Audio Colloquies: An Interview With R.D. Laing
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Introduction:

The tape which you are about to hear is part of the series Audio Colloquies produced by Harper & Row publishers. Audio Colloquies is a series of discussions with leading individuals in a variety or fields. The following is an interview with the internationally renowned psychiatrist, Dr. R.D. Laing. Laing has done innovative and controversial work with severely disturbed mental patients at Kingsley Hall. He is the author of many professional and popular works in the field of psychiatry. Dr. Laing is interviewed by Dr. Desmond Kelly, consulting psychiatrist at St. George's Hospital, University of London. He is a psychiatrist and psychoanalyst in private practice. Dr. Kelly speaks first.

DK: Dr. Laing, you're Britain's most influential psychoanalyst. As you approach the mid-point of your career, what do you see as the greatest successes thus far?

RDL: Well, I was very glad I was able to give an articulate statement in *The Divided Self* of what is usually called the existential tradition in psychiatry, existential position, and the phenomenological approach and apply that in a relatively consistent and coherent way to the data, clinical data, a certain amount of the clinical data of psychiatry because there wasn't such a book that covered that ground. So that was an attempt to extend the domain of sense like Freud in his Introductory Lectures gives such emphasis to slips of the tongue and faulty actions that these things are not non-sensual but they do have meaning, a sense, and behind the apparent purposelessness of these that there's a purpose and an intent and that's more or less granted now, I would think, but quite what purpose and intention is still up for grabs of course. But it seemed to me a lot of what are called psychotic symptoms and psychotic delusions and transformations of the sensorium and so forth *like* dreams and neurotic symptoms had more *sense* and was more open to intelligibility than had or has been granted.

DK: Dr. Laing, could you tell me how your own childhood so graphically portrayed in your book, *The Facts of Life*, influenced your choice of profession, and later, your classification of social phenomenology?

RDL: In my childhood and particularly in the early part of the childhood I had both the experience of being very isolated from other children, I was an only child, and most of my relationships were with the adult members of both sides of my mother's and father's sides of the family. There was a great deal of feuding that went on in the family, different people had, practically everyone had their own story about what was going on and what they thought was going on and what this and that aunt or uncle was up to and my mother didn't get on with her mother very well, my father didn't get on with his father very well and at a

very early age at least as young as I can actually remember I had begun to try to figure out what they were up to rather than be completely sucked into it. Of course I took for granted at the time that the eccentricities of my family were pretty well like any other family. I suppose because I'd grown up with a certain amount of eccentricity which if it came under the purview of psychiatry I think there would be a good chance they all would have been [laughing] locked up and certified. If someone had really wanted to get down to it. So I had plenty of chance to live, feel quite at home with you might say…well I don't want to make it too dramatic and I do not want to make it sound too bizarre but with different styles nowadays it now might be regarded perhaps falling within the range of relevance to psychiatry. Of course in those days there were no psychiatrists around. It's often been said that psychiatric disease increases with the number of psychiatrists, no one even thought in those days that psychiatry was relevant to the ways people got on together as part of ordinary living.

DK: Do you think that there was more violence in your home than in other homes in Glasgow?

RDL: In *The Facts of Life* there's the impression that there was a great deal and certainly more than the fact they're there that at all is quite something. But. No. Glasgow, and Glasgow in those days it was considered as normal to thrash children and in fact if you didn't do that, many God-fearing quiet Presbyterian parents felt that they weren't doing their duty. I was interested to come across recently in that book put together by a symposium from American historians on the history of childhood in which they make the statement that up to the beginning of the 19th century at least, the *normal* child in Europe as they put it would be what we would now call a "battered baby". Well I got beaten up some times but I was never sort of habitually black and blue, sort of couldn't go out of the house or sort of I was never knocked insensible or anything like that.

DK: Do you think though that you would have been a different kind of psychiatrist if you'd been brought up in an idealised household where violence wasn't an everyday occurrence?

RDL: It wasn't an everyday occurrence in mine but it was an every month occurrence you might say. I am sure, yes, I'm sure, if in the first 5 years of my life I'd been allowed out to play with other children and if people had come round to our house and we'd gone round to them, we never did that, it was only, no one who wasn't a member of the family hardly came round except for a musical evening. As my father was principal baritone at the Glasgow University chapel choir so there was music and there was culture in the house and so forth. But, if I'd had more, if it hadn't been such a closed family system, I wouldn't have had to adapt to that system by coming to terms with that system in an unusual way. I mean I think I could have either in a way come to terms with it by an intensification of my awareness of it or I could have intensified my unconsciousness of it. I think if I'd grown up in a, the same family perhaps my children have, I'd have taken the family so for granted they would have been quite invisible. You know. It wouldn't have been problematic, it

wouldn't have been an issue. But you know if I'd grown up in a culture that wasn't so extremely sexually repressive then sexual issues wouldn't have been something that I was sensitised to notice. I remember one very urbane London psychiatrist saying that I was basically 'provincial'. If I'd grown up in a more urbane, opened-out sector of family and living, etc., I perhaps wouldn't have been so sensitized to notice and attribute importance to some things that people who've had these things find it very different to imagine what it's like they hadn't had that.

DK: What about your ambitions? Were you an ambitious young man?

RDL: I would say I was ambitious in a way that was almost in a sense past being ambitious. It was like Sartre describes how when he was 19, 20, 21 before he had really written anything he never really went through any doubt about being a writer because he said he thought he always *was*. Well, I went through both. From a comparatively early age what I mean that, maybe 15, 16, 17, 18 on through the teens I felt I was grooming myself in everything I was reading, etc., eventually to make some sort of record, some sort of statement, but I wasn't sure how best to do that in a way that wouldn't be trivial. I think I fully misunderstood the value and function of a novel or fiction. I think I was too ambitious to write fiction I wanted to be a scientist to probe into the depths of the human heart and soul and particularly to be a psychiatrist. So as soon as I'd read Nietzsche, soon as I'd read Freud, any of these people I would note at what age they were at when they had written this and that for instance Havelock Ellis wrote in his biography that when he was 19 he decided he would have his first book published by the age of 30. So I thought 'Well, I won't be behind that.' [laughs]. And that was my pace I thought it would take me all my time of reading and that sort of thing to be justified to join in that conversation of the scientific-academic tradition of Europe. I wanted to join in that conversation. Because books had meant so much to me because I think to a large extent they kept me sane because they gave me an awareness that there were people outside my little fish pond swimming the larger ocean, who had felt these things, observed these things, articulated these things and that was a great consolation.

DK: When you were at medical school was it a natural progression that you moved into psychiatry or did something in particular happen to you as a medical student that led you to go in this direction.

RDL: It wasn't so much that anything particularly happened, I think I only retrospectively discovered that psychiatry was in a sense my natural habitat. I'd gone into medicine in the first place as a combination of my own ambitions if you like and my parents. I felt that I wanted to find out about life, I wanted to find out directly about death and suffering and birth. Other subjects, generally speaking, at university one can study without being enrolled. Literature for example is up for grabs you don't have to go to university to become a writer but there are some things that one is precluded from, and psychiatry seemed to be that branch of medicine that gave explicit recognition to different varieties of misery and suffering and so a great deal of medicine is not so much trying to come to an

understanding of these matters but simply as far as one can contribute physically, eliminate, and that is fine, but that wasn't so much my *métier*, as I say it came naturally to me. When I was in my first year as a medical student my father had what would now be called a bit of a nervous breakdown it wasn't a mental breakdown, he became very anxious at the point of about to get the job he'd been after for years and years when his boss was leaving. He became convinced that his boss was going to do everything to stop him getting that job, and this reduced him to a state of trembling and continued agitation for the best part of three months. He was in a sense my first patient at that point because he turned to me and sort of poured it all out to me and I remember saying to him before I realised it was an "interpretation" quite, "Well it's not your boss you're worked up about it's your *father*. And you're going on about exactly the same things about your boss that I've heard you say for years about your father." And this actually did get through to him and he afterwards expressed a lot of gratitude to me for saying that because he thought that it pulled him out of it. And he did in fact get the job and kept it and so on. So I suppose if one's got behind one that sense of assurance of reversal… and also I seemed to have some sort of flair as a medical student of being someone that other people talk to. I became the sort of person that fellow students and other people would seek me out to tell things to. And I had also in my childhood been to a considerable extent my mother's confidante. So I was used to that role I found it easy to listen to the other person, and was interested in it. So I sort of gradually discovered that in fact there was a branch of medicine that at least in one side of psychiatry, one aspect of psychiatry, one school of psychiatry that's what it's all about.

DK: And you say you were interested in death and birth and now you've been stating your current views of the birth experience. Could you tell me more about that? And the possibility of neonatal and even intrauterine memory.

RDL: Well this has been up for grabs for a while, from the days of the French clinician Charcot, with whom Freud studied and so on, it's been apparent that adults, some adults, use very regularly the metaphor of birth to describe crises and phases in their lives. As a clinical psychiatrist we see a lot of people who look as though, you might say, they look as though they've regressed to an intrauterine state and they're often catatonic, regressed schizophrenic often referred to as lying there in a fetal position and so on. And so simply to summarise my clinical experience and giving weight to the work of a number of people like Stanislav Grof for instance, who've recently, he in particular with LSD therapy in Czechoslovakia and later in America have gotten an enormous amount of data now about adults who curl up and go through all, etc. etc., so it seems to be a physicalised, dramatised and ritualised, anthropologists are very familiar with the metaphor, way of working through something or going through something. And of course in order to be born one's got to go back to before birth, I mean you've got to get inside the womb in order to come out of it again. And it seemed with this to be such a common pattern, it's one of the patterns that in our society, there's no cultural place for it within the normal framework. When some, say, possibly very valuable ritual pattern is cultured out of a particular society it's possible that it's needed and it's possible that we haven't got any alternative ordered recourse to what is being worked through in that pattern through in some other way. So in the absence of this

avenue to go through… you see I wonder if we had an ordered initiation ceremonial at a teenage, adolescent phase, how many teenagers that have sort of schizophreniform episodes who go to pieces and into some sort of set of experiences that society has got no coherent way of responding to in such a way that brings order to it and a method into it, if it wasn't obviously present in the first place, so some people might be stumbling willy-nilly into this territory that society not having an adequate response to it, what we have is a schizophreniform breakdown. Of course, in dreams, and myths and metaphor there is an endless amount of material that one can construe in birth and pre-birth terms but that's of course open to all the problematic of what criteria one uses to justify a particular construction and the evidence in that direction is much thinner. Freud looked at all the evidence and rejected the balance of construction I would place on it. I wonder what Freud would make of the re-enactment of so much birth material nowadays and growth and development groups and primal therapy and all that sort of thing where it seems to be the day-in and day-out experience.

DK: It seems that you've used it as a particular therapeutic maneuver. How do you actually do that with a person?

RDL: I've done it in a number of different ways. In the first place we did it being very much defined as a birth ritual in a workshop in a place that might accommodate thirty or forty people in tracks suits, dressed for a workout as in a gym. And we had long strip of Dunlow pillow matting on the floor, a person would lie down on that, and people could either make a tunnel with their legs, or they could just shut their eyes and go into it. I needn't describe here the precise details but simply by giving someone who really wanted to do it the go-ahead with their eyes shut, so the simple injunction to "go" is sufficient. And people then go into an imaginary or self-made tunnel or space. What you see someone doing is on their back, usually on the floor with someone with their hand say on the crown of their head or jamming their head through someone's legs, or burrowing their head into the floor, starting to writhe and grimace, twist and contort and sweat and heart usually starts to beat very much faster, and people in the course of ten to twenty minutes report that while they're doing that with people around them that they have a vivid sensation, or a vivid subjective feeling as though it is very familiar and what they're going through is what they say is the experience of being born. They're very specific about it, they go on and on and on with considerable intensity usually for quarter of hour, twenty minutes, very seldom longer, pressing or feeling themselves, even if there aren't any actual legs there or hands there to provide the impression of a narrow thing that they're going through, they feel it or they say they feel as though they're being crushed, or they feel a band passing over their body, sometimes that band gets stuck. People usually are able while they're immersed in this inner subjective experience tend to say a few words to people what they want them to do sort of pull them out. So there's a very human, sweaty, close thing that happens for about twenty minutes and then the person feels that the struggle suddenly is over and they're out. The person can often move their legs for the first time or that they can breathe for the first time, but just like that, it's over and they're out. Some people at that point do further twitches or jerks which *they say* is the further feeling of being turned up and

smacked or the umbilical cord… some people suddenly get very cold, some people hear sounds or voices in a hallucinated way within that span of time, ten or twenty minutes and then they come out of it. Well. That is a *device*. What all that is about and I'm being quite explicit that I don't know, the point is that it is a number that I found it comparatively easy to set the scene for people going in, and then one observes people going in this and takes their report that what they think has been happening is some birth experience and they feel new and different and all the rest of it. I've certainly been impressed that in a remarkably short period of time people can look so different from one side of this to another. Some people said that they felt permanently different. But I don't want to represent this as some sort of new, gimmicky miracle cure, it's far from that, but it does do something for some period of time, and it's something the person seems to do pretty well entirely on their own initiative. In a way it doesn't look the least like birth, because when one is being born one doesn't go through all these muscle movements, one is passively fairly well impacted *upon*, and the struggle for breath and the grimacing and teeth and pressure… is not actually what I would think is directly mimicking the actual movements that one made at birth, although people habitually feel that they can't use their arms, they're pinned, they can't move their legs until they're out, some people go through very vivid feelings of confusion because they'll report that they've been turned around and they don't know which way up they are, and people reporta *detailed* feelings that it's come too late or it's come too soon. People start to check up on their hospital records, etc., etc., try to correlate… I've got no systematic data however on that.

DK: Do you think that it's a personal memory rather than an archetypal memory?

RDL: Well that's a major unanswered question. See if it's an ancestral memory, then that ancestral memory would have to have been carried through the nucleus and cytoplasm of the zygote. If an ancestral memory of an archetypical order, it's the only link through actually one cell, and it seems to me just as plausible that one cell in its prenatal derivatives could receive some registration of patterning before the neural tissue is… you've got the one cell must somehow carry the genetic memory that is mapped into the nervous system if it's archetypal when the nervous system is developed. It seems quite plausible that certain bio-patterns could be, well *are* carried before our nervous system is differentiated and imprinted into the nervous system from pre-neural system.

DK: I'd like to change the subject slightly, many argue that neurosis is a historical phenomenon, that the kind of neurosis described by Freud was created by the conditions of his time. Would you extend this to say schizophrenia, if we may use the label, might this also be a historical condition?

RDL: Well in the sense that we believe that the gene pool is reasonably constant, but our environment, particularly the artifactual, human environment that we create for ourselves in terms of culture, is in the process of continued change, so one would think that there would always be shifting nuances, the outcome of the product of our genetic response system to changing environmental circumstances, though, so what is 20th century

schizophrenia is possibly a variation on a theme which is a product of our genetic constitution and our 20th century environment. Another variation would be the 16th century environment in other words that the clinical picture of certain conditions where the relevant environmental variable is our cultural variables rather than physical constants, would be open to transformation with transforming environmental circumstances. Of course it's very difficult with Freud's terminology because if we go back in Freud's five original studies of hysteria and the people he called hysteria, a fair number of them would now be called schizophrenia. Among these five hysterics if I remember there's one who had visual hallucinations one had olfactory hallucinations and quite a lot of schizoid phenomena I think one committed suicide eventually I think one ended up in a mental hospital. We remember that, say, what American psychiatrists now call schizophrenia, has a big overlap with what Freud was calling hysteria. It just adds a bit more piquancy to the semantic confusion of the subject.

DK: Yes. I'd like to stick with the diagnostic dilemma. Do you feel that diagnosis is actually helpful to psychiatrist and patient or do you think it's merely a label which disguises a complex reality?

RDL: Well I think that reality is very complex and I think that there can be some labels that disguise complex reality and other labels that bring out clarity within and enable us to see in an articulated manner the complexity. And I have got absolutely no objection to naming, to classifying, to ordering our universe, including the domain that psychiatry is concerned with. To giving it an order and to putting it in sets where there's a homogeneity to all the members of the one set. The argument is not against the process of naming or ordering specifically, but on two scores. The naming and ordering of phenomenon in the sphere of psychiatry, this naming and ordering regarded as a branch of medicine means that we have to suppose that the phenomena that are being named are of the same order as the phenomena studied in the rest of medical pathology. Now the phenomena aren't *quite* of the same order because we're studying a person's words, of course we study a person's word neurologically and so on but it's a person's words not so much in terms of indications of an organic order through the words but confusion with I suppose in the connotation or significance of words both as heard and as uttered.

[Part II]

We're also considering different states of perplexity and confusion and misery and bewilderment and mental suffering. And I'm not sure, I'm not entirely happy that this should be pre-empted or it is appropriate to pre-empt this by an exclusively medical perspective. Medicine in a way is having a bit of an adventure in certain aspects of psychiatry. Looking at age-old forms of human distress which have only recently been regarded as appropriate to the domain of medicine and so at any rate there's something very problematic in that. And the other thing is the simple, straightforward within-medicine argument that we know in the history of medicine, a great deal of the history of medicine has been either discarding diagnoses that have been discovered to have never

have existed or to have covered such a wide range of disparate phenomenon that they become useless. Such as, what was it, cholemia, which used to cover all sorts of forms of debility and "looking greenish", etc., etc., it's now specifically associated with leukemia some forms of leukemia, but that was much more common in the 19th century as any run-down, thin, neurasthenic, hysterical, or as we would say it now, young woman might be regarded as suffering from that. Or in the way epilepsy was thought of until we've narrowed it down and made it much more precise with EEG findings, we can now distinguish behaviour which is the outcome of actual recognizable EEG patterns in the brain we might even *define* epilepsy in terms of the EEG rather than in terms of twitches and whatnot, etc. And also a great deal of the treatment that has been related to these past diagnoses in medicine has been discarded. So, I'm remaining obstinately skeptic that some of the solutions that we presently have and that diagnostic categorisation in psychiatry are really here to stay and I'm saying that I'm not comfortable with them in the way I am with a great deal of the rest of medical diagnosis.

DK: Dr. Laing what is the value of hospitalising severely disturbed people? Is it corrective, punitive, or merely the removal of that person from society?

RDL: I think the main value is to provide asylum to someone who's terribly frightened, who's scared stiff, catatonic in other words, frozen stiff. This is someone who can't talk, can't move, they're struck dumb, and they're scared stiff in what we call medically a catatonic state. Well if I was in a state like that and people are at a loss to know what to do with me I would like to be taken somewhere, where I'd be taken care of and offered sanctuary where environmentally the circumstances would be as minimally threatening, dangerous, persecutory as we could make them. It's one of my regrets, not all but so many mental hospitals are so far away from being places of hospitality you might say, for someone who's very frightened. And of course, and I really do say of course, we have to protect society from dangerous, irresponsible people who are recalcitrant to reason, can't do anything about, and so forth. The "corrective" function of the mental hospital is a slightly too Chinese for me, I don't like the idea of it being compulsory, correction centres, I'd rather that be straightforward crime and punishment and prison than correction administered under the name of therapy. So sanctuary for the person and protection for society with an overlap between prisons, there can be crazy prisoners as there can be crazy patients.

DK: Was this what led you to set up Kingsley Hall and later to develop the Philadelphia Association? How did Kingsley Hall start?

RDL: Several of us thought the same way, one was actually one of the charge nurses in Dr. Seargent's unit at St. Thomas's who became very disillusioned with the efficacy of so much electric shocks with young and old and new and chronic and three other psychiatrists and a social worker and a writer. We thought we would put our resources together to see if we could get a place which would let it happen. This was based upon my clinical experience in mental hospitals where I'd become very doubtful whether by and large, over the long run,

psychiatric methods of treatment broke more than even. Except for perhaps preventing someone from literally physically running themselves into death with exhaustion. I remember one woman who actually did die with persistent manic…we poured everything into her that we had, there was just no way of stopping her, she went on and on and on, no way we could get her to sleep, no way we could get her to stop anything and she died. Well short of the exceptional, within the limits of life itself not being endangered it seemed to me to be worth it medically, scientifically, to be able to have a door open to see now that so much early electric shocks and tranquilization was coming in that there was hardly any mental patient in a hospital for more than maybe two or three months at the very most, where the natural course of whatever it was disease, process, or whatnot they were going through was therapeutically affected, interfered with by chemicalisation or electricity, so that we were now going to be, I felt, in a position where *no one* was going to know what we in effect were doing because very few people had ever looked into what happened before someone got into this position and now we were not going to have any special unit, even one in Europe or one in America where a clinician could see what went on if we didn't bring these measures into play. And I still think it is very important to keep that door open.

DK: Did the Kingsley Hall experiment lead to the development of the Philadelphia Association?

RDL: The Philadelphia Association was actually in existence to start the Kingsley Hall thing, but it has led to the further development of that work that happened there. We had Kingsley Hall leased to us for five years, from '65 to '70, the work that began there has now spread out to eight houses in London, about 50 people staying in them.

DK: And what are the major findings from this work?

RDL: The findings have got to be presented very tentatively at this stage, there have been about 400 people, over these ten years, who have stayed in these places and something like 75 to 85 percent of these people would be diagnosable to fall into some psychiatric category, a lot of them would be diagnosed as psychotic. In the places there has been no use of any drugs at all, but there have been sometimes people around who are more together than others, but some times hardly anyone around who was someone we would regard as in an ordinary state of togetherness and going concern and so forth. I think what we found to a greater extent than has come to be supposed, people who are often very confused and miserable and disorganized can if they want to, and many of them do want to, keep themselves going, and it seems to be such simple things such as going to sleep when one wants, there's a day/night reversal, people can sleep during the day and be up all night. Now if that's stopped, as happens necessarily practically always within the hospital regime, it usually takes drugs to stop it. However if you let someone go into you might say, free-fall of biorhythm, and spin around reversed, they practically always do that for a bit and then come back into a usual pattern again. Issues of let's say eating, and cooking meals for oneself and making food for oneself that the people don't have to have food cooked for them, don't have to have it presented at the same time, whole issues don't have to be

there, well this seems to suit some people, it doesn't seem to suit everyone, some people need and want a structure imposed. I think people who need an imposed structure to contain their incoherence, these are the people who maybe are best in mental hospitals. On the other hand, since mental hospital's practically the only option, there do seem to be people who find this other option where what they're after is in fact, to go into… I think the monks in Mt. Athos in their monastic regime talk about autorhythmia, they have an understanding that they all live together but they can find their own place and their own time and don't have to eat together don't have to sleep together, they can find their own idiosyncratic rhythm and thereby find their balance. Well that seems to work for some people. It seems to keep also open a place where someone that I would from clinical psychiatric point of view say has gone into a schizophreniform episode, let's say without quarrelling about these matters they're not the sort of person who in fact would be taken to be a long-term chronic constitutional process schizophrenic sort of person that if you don't do anything we expect will further deteriorate and become more dilapidated. There do seem to be some people whose mental functions disintegrate under the impact of perhaps, as they feel, mind-boggling paradoxes and contradictions and confusion within their communicational web. So it all sort of falls apart – and then grows in again – quite quickly, and if one doesn't interfere with that process there seems to be a process of disintegration and reintegration. And in fact quite a few people have gone through that sort of thing, in other words they maintain a momentum of energy through their confusion and bewilderment and transformations of time and space, and go through it and come out of it, but some people of course get stuck. Well, four hundred people over ten years I haven't been able to see them all, but out of that maybe a couple of dozen people who have *clearly* come in, in great states of scatter and disarray, or have come there keeping themselves together and then the cookies crumbled you might say and become quite disorganized and unable to maintain themselves and then spontaneously seem to begin to pick themselves up, get themselves together and stay for a while and leave. Well what I'd very much like to do is I'd like very much to be able to say in advance which are the ones who are going to do this and which are going to do that. And still very much working on that.

DK: From the viewpoint of a social scientist Dr. Laing, how would you label yourself and your philosophy?

RDL: I would call myself a psychiatrist, I would like very much to disclaim the label of being an 'anti-psychiatrist', I don't regard myself as an anti-psychiatrist any more than Pasteur might have been called an anti-physician because he might have opposed some of the medical practices of his time, or Amroth Wright because he said "feed fevers" when people were starving fevers, in other words within the medical framework there's open, I hope, to disagree with perhaps more than the majority of one's contemporary physicians would disagree about in terms of the prevailing practice. I've got certainly criticisms about a lot of the prevailing practices of psychiatry both in the theoretical and the practical aspects. But that doesn't make me an anti-psychiatrist, it's *on behalf* of psychiatry that I'm making these criticisms of psychiatrists, some psychiatrists, who I feel are on an anti-psychiatric position. I regard myself as a psychiatrist in the tradition of western medicine. And the

philosophical background I have is basically within the tradition of western medicine, western philosophy, western thinking. I feel closest to the humanists and the skeptics, the skeptic school of philosophy that is picked up in the contemporary phenomenological school of philosophy I find very congenial, training oneself to see things as much as one can bring oneself to as they are, with the actual suspension of judgement for the time being. I don't mean skepticism in the sense that it is sometimes being used as falling into a nihilistic attitude or a cynical attitude, the practice of suspension of judgement; in that sense I would be honoured to regard myself as a skeptic, in the tradition, say, of David Hume.

DK: What are the points of difference between yourself and an American with whom you're often associated by reviewers, Thomas Szasz?

RDL: Well in relationship to Thomas Szasz I'm not quite sure if I'm attributing to him something that he would disclaim, I get the impression, I don't know what you would say about this, he writes sometimes as though he didn't really feel in this crazy world it's appropriate to call *anybody*, specifically, crazy. Now, if that's the case, I really do think that it's indispensable, to me anyway, to retain the category of madness, craziness, out of one's wits, out of one's senses, daft, *verruckt*. That there are some people, it could be any of us, who at some time could lose the place, become disorientated in terms of time, place and person, take things that we're not going to abandon common sense entirely, to be real which we wouldn't say are real, etc., etc. Well, I would say that there is this domain. Now, Szasz seems to have given the impression, to some of us, anyway, that he doesn't really think there's any *separable* domain in that territory in the whole continuum of the vicissitudes of the human mind. I think it's useful to retain a distinction, I agree, however, that the exclusive medicalisation of that distinction is… I agree with that criticism. In other words I avow severe dysfunctional states and it's a matter of debate whether all dysfunction in the organism is automatically pre-empted by the medical way of looking at pathology, at dysfunction. However I do very much agree with him about human liberty, libertarian side of this, and that we're often very, very too casual about stripping someone on that pretext of their liberty and all their human rights and sometimes it takes years and years and years before they can ever get them back again once that's happened.

DK: How do you see the role and function of the psychiatrist in western society?

RDL: There are so many things that psychiatrists actually do, there's child psychiatry, there's psychiatrists concerned with mental defect, there's the problem of people crumbling into ruination in mental and physical functions as they get older, there's all sorts of known organic conditions that produce behavioural and mental transformations, etc., etc. I think that there's a clear role for a psychiatrist insofar as he remains a proper doctor and as a physician. Then I think there's a role that the medically-trained man has to win for himself or herself an open competition, in terms of a domain of distinctive competence that has to do with the understanding of disturbances in communication between people. There's no particular reason why the people who become the 'elite' in that respect, students of human

communication, need be medically trained. But at the moment, a lot of the people who are in this field regard themselves as primarily… the real matrix of psychiatry, is communication according to some people. Harry Stack Sullivan and Ruesch and other people would argue that there's a misalliance between neuro-psychiatry and the study of interpersonal relationships, that they've really got very little to do with each other. I think that if we take both of these as a continued role for both these functions, there's a clear role for a medically-trained man, in one of them, and there's a clear role for a medically-trained man if he amplifies his medical training to be ambidextrous as it were.

DK: In the United States, as here, Transcendental Meditation is being put to a wide variety of uses never dreamt of by its first users. Even businessmen are employing it at their desks, as a means of both relaxing and restoring their energy. Following your recent visit to India and Ceylon, do you see any applications of TM to psychiatry, Dr. Laing?

RDL: Well I wouldn't say that the way these things are being used was never dreamt of by the original users. Transcendental Meditation is the use of a, well let's call it a vibration, a particular sonic pulse that can be alluded to by a word, but the word is only the opening of that pulse which one repeats to oneself and can locate it one's mental space in any part of the body and just let it purr away, and also just see where it goes, and what it does. Different of these mantras have got different effects, some are very sharpening, induce a lot of energy, others are very calming. These mantric, sonic vibrational things have been used in a common way in India for as long as any contemporary Indians assume, I mean millions of people in India, taxi drivers, shopkeepers have got their mantras, from childhood, and they repeat them to themselves day in and day out. Any time they feel like it, tune in with this mantra, or that. It's traditional that… there's a boon which will open out to the person… facility in life, in the direction of business, in the direction of trading, in the direction of this, etc., etc. It's a boon, without any restraint. Well of course one's not encouraged to technicalise this, they simply use it in an instrumental way, for one's own advantage, but the devotion to the mantra may bring with it all sorts of happy, fortunate, material side effects.

DK: Do you think we will use it more in psychiatry?

RDL: Yes, I think that as the world opens out and we discover what our fellow, our brothers have been doing across the other side of the globe and they discover what we've been up to, etc., eventually we'll have a transglobal array, we'll have the pick of the best elements from all traditions will suffuse every tradition.

DK: Dr. Laing, as early as 1960 you were questioning some of the basic assumptions of the behavioural sciences. Would you care to elaborate on how this skepticism originated?

RDL: Well I don't know whether I can put my finger on a spot, but the issue is that what we have got as most immediately available to us to study and understand is our own experience. For instance, as we are sitting here just now, my precise experience of being

here is only mediated through my conduct to you as yours is to me. We don't have a direct, immediate objective observation of each other's experience. And experience covers a great deal. Now it doesn't seem that in the rest of the physical world, which the physical sciences are concerned with, there's any complexity of this order, we're only looking at how things behave. And there's no problem of correlating that behaviour with experience, of the object. But we can't say "the object" now we've got to say the human being, the sentient creature, the *person*, and so on. So it's not an objection to a science of behaviour as such, but to the theoretical presuppositions the methodological practices of a certain school of the science of behaviour that seemed to me to, while studying behaviour, not be prepared to see behaviour as intelligible in referring how we conduct ourselves to how we experience ourselves and the world. So there's some behaviour scientists who are very sensitive to that and some who are not.

DK: If you were to redefine some of the basic assumptions behind the behavioural sciences, how would you do so?

RDL: I don't think it's possible to find a sufficient homogeneous ground between the different behavioural sciences because we have to go all the way from sociology all the different schools of sociology [inaudible]…. History, anthropology, to animal experimental studies in laboratories to ethology, I don't think there's a single body of presuppositions, in fact it is absolute babble of contradictory contentious argument and many behaviour scientists never read anything of what someone in another school is on about even though they're crossing territories all the time.

DK: You've had a very varied career so far, where do you see yourself going in the next five years from a professional point of view?

RDL: I'd expect to be continuing as I'm doing, which is a rather straightforward, orthodox private practice, and contact with residental context that we have, the particular programme that I've planned for myself is that I'd like to take the chance now to go over my records for the last 25 years or so and comb through them and see what I can go back and bring that up to date instead of leaving too much behind me that I haven't had a chance to look at. I'd like to take the chance to look back and sift it through and see what out of that I can present to my colleagues as worthy of their interest.

DK: Looking back to do you see any steps as professional disasters or professional faults, possibly?

RDL: I don't see anything as gross as disaster, I regretted very much that in order to pursue what I wanted to pursue, I had to step out of the National Health Service to do it because there were no contexts within the National Health Service for such practice. So I've had to be a bit more out on a limb than I was used to, and feel comfortable with, and don't regard myself as that sort of person… This is one of the things that I would hope to make a list of, there are a number of things I would do differently if I had a chance to do them over

again. In a way I'm still too much in mid-stream to know exactly, I think, where I've made a mistake, I often go where one side of my brain says 'that was a disaster' and look at it from another point of view and think well, that was a great learning experience. I haven't had time, yet, in a way to look back on my life, and make that sort of assessment. I don't carry along with me either notable feelings of 'this was absolutely right' or 'this was absolutely wrong', it's still to me very much the answers as I learn them.

DK: Well for me this afternoon has been very much a learning experience. Dr. laing, thank you very much indeed.

RDL: Thank you, Dr. Kelly.

[END]

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