disorder is the outcome of a relationship of contradictions that are internalised. This insight is central to understanding a person's consequent behaviour.

For instance, for a person who is experiencing a situation of relational contradictions as untenable, a decision is made as to how to cope with it. A behavioural response, or 'special strategy' according to Laing, is based on a decision of how to cope. Once this strategy is established as a persistent pattern, if it is not socially acceptable may be labelled as pathological. This 'special strategy', then, becomes the source of the label of 'mental illness'. For example, delusions are based on a 'special strategy', a decision about how to cope, which affects subsequent experience (Laing, 1966).

The central issue is whether a safe environment has been provided to allow a person's subjectivity to develop. Laing argued that this is missing in the case of those considered to have a 'mental illness'. This is why Laing finds the role of identification of a member of a family as 'schizophrenic' to be misleading. Recognising mental health problems as the outcome of a situation, and not an individual's problem alone, is to recognise that pathologising a person becomes a form of scapegoating or labelling.

Sanity Madness and the Family (Laing, 1965b) was a study that examined the relationships that precipitated a person's symptoms. Identifying the role of context in precipitating symptoms has brought intelligibility and understanding to the symptoms people experiencing schizophrenia suffer. This work highlighted the need for identification of the social history for symptoms to be understandable. More than that, Laing and Esterson (1965b:13) stated 'we believe that the shift of point

of view that these descriptions both embody and demand has an historical significance'.

Laing's recognition of the role of the social context and relationships as the site of a person's mental health problems reintroduces the importance of the interpersonal in mental health. Omitting the interpersonal from the understanding of human beings Laing sees as 'violence and mystification'. It is in Laing's (1966) shift of focus, from the patient to the context, which makes the patient's behaviour understandable. In an attempt to understand the individual, Laing looks at the interaction of the family. This is not an attempt to describe the family as pathological, but to identify counterproductive family interaction as the site where the problems in construction of the subjectivity of the vulnerable member develop.

Conclusion

Laing's extensive writings on clinical psychiatry offers an alternative paradigm to explain the internal and interpersonal life of someone considered 'mentally ill'. Laing (1965a: 17) developed a theoretical framework for understanding a person experiencing psychosis by considering 'the context of his whole being-in-his-world': a context missing from Jaspers and subsequent acute public psychiatic theory and practice. The context, Laing explains, includes the important role of the interpersonal in the constitution of the experience of psychosis. As has been discussed here, Laing reconceptualised psychosis as an

intelligible praxis in the context of an otherwise untenable social position.

Laing's understanding approach to people experiencing acute psychiatric episodes, involved setting up alternatives to mental health services such as community houses, which it could be argued, have been the model for deinstitutionalisation. However, though Laing's work can be seen as constituting 'a bridge between past and future efforts in the understanding of madness' (1965b: 26) his theories have not provided an adequate basis for alternative praxis. So although Laing drew attention to the importance of context in the development of and understanding of psychotic experiences, he did not articulate just how this understanding approach might be practiced.

The counter paradigm Laing developed pointed towards conceptualising a subject as one constituted through a biography or narrative that operates internally at two different levels at least—the social or contextual, and the internal or at the level of the self. Laing made clear that the failure to acknowledge another person's dialogue, narrative, account or response to a situation, results in a denial of that person's being, and produces an autistic or enclosed or disturbed sense of self. Hence, the failure to recognise a person's narrative, which is the site of the identity of the self, is also a failure to recognise and respect a person.

As Laing's discussions indicate, the development of the capacity of a subject to experience him/herself as a self relies on the social environment to recognise him/her as a person through a narrative account. In chapter seven, this idea is developed further as the role of narrative is recognised in the development of the concept of the self, such that narrative is recognised as the site of identity. The ethical implications of the concept of the subject as a narrative subject will be taken up in chapter eight where the importance of the role of listening is theorised as central to the recognition of the ethical subject in acute public mental health services.