The Fidelity to Experience in R. D. Laing's Treatment Philosophy[1]

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> *He who calls to mind the ills that he has incurred and those that have threatened him, and the trivial occasions that have moved him from one state to another, thereby prepares himself for future changes through the examination of his condition.*
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> - Montaigne, *On Experience*

R. D. Laing wore many robes in his career - psychiatrist, psychoanalyst, philosopher, social critic, author, poet, mystic - and at the peak of his fame and popularity in the 1970s he was the most widely-read psychiatrist in the world. Renown of that magnitude is dependent on the happy coincidence of a multitude of factors, including the right message at the most opportune time. This was no doubt true for Laing, when the student unrest of the Vietnam War intersected with his impassioned critique of a society intent on subverting the minds of its youth for unforeseen purposes. At a time when authority figures of every persuasion were suspect, the so-called "counterculture" embraced this disarming Scotsman and trusted him to explain how they were being mystified and why. Perhaps the war explains why Americans were especially drawn to

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Laing's message, making him a social icon for a generation of psychology students, intellectuals, and artists, while his impact in Europe was reserved for the intelligentsia.

That his influence was more pronounced in academic circles than psychiatric ones was no doubt a bitter disappointment to him. The (albeit reluctant) "father" of anti-psychiatry could hardly expect his psychiatric colleagues to embrace someone whose goal they saw as undermining their best efforts. Laing - like Freud before him - wanted it both ways: to thumb his nose at convention while enlisting society to adopt his way of thinking instead of the reverse. Like Freud, Laing aimed to change the rules of how the game was played, but where Freud succeeded Laing ultimately failed to conceive a method of treatment that could be "packaged" for universal consumption. Indeed, it is only now, a century after Freud laid the foundations for a method that changed our understanding of human misery that the psychoanalytic edifice has begun to unravel.

Laing's impact on the mental health profession over the last quarter of a century has been complex and diverse. Yet, there is one prevalent theme that persists in all of Laing's books that is readily discernible to anyone who is acquainted with his message. Simply put, Laing's work is epitomized by his opposition to the use of any intervention that runs the risk of alienating psychiatric patients from the very people who are trying to help them. Laing believed that many of the tools customarily employed by psychiatrists, psychotherapists, and even psychoanalysts, unbeknownst to themselves, often objectify the patients they treat.

Perhaps the most telling feature of Laing's clinical technique was his radical - some would say provocative - efforts to eliminate the enormous gulf that customarily exists between therapists and their patients. This is why Laing insisted that it is important to behave in such a way that reassures one's patients that they're in the presence of another human being like themselves; a person who is no doubt more together, but who nevertheless shares the same day-to-day concerns - and the same kind of pain.

Existence and Experience

The purpose of this paper is to explore how Laing endeavored to create a therapeutic environment that served his specific concerns. I shall couch my remarks in the very practical context of my association with Laing who, since his death in 1989, has aroused increasing curiosity about his clinical work, the nature of which he wrote almost nothing.[2] More than most psychoanalysts, Laing linked the concept experience with his treatment objectives in such a way that the exploration of the one became synonymous with the employment of the other. I would like to show how the two are interrelated by sharing with you the treatment of a young psychotic male who stayed at one of Laing's post-Kingsley Hall therapy centers. I will try to explain how Laing's innovative treatment of psychotic patients worked and the philosophical basis of his unorthodox approach to relieving the anguish of many who suffered both acute and chronic psychotic episodes.

Laing's reliance on existential philosophy had an enormous impact on his clinical work and transformed his views about how psychoanalysis should be employed with a psychotic population. I believe this is the first published attempt to situate Laing's treatment philosophy at Kingsley Hall in the inherently transformative nature of experience, as he understood it, from an existentialist perspective. Though this connection is frequently alluded to in his writings, it has never been explored in the context of his treatment of schizophrenia.

It should be noted, however, that Laing's clinical work wasn't exclusively based on a reading of existential philosophy. He owed a great deal to psychoanalysis, particularly Freud's innovative use of technique. Freud's conception of the free association method was the centerpiece of his technique and Laing, as a consequence of his analytic training in London, was thoroughly schooled in this method. Free association simply means to utter out loud whatever comes to mind during the therapy session. Hence, patients are refrained from keeping specific thoughts to themselves, no matter how personal, private or embarrassing the disclosure of those thoughts may be. This rule was introduced when Freud became convinced that neuroses were the consequence of extremely personal secrets that we somehow hide from ourselves;

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[2]See Laing's "*Metanoia*: Some Experiences at Kingsley Hall, London" (1972) for a singular exception.

secrets that are repressed from consciousness because they concern disappointments we experienced in the earliest stages of our development. Suppressing our knowledge of these experiences by forgetting them temporarily relieves the anguish and frustration they originally elicited. Freud concluded, however, that the suppression of these experiences produce psychical conflicts which, in turn, give rise to psychopathology, symptomatic expressions of the pain that is being denied. This led to Freud's conception of a treatment method for psychical symptoms: psychoanalysis. It's cornerstone was the fundamental rule of analysis - the pledge to be candid with one's therapist during the course of each analytic session. If carried out scrupulously, the exercise of candor often reverses the conflicts that had been elicited earlier by repression. In effect, the fundamental rule of psychoanalysis was nothing more than the promise to be honest with one's analyst, by agreeing to free associate with him (Freud: 1913, pp. 134-6). Unnoticed by many, Freud's conception of "psychical" therapy was rooted, on a deeper level, to a form of moral therapy, since its curative power lay in one's pledge to be honest - something that neurotics are invariably reluctant to do.

Laing accepted Freud's basic premise but took it further. He believed that our tendency to conceal painful experiences from ourselves is compounded in families where secrets are kept from each other. I know what you just said, but you deny it and insist that I'm mistaken. Or, I know how I feel, but you insist that I couldn't possibly, and so on. This type of "mystification" can become so extreme that a child may be overwhelmed with confusion (Laing: 1965). His sense of reality can become so compromised that he seeks refuge in psychotic (not merely neurotic) withdrawal from an intolerable situation (Thompson: 1985, pp. 88-117).

Following Freud's lead, Laing concluded that the therapeutic treatment of psychosis must serve to reverse the pathogenic process that had been initiated in order to escape an unlivable experience. Laing decided that this could best be realized in a group setting where the fundamental rule of analysis could be adapted to a more disturbed - and disturbing - population; indeed, a population that is deemed "unanalyzable" by conventional analytic methods. Each person's relationship with the others would be free of any coercion while the rule of thumb would endeavor to approximate a "live and let live" philosophy. Laing questioned why the free association

method should be confined to only one hour a day, four or five days a week. Why not apply this method to a setting in which one lived, in the nitty-gritty of one's everyday existence?

In order to make this transition possible — the transition from the treatment of neurotic to that of psychotic experience, and the transition from individual to group dynamics — Laing needed a more radical conception of experience than Freud had formulated. He turned to the philosophers who had made experience the cornerstone of their thinking: G.W.F. Hegel and Martin Heidegger. In the briefest possible terms I shall summarize Hegel's and Heidegger's respective conceptions of experience, emphasizing those elements that influenced Laing's clinical method.

Hegel believed that experience can't simply be reduced to one's subjective awareness of or involvement in an event, in the manner that I have an experience of writing this sentence, for example. According to Hegel, when I truly experience something I'm affected by it; it comes as a shock. In other words, my experience confronts me with the unexpected. It violates my familiar view of things by forcing something new into consciousness. Due to its intrinsically unsettling nature, Hegel concluded that experience also elicits despair because it disturbs my cozy accommodation of reality. On the other hand, despair leads to something new since experience always occasions a transformation of some kind. In other words, since experience subverts what is familiar, it changes things. Hegel was the first philosopher to realize that experience isn't simply subjective; it is also transcendental because it takes me "outside" of myself and puts me in a situation which alters my perspective. Hence, the effect my experience has over me changes "who" I am. Hegel's term for my relationship with the things that affect me *through my experience of them* was the famous "Hegelian dialectic."

> This dialectical process which consciousness executes on itself — on its knowledge as well as on its object — in the sense that out of it the new and true object arises, is precisely what is termed EXPERIENCE. (Hegel: 1949, p. 142)[3]

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[3]See also Heidegger's commentary on Hegel's critique of experience, in Heidegger (1970).

Hegel arrived at this unusual conception of experience while exploring the nature of consciousness and its relationship to change and history. It had an enormous impact on the way philosophers saw the relationship between thought and action. Heidegger was among those philosophers who was influenced by Hegel's work, but he took Hegel's conception of experience even further. Heidegger was more interested in the revelatory aspects of experience than the strictly "transformative" ones. In other words, experience doesn't merely change the world I inhabit; it also reveals things that I hadn't realized. Consequently, experience elicits truth. Heidegger was especially drawn to the "handy" and inherently practical aspects of experience whereas Hegel was seeking a path to absolute knowledge. Heidegger believed that one's experience could be purposefully nudged in a particular direction for a deliberate task. By anticipating my experiences with a specific aim in view, I can make use of experience to gain knowledge about myself. In other words, there are degrees to experience; it isn't all or nothing. Experiences don't just "occur" haphazardly, whether I want them to or don't. I am also capable of resisting experience, avoiding it, and even forgetting the experiences I object to. In turn, the degree to which I am able to experience something is determined by how willing I am to submit to the experience I have of it. According to Heidegger,

> To undergo an experience with something — be it a thing, a person, or a god — means that this something befalls us, strikes us, comes over us, overwhelms and transforms us. When we talk of "undergoing" an experience, we mean specifically that the experience is not of our own making; to undergo here means that we endure it, suffer it, receive it as it strikes us and submit to it. It is this something itself that comes about, comes to pass, happens. (Heidegger: 1971, p. 57)[4]

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[4]For a more detailed treatment of Heidegger's conception of experience and time, see my *The Truth About Freud's Technique* (1994, pp. 192-204); for more on Heidegger's conception of language, see my *"Logos,* Poetry and Heidegger's Conception of Creativity" (1996c).

This view of experience is remarkably similar to Freud's conception of the fundamental rule of psychoanalysis, the conscious willingness to comply with the injunction to be candid with one's analyst. The extent to which I am able and willing to listen to what experience tells me will determine how fully I experience, whether the experience in question is that of eating a meal, solving a problem, or undergoing psychoanalysis. Heidegger realized that because experience is also transformative, I'm afraid of it and resist by holding back. I'm perfectly capable of suppressing my experiences and even repressing the significance or memory of experiences I've had in order to forget them. In other words, I can resist change by suppressing experience, just as I can further change by submitting to it.

Laing was introduced to Hegel's and Heidegger's views about experience as a student in Glasgow. This encounter made a profound impression on him. He subsequently studied a variety of practices throughout history that advocated this inherently "Eastern" approach to the nature of change, including forms of meditation, yoga, and psychedelic drugs. Laing was particularly drawn to LSD and briefly incorporated its use into his clinical practice because it helped patients to "surrender" to experiences that they typically resist. (In fact, Laing once told me that he believed the prerequisites for psychoanalytic training should be: 1) undergoing a personal analysis; 2) reading the Standard Edition of Freud; and 3) ingesting LSD!)

Laing conceived of Kingsley Hall as a place where one was free to *undergo* whatever experience one was compelled to, without interference. People were given permission — a license, as it were — to endure and even court forms of experience that we are typically alarmed by, including psychosis.

Laing's views about psychosis were both subtle and complex. He conceived it as a desperate effort to stay in touch with an experience that one's environment is violently opposed to. Whereas the neurotic is frustrated by his efforts to obtain his desires and is subsequently disappointed by them, the psychotic, on a more radical level, is "forbidden" to experience the most basic desire of all: to <u>be</u> oneself. This is paradoxical because psychosis, as Laing understood it, is both an attempt to escape an unlivable situation while clinging to what one is escaping. This conflict ultimately engenders a

"psychotic breakdown," a means of camouflaging an experience that one is forbidden to have. Hence, the psychotic is secretly true to his experience, but in a convoluted manner. Due to the opposition encountered in his environment, the psychotic feels obliged to withdraw from the reality he inhabits *in order to protect his experience*, whereas the neurotic typically disavows his experience (via repression) in order to conform with society's expectations. This thesis is essentially a more philosophical rendering of Freud's distinction between neurosis and psychosis (Freud, 1924).

Laing's theory of psychosis was indebted to a considerable degree to Freud's view that psychotic symptoms are the consequence of a desperate attempt to heal the rift with reality that the psychotic himself initiated (Freud, 1924, pp. 185-6). The problem with this strategy is that it usually ends in failure: the psychotic gets stuck in his psychosis and can't find a way through.

Laing and Experience

Laing believed that anything one is capable of experiencing cannot serve as a toxic or pathogenic agent. Instead, it is the denial of experience that elicits the distortions in consciousness we typically associate with psychopathology. Hence anything that we're prone to experience must have an intelligible purpose. Following Heidegger, Laing concluded that *fidelity* to experience is the prerequisite for any kind of change one is endeavoring to obtain. The transformative nature of experience as a therapeutic tool epitomizes the clinical component of Laing's work. Any treatment methodology, whether existential, psychoanalytic, or otherwise, should be structured in such a fashion that gives rise to experience by giving voice to it, no matter how frightening or disturbing that experience might be. It is important, however, not to reduce therapy to the simple task of getting "in touch" with one's feelings, as though that were transformative in itself. In order to be therapeutic - which is to say, transformative - one's conception of experience should also be "revelatory," in the Heideggerian sense. *It should exploit the way consciousness keeps pace with experience by yielding to the effect it has over us*. Freud's free association method is essentially faithful to this conception of experience,

due to the premium it places on “submitting” to the analytic hour - through the medium of verbalizing one’s experience of it.

Finally, before turning to the clinical portion of my presentation, I should say a final word about Laing’s conception of groups and the nature of their transformative power. While training as a psychoanalyst at the Tavistock Clinic, Laing was exposed to Wilfried Bion’s famous experiments with “leaderless” groups (Bion, 1961). Laing saw Kingsley Hall as a place where the people who lived there were constantly confronted with their own expectations of what kind of place it should be. It would be rooted in the same principles of a group whose leader resists the function of “leading.” In order to create such an ambience, Laing refused to employ staff or attendants to “run” things. Hence, even the therapists involved there would refuse responsibility for anyone’s experience but their own. In keeping with the principle of analytic neutrality, they would endeavor to elicit experience, not shape it, and understand behavior, not change it. Laing wanted an environment that more closely approximated a home than an institution, a place where — stripped of coercive rules — the relationships that people share are more personal and less stereotyped. The gulf in power that one typically encounters in institutional settings — even analytic ones — would be diminished if not entirely erased. Finally, “group therapy,” per se, in the sense of formal sessions, were rejected in favor of spontaneous conversations that would arise unexpectedly, even violently, in the heat of the moment.

In short, Freud’s conception of the analytic session and Bion’s leaderless group experience would be transplanted to a lived situation where it could emerge as a piece of real life. Freud’s model of candor would serve as the basis, but in lieu of *interpreting* experience in order to make sense of it, the focus would be to *elicit* experience in order to live through it.

Jerome

Kingsley Hall was the first of Laing’s household communities which served as a place where one could live through one’s madness in order to obtain a more viable existence. It was an “asylum” from forms of treatment — psychiatric or otherwise — that many

were convinced were complicit in their insanity, and even its instrument. Laing and his colleagues, including David Cooper and Aaron Esterson (Cooper: 1967; Laing and Esterson: 1971), leased the building from a London charity and occupied it from 1965 to 1970. The house was of historic importance, having been the residence of Mahatma Gandhi while negotiating India's independence from British rule. Muriel Lester, the principal trustee of Kingsley Hall, agreed that Laing's vision for its use was faithful to its long-established purpose. Kingsley Hall was leased to his organization — the Philadelphia Association — for the sum of one British Pound per annum.

In 1970 the lease expired and Laing moved his, by now famous, operations to a group of buildings that were acquired by a variety of means. Esterson and Cooper had departed and a new cadre of colleagues and students who shared Laing's unorthodox views about the "non-treatment" of schizophrenia joined him. They included Leon Redler, an American, Hugh Crawford, a fellow Scotsman and psychoanalyst, John Heaton, a physician and phenomenologist, and Francis Huxley, the anthropologist. Numerous post-Kingsley Hall houses began to emerge, each adhering to the basic "hands-off" philosophy that had been initiated at Kingsley Hall. Each place reflected the personalities of the people who lived there as well as the therapists who made themselves available.

By the time I arrived in London in 1973 to study with the Philadelphia Association, there were four or five such places, primarily under the stewardship of Leon Redler and Hugh Crawford. I opted to join Crawford's house at Portland Road. Though it was essentially like the others, I was drawn to Crawford's personality and the unusual degree of involvement he enjoyed with the people who lived there. While some of the houses went to extraordinary lengths to adopt a disaffected approach to the members of their household, Crawford employed a somewhat intense, in-your-face intimacy that was both inviting and reassuring. Most of the people living there were also in analysis with him, an arrangement that was unorthodox, though appealing. Getting in wasn't easy. Since there was no one "in charge" there was no one from whom to seek admittance. And because I wasn't psychotic, I lacked the most compelling - and convenient - rationale for permission to join. Some of the students I had met told me how they had visited Portland Road and, while sipping tea, offered to "help out."

"What's in it for you?" - they were asked. When they replied that, being students, they wanted to learn about psychosis, they were summarily rejected. Having failed the "test," they were never invited to return.

It occurred to me it would take some time, as with any relationship, to gain sufficient trust to be welcome. I attended Crawford's seminars on Heidegger and Merleau-Ponty, went to the occasional Open House that welcomed strangers, and slowly made my presence felt. Eventually I was invited to participate in a "vigil:" a group of around-the-clock, relay of teams commissioned to accompany a person who had succumbed to a psychotic episode. These affairs usually lasted two weeks, sometimes more.

In my first such experience, a man in his twenties was in the throes of a manic psychosis: in Laingian terms, a psychotic "voyage." Having managed to stay cool and not panic, I suppose I proved I could be counted on. After six months, I was invited to live at Portland Road. Crazier people fared better. Typically, a person would call, say he or she was going through something terrible, and they would be invited to come around. On arrival, everyone who lived there — a dozen people or so — would meet with the visitor. He, in turn, would have the evening to himself in order to make his case heard. What were people at Portland Road looking for? By the same token, what criteria do psychoanalysts use in evaluating a patient's analyzability? At Portland Road this was especially problematical because none of the applicants were "analyzable" in the conventional sense of the term. Still, there were similarities between the two.

Freud was looking for patients who, irrespective of how neurotic they might be, were prepared to be honest with him. The fundamental rule of analysis assumes a capacity for candor. Similarly, at Portland Road people were expected to be candid with the people to whom they offered their case, no matter how crazy a given person might be. They looked for a sincerity of purpose and a hint of good will beneath all the symptoms they were invariably saddled with; seeking, no matter how crazy they seemed, to contact the sane part of their personality.

To complicate matters even further, people had to be admitted unanimously. Yet, once in, the new member could count on the unadulterated support of everyone living there. The sense of community was extraordinary. So was the frankness with

which everyone exercised their “candid” opinions about everyone else. The effect could be startling, as one was slowly stripped of the ego that was so carefully created for society’s approval. I soon realized why candor is something most of us prefer to avoid, however much we complain about its absence. Again, the similarity to the analytic experience was unmistakable. But now, instead of having to contend with merely one analyst for one hour a day, at Portland Road one was confronted with an entire cadre of relationships, all of whom engendered transference reactions, all of which one had to manage and work through.

With these particulars in mind, I would like to introduce Jerome, a twenty year-old man who had been referred to Laing by a psychiatrist at a local hospital. Jerome was a rather slight, dark-haired and extremely shy individual who, in a quiet and tentative manner, told us the following.

Over the past two or three years Jerome had developed a history of withdrawing from his family — mother, father, and a younger sister — by retiring to his bedroom and locking himself in. His parents would endeavor to cajole him, then they became angry and threatened him. Eventually, they called in a psychiatrist. Jerome was then taken from his room and removed to hospital via ambulance and restraints. Once there, he persisted in his behavior and refused to speak. All the while, he couldn’t say why he was behaving this way or what he hoped to obtain by it. He simply felt that he must.

He was diagnosed as suffering from catatonic schizophrenia with depressive features. A series of electro-convulsive therapy was administered and before long Jerome was returned to his ordinary, cooperative self. Six months later he repeated the scenario: withdrawal; removal to hospital; electric shock; recovery. Never any idea precisely <u>why</u> Jerome persisted with this series of events was ever determined. But each time he did so, a lengthier course of treatment was required to bring him back “to his senses.” He and his family endured this routine together three times in a period of two years.

The psychiatrist who contacted Laing confessed that his colleagues at the hospital had thrown in the towel and vowed that if Jerome came back “he wouldn’t leave.” This, now, was the fourth such episode. On this occasion, when his parents implored Jerome to come of his room he replied that he would on the condition that

Laing would see him. He had read *The Divided Self* and decided he was the only psychiatrist he could trust not to "treat" him for mental illness.

When Jerome visited Portland Road, he recounted what he had in mind. He wanted a room of his own, to stay till he was ready to come out. We were asked to honor his request and, somewhat reluctantly, we accepted his terms. I single Jerome out, of all the other people I came to know at Portland Road, because he presented us with the most trying challenge we had ever had to face. Due to the nature of his terms, he effectively deprived Portland Road of its most effective therapeutic weapon: the communion shared by those who lived there. His plan undermined the treatment philosophy which Laing and Hugh Crawford had formulated, a sense of fellow-feeling the nature of which honored a fidelity to interpersonal experience, no matter how crazy or alarming an individual's participation in it seemed. Hence, Jerome was entitled to pursue the experience he felt called upon to follow, even if the outward behavior it effected was uncertain. Though an individual's experience is a private affair, the behavior by which one engages others isn't. Since the two are invariably related, the philosophy at Portland Road was to tolerate behavior to an unusual degree in order to facilitate the underlying experience that gave one's experience its voice.

The conventional psychoanalytic setting places enormous constraints on a patient's behavior, including the use of a couch to facilitate free association. At Portland Road, one was obliged to live with the behavior that everyone else effected, so the course of a given individual's behavior was necessarily unpredictable, and occasionally violent. Hence, there was an element of risk as no one knew what anyone else was capable of and what lengths some people would go to in order to be "true" to what they were experiencing.

Recounting Jerome's Experience

True to his word, Jerome took to his room and remained there. He had his own room, which no one saw him come in or out of. Though it wasn't uncommon to forgo the occasional meals, the way Jerome removed himself from everyone else was extreme. No one even saw him sneak downstairs for food in the middle of the night, or

even use the bathroom. We soon became alarmed. He wasn't eating anything and it became increasingly clear that he was incontinent. We talked to him. "This wasn't part of our agreement", we said. "Oh yes it is!" he insisted. Still, Jerome wasn't in any ostensible pain. He didn't seem depressed, or anxious, or catatonic. He was just stubborn! He insisted on doing things his way, even if he couldn't/wouldn't explain why.

We reminded him that we had put ourselves out on a limb for him; where was the gratitude, a gesture of good will, in return? Jerome refused to discuss his behavior or explore its underlying motives. Nor would he acknowledge his withdrawal as a symptom of the condition he was in. He simply submitted to, and was inordinately protective of, his experience. He eventually agreed to eat some food in order to ward off starvation, as long as we brought it to him. The stench became onerous, though Jerome was apparently oblivious to it. Not surprisingly, he soon became the topic of conversation every night around the dinner table.

"What are we going to do about him," we wondered? Ironically, he had transformed Portland Road into a "hospital." We grew concerned about his physical health, his diet, and the increasing potential for bed sores. He continued to lose weight precipitously. We could either tell him to leave or abide by his extraordinary demands. As news of the situation leaked out, Laing became nervous. If Jerome developed bed sores he would probably be taken to hospital. Compounding everything else, Jerome couldn't keep his food down and vomited frequently. Whether this was self-imposed or involuntary we didn't know.

None of us possessed the expertise of a hospital staff. Who, after all, was going to clean him, bathe him, and all the other things that were essential to survival? Some of us consented to "nurse" him in order keep his condition stable - probably due to a sense of misguided, or neurotic, guilt. But at least he was there and, more or less, surviving. How much longer would we have to wait before he came out of it?

Four more months went by. By now Jerome's family insisted they visit and threatened legal action if we wouldn't permit them to. We weren't, however, about to. Crawford implored us to remain calm. Laing, meanwhile, became increasingly alarmed, but given our determination, agreed to back us a while longer. Meanwhile, Jerome continued to lose more weight and was on the verge of becoming ill. Now, six months

later, we faced a real crisis. Still, Jerome refused to talk to us or relax his behavior. He bitterly protested our efforts to keep him clean him and even to prevent starvation.

We finally decided that a change of some kind was essential. We decided that Jerome needed to be in closer proximity to the people he lived with, whether or not he liked it. The threat to his physical health and the lack of contact, in the most basic human terms, was alarming. If he couldn't, or wouldn't, join us, perhaps we could join him. We moved him into my bedroom. In deference to the sacrifice of my living quarters, others agreed to bathe and feed him, change his bed, spend time with him, and endeavor to talk to him - even while he refused to reciprocate. We gave him therapeutic massages to relieve the loss of muscle tone and for some physical contact. We resigned ourselves to the fact that we had become a "hospital," however reluctant we were to. We felt confident, however, that the situation was bound to improve.

His condition stabilized, but that was about all. I got used to the stench, the silence, the close quarters. I became depressed, sharing a room with a ghost who haunted the space but couldn't occupy it. I needed something to relieve the deadness that now permeated the space, so I invited the most floridly schizophrenic person in Portland Road — a young man who thought he was Mick Jagger — to move into our room with us. He serenaded Jerome morning and night and probably made Jerome feel even crazier than before. At least it was a livelier, if more insane, arrangement, and I recovered from my depression. Whether Jerome liked it or not, our "rock star" was here to stay, and I admit to the pleasure I felt in the comfort that Jerome wasn't in complete command of our lives.

Before long a year went by, but still no discernible change. In the meantime, a number of crises had transpired between Jerome's family and Laing, Laing's growing impatience with us, between our impatience with Jerome, and finally, between ourselves and Hugh Crawford for not supporting the many efforts to remove Jerome from the house. We were ready - eager! - to admit defeat and resign ourselves to failure. Jerome's condition seemed interminable. His "asylum" with us had become a way of life. Apparently, this was all that he really wanted from it.

The time - in the words of the immortal Raymond Chandler - staggered by and the urgency of Jerome's situation gradually became a commonplace, and less urgent.

Life continued at Portland Road independent of Jerome's situation; others had their problems too. Another month slipped by, and then another, until I finally lost track of the time and stopped counting. Nobody noticed when the year and a half anniversary arrived since Jerome had arrived at Portland Road. We were so used to his odd definition of cohabitation, the baths, the linen changes and serenades, that we hardly noticed that evening by the fire when Jerome came downstairs to use the bathroom. He flushed the toilet, peeked his head into the den to say hello, and quietly returned upstairs.

An hour later, Jerome came back, announced he was famished, and finally terminated the fast that had reduced him to 90 pounds of weight. This was a Jerome we had never seen: talkative, shy, but social nonetheless. We couldn't believe our eyes. How long would this last, before he returned to isolation?

The next day, Jerome had taken a new turn. He was finally, if inexplicably, finished with whatever he had been doing, engaged in God-knows what manner of bizarre meditation. Naturally, we wanted to know. "What on earth were you up to, Jerome, all that time by yourself?" "What was it you finally got out of your system?"

We didn't expect an answer. We didn't think that Jerome had one - but he did. He said that the reason he had isolated himself all that time was because he had to count to a million, and then back to zero, uninterrupted, in order to experience his freedom. That was all that he had ever wanted to do, the past four years, since his first compulsion to withdraw. No one had ever let him do it.

But why, we wondered, did it have to take so long - a year and a half? Did it have to take so much time? We had given him his way, hadn't we? According to Jerome, yes and no. After all, we intruded and interfered, talked to him, and generally distracted him from his task. Every time he got to a few thousand, or a few hundred thousand, someone broke his concentration with a song, a massage, or whatever, and he was obliged to start counting all over again. The worst, he said, was when we added the guitar player! "But why didn't you simply <u>tell</u> us," we asked, "what you were doing?" "We would have helped." "That wouldn't have counted", he said. "It was important that you give me my way, without having to explain why."

Apparently, it was only when our collective anxiety over Jerome's behavior subsided, after the anniversary - when we finally gave up and backed off - that he was able to finish his task. We had, without entirely appreciating its significance, finally submitted to *our* experience of him, permitting him to get on with, and submit to, *his* experience, of whatever mad inspiration had compelled him to count to a million and back again, uninterrupted, without explanation.

"Treatment" - and Otherwise

The unorthodox nature of the "treatment" that Jerome received at Portland Road is impossible to compare with conventional treatment modalities. Nevertheless, the question is invariably asked: did it really "work?" Twenty years later, Jerome has never experienced another psychotic episode again. He resumed and got on with his life, and proved to be an unremarkable person, really, ordinary in the extreme. Naturally, we wondered why Jerome had felt the need to withdraw in the first place. What were the dynamics, the unconscious motivation that prompted such a radical solution to his problems? These were questions that Jerome couldn't answer. It is telling, and doubly ironic, that Jerome didn't need those questions answered <u>in order</u> to repair what he, in his shattered condition, couldn't comprehend.

This story won't make much sense to anybody who attempts to glean from it an identifiable treatment philosophy, unless they take into account the central importance that Laing gave to the inherent problem of freedom in every treatment situation. This was a concern that also preoccupied Freud in the development of his clinical technique, just as it did the existentialist philosophers - eg, Kierkegaard, Nietzsche, Heidegger, Sartre - with whom Laing was principally identified. How does one "help" those who are in some measure of personal jeopardy without impinging on that person's inherently private, though socially intelligible, right of freedom?

Freud's solution to this problem was analytic neutrality, the cornerstone of his clinical technique. It followed the ancient dictum: "do no harm." Laing was already acquainted with the concept of benign neglect from his study of the Greeks and their sixteenth-century champion, Michel de Montaigne, the man who conceived the "essay" -

literally, an attempt or a trial - as a literary genre. Laing once confided to me that Montaigne was one of the three or four most important influences on his intellectual development, and that Montaigne's essay "On Experience" (Montaigne, 1991, pp. 1207-69), finally convinced him how it is possible to do violence on those one presumes to be helping, by subverting their experience of themselves. A genuine sceptic, Montaigne based his voluminous essays on his reading of classical Greek philosophy, relying principally on the ancient sceptics who flourished from the 4th century BC to the 3rd century AD, until they were suppressed by Christianity. The sceptics were the first philosophers to champion the centrality of experience in the pursuit of psychic freedom. Through the practice of *epoché* - the suspension of judgment, or openmindedness - the sceptics subverted dogmatic beliefs in every quarter, especially in medicine.

Many of the early Sceptics, such as Galen, were physicians who knew how easy it is to transgress the patients one treats and do them more harm than good. Anyone who is acquainted with the Sceptics will recognize in them the source of modern existentialism and the origin of Freud's conception of neutrality, who was intimately acquainted with Montaigne's writings[5] (Gilman, et al: 1994). Though most people identify Laing with the existentialist camp, he saw himself as a twentieth-century Sceptic. This explains, for example, the absence of a "Laingian theory" (the Sceptics were opposed to theory in principle), and also helps explain why Laing never presumed to "know" that much about mental illness, the basis (or even the existence) of psychopathology. Significantly, Laing never claimed to have developed a treatment method that claimed to repair whatever difficulty a given patient presented to him.

In many ways, Jerome's experience at Portland Road is a perfect example of the principles upon which Laing's treatment philosophy was founded. The respect we endeavored to pay this young man was all that any of us felt commissioned to offer. We didn't understand what was the matter with him, nor did we pretend to. We weren't sure what would help nor what would make matters worse, so we "did" as little as possible.

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[5]See my papers, "Freud's Conception of Neutrality" (1996a) and "The Rule of Neutrality (1996b) for a detailed critique of Freud's use of neutrality and its relationship to the Greek sceptics.

Following the principle of neutrality, we employed benign neglect as as unobtrusively as we could. Neither Laing nor Crawford actually directed the treatment - there was no "treatment" to direct.

The way that we struggled with and responded to Jerome's impasse as if unfolded will be regarded reckless, indulgent, or dangerous, even bizarre by the psychiatric staff of virtually every mental hospital in the world. His behavior — intransigent, stubborn, resistant — would no doubt be met with an even greater force of will, determination, and power than his own. Who do you suppose, given the forces at play, would ultimately "win" such a contest? Naturally, the use of medicating drugs would be brought to bear, and electric shock, and whatever form of incarceration was deemed necessary.

On the other hand, few, if any, psychoanalysts believe it is possible to treat such an impasse with analysis. Yet, our treatment of Jerome was essentially a form of analysis. Since Jerome refused to talk, we were obliged to let his behavior do the "talking." D. W. Winnicott, Harry Stack Sullivan, Frieda Fromm-Reichmann, Clara Thompson, and Otto Allen Will, Jr., amongst others, have recounted the many hours they spent with silent patients, letting time run its course until something broke through the impasse that had impaired a resolution. Who would deny that Jerome resisted treatment? But what manner of treatment can a patient wholeheartedly submit to when it coerces it's way in, without invitation or sympathy?

In my view, acting out isn't necessarily, nor always, a pathological defense. It can be, and often is, a plea for patience. We can't always be sure that we understand what another person's behavior intends. With psychotics, we seldom do. Unlike conventional treatment of neurotics, psychotics deprive us of our most valuable tool: the sympathetic recognition, in <u>their</u> suffering, of a similar devastation <u>we</u> have ourselves experienced, and worked through. The treatment of schizophrenia is necessarily uncharted territory, precisely because it is foreign to us.

Another important difference between typical psychoanalysis and the Laingian variety is that, because analysts value the spoken word to an uncommon degree, they rely exclusively on the patient's facility with speech. Hence the Kleinian and Lacanian approach to psychosis, for example, would be lost without some form of utterance, no

matter how crazy or bizarre, to "analyze." But in so doing, they oftentimes risk overlooking that patients can "speak" in mysterious ways. Sometimes, the only vehicle that we have for listening, when our ears fail us - allow me this sentiment - is our hearts. We're left with no other recourse than to let our conscience be our guides. At the end of the day, Jerome was finally permitted to express what anyone who was able to listen could hear, when words, alone, failed him.

Conclusion

Laing saw his role as one of helping patients "untie" the knots they had inadvertently tied themselves in. He believed this entailed extraordinary care to not repeat the same types of subterfuge and coercion that had got them into those knots in the first place. In my supervision experience with Laing he treated students with the same degree of openness and non-interference that he brought to bear with his patients. He never dictated the course that analytic candidates should follow, nor did he undertake to "correct" mistakes that were invariably committed. He was there to listen and offered advice only when it was asked.[6]

This degree of non-intrusion in the context of analytic treatment - as well as the training situation - is a rarity (Thompson: 1994). Those analysts who believe it is incumbent on them to run a "tight ship," to maintain their authority over patients (and students) at all costs, and who attribute analytic failures to insufficient "treatment" aren't likely to embrace a method of treatment that is modest in its claims and cautious with its interventions.

In closing, I would simply add that Laing's unusual - and sorely misunderstood - treatment philosophy for schizophrenia is just as applicable a clinical method with other, non-psychotic, scenarios. He taught me that the fidelity to experience is the agent of change in any therapeutic endeavor that ultimately meets with success, whatever

[6]For a more detailed account of Laing's relationship to psychoanalysis, see my paper, "Existential Psychoanalysis: A Laingian Perspective" (1997).

school of therapy it is, whichever technique it employs. Each time two human beings meet with the purpose of baring their souls, experience is waiting its say.

Whether we call that experience existential, psychoanalytic, or something else, its voice cries to be heard by someone who is ready, and prepared, to listen.

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