Introduction

par Maud MANNONI

Ce recueil constitue la suite de la première publication ENFANCE ALIENEE, il contient les textes présentés aux Journées d'Etudes sur les Psychoses chez l'enfant**, ainsi que des travaux cliniques inédits consacrés au problème de la psychose.*

L'axe de ces Journées a été constitué par la confrontation entre les conceptions structurales du groupe français et les conceptions existentielles du groupe anglais animé par David Cooper et Ronald Laing.

Ce sont les fondements mêmes de la psychiatrie classique qui se sont trouvés remis en cause lors de ce colloque: au classement systématique d'entités nosologiques, les auteurs ont préféré substituer l'étude du sujet qui parle (de ce sujet qui disparaît dans les classifications).

A placer le terme de « malade » dans une parenthèse phénoménologique, on gagne de quitter l'étude de la maladie pour un abord plus juste du « malade ». Mais encore faut-il (nous rappellent les auteurs), ne pas se laisser piéger dans une idéologie qui se fonderait sur des critères adaptatifs.

* Enfance Aliénée, n° spécial *Recherches*, septembre 1967.

** Maison de la Chimie, Paris, 21-22 octobre 1967. Ces Journées d'Etudes ont été organisées par un groupe de psychanalystes affiliés à l'Ecole Freudienne de Paris. La Fédération des Groupes d'Etudes et de Recherches Institutionnelles a participé à ces Journées et a assuré d'autre part une partie du travail matériel, de quoi nous la remercions.

Les participants ont dénoncé l'aplatissement subi par la théorie freudienne, ramenée ici et là, ces dernières décades, à une pure technique du comportement. Les notions de « moi fort et autonome », la croyance à la nécessité d'un rôle *parental « sécurisant », « solide », toute cette stratégie adulte dénaturent la psychanalyse réduite à n'être qu'un outil au service d'un idéal de rendement.*

La psychiatrie et la psychanalyse ont failli prendre dans l'histoire le relais de la Police et de l'Eglise défenseurs de la moralité, elles proposent aux « patients » des valeurs standards.

Dans le domaine de la recherche, toute innovation se heurte à des tabous, le psychanalyste ou le psychiatre se trouvent gênés par l'empire exercé sur eux par une tradition médicale opposée à tout changement et gardienne du savoir reçu.

Si Freud inventa la psychanalyse pour libérer l'individu, certains de ses successeurs, dans le style autoritaire des maîtres de toujours, mirent cette liberté au pas. Le langage psychanalytique s'est appauvri, ritualisé, gadgettisé.

Devenue rassurante, la psychanalyse pour avoir absorbé les clichés d'un certain discours universel, se trouvait perdue pour la science. En réinterrogeant la science, Lacan, de qui on lira ici la communication finale dévoile une situation dans laquelle le psychanalyste se trouve confronté à une vérité dont il ne veut rien savoir. Le « scandale » freudien énucléé de la psychanalyse contemporaine, il le réintroduit non seulement dans le langage, mais au cœur de l'Institution psychanalytique elle-même. Les structures des Ecoles psychanalytiques traditionnelles favorisent le recentrage *du sujet et lui permettent de demeurer à l'abri de toute interpellation de l'inconscient. Or, c'est de la* division du sujet *que peut seul se maintenir ouvert un rapport à la vérité garant de la science. Toute l'œuvre de Freud est là pour nous le rappeler.*

Ce Congrès a accueilli des rapports classiques, mais il a cherché surtout à donner une place aux travaux d'équipe, il s'est efforcé de maintenir la porte ouverte aux hypothèses les plus hardies, aux expériences les plus diverses ; il n'a pas craint d'introduire quelque scandale en bouleversant les idées reçues. Ces travaux se présentent ainsi comme un hommage rendu à Freud, et à Lacan, qui nous a aidés à le redécouvrir. *

---

* Nous avons maintenu le *caractère parlé* de la plupart des interventions. Nous remercions les auteurs qui ont accepté que soit publiée *sans modification* la transcription de l'enregistrement.

Aliénation mentale et aliénation sociale

par David COOPER *

J'avais l'intention de vous parler des nouvelles communautés créées par nous à Londres pour ceux que l'on appelle « schizophrènes », communautés dénommées « antihopital ». Apprenant que mon collègue Ronald Laing serait des nôtres aujourd'hui, j'ai choisi de vous présenter certains aspects théoriques de cette anti psychiatrie, laissant l'abord clinique du problème à Laing, qui vous parlera de la nature et du fonctionnement de ces communautés.

Il existe même dans les milieux psychanalytiques d'avant-garde une tendance à considérer la schizophrénie comme une maladie d'origine constitutionnelle. La « faille dans la formation du moi » serait ainsi la marque d'un « défaut de fabrique », la psychopathologie cédant allègrement le pas à une sorte de pathologie de laboratoire...

D'après notre expérience le diagnostic médical de « schizophrénie » ne se justifie guère dans les faits. Je dirais même que toute approche du « malade » risque de se trouver faussé si nous maintenons ces méthodes d'étiquetage conditionnées par la société, méthodes ou pratiques qui ont créé de toutes pièces ces entités telles que : « schizophrène », « psychiatre », « malade ».

Notre groupe à Londres a centré ses efforts sur l'étude des formes spécifiques d'interactions familiales qui déterminent le dire et l'agir de celui que l'on appelle « schizophrène ». L'aliénation sociale vient recouvrir la plupart du temps les diverses formes « d'aliénation mentale ». Traqué dans sa famille, le sujet est tout aussi bien « piégé » dans la société.

Pour comprendre ce qui est en jeu dans la dynamique familiale du schizophrène, il faut pousser l'étude jusqu'à la troisième génération et saisir là ce qui est en germe comme facteur psychosant. C'est bien en fonction de leur propre histoire personnelle (de cet « accident » survenu dans leur rapport à leurs ascendants) que les parents se trouvent en position à ne pouvoir réserver à leur descendance aucune autre place que celle justement

* « Anti-psychiatre » et écrivain, 39 Harley Street, Londres W.I.

de schizophrène — c'est lui qui de cette place est appelé à s'instituer comme porte drapeau, bouc émissaire d'un mal dont souffre la société. Le fou — dans cette perspective — est bien celui dont nous avons besoin pour pouvoir nous définir comme sains d'esprit.
Nos travaux nous ont permis de mettre en évidence ceci : ceux qui sont admis en hôpital psychiatrique, le sont non tant parce qu'ils sont malades que parce qu'ils protestent de manière plus ou moins adéquate contre l'ordre social. Le système social dans lequel ils sont pris vient ainsi renforcer les méfaits produits par le système familial dans lequel ils ont grandi. Cette autonomie qu'ils cherchent à affirmer à l'égard d'une microsociété joue comme révélateur d'une aliénation massive exercée par la société toute entière. A un moment donné, souvent à l'acmé d'une crise, nous nous trouvons devant un sujet qui prend brusquement conscience de la violence dont il était l'objet. C'est cela même qui généralement le précipite en hôpital psychiatrique pour « admission d'urgence »... Et là, notre « malade » va se trouver happé dans le système binaire de la vie psychiatrique conventionnelle (médecin-malade, fou-non fou) système qui reproduit les méfaits de ces familles appelées « schizogénique », où tout se trouve générateur de sentiment de culpabilité figeant le sujet dans ses difficultés, ou le clouant dans un nœud de contradictions.

Ainsi la psychiatrie, dans le rapport qu'elle a institué entre la santé mentale et la folie, se contente-t-elle de sauvegarder la dite santé mentale *en faisant violence* à la folie qu'elle prétend guérir par électro choc et autres « traitements ». La psychanalyse elle-même n'est pas à l'abri de tout reproche — certains psychanalystes ne font pas autre chose que de fonder leur technique sur une idéologie bourgeoise, s'offrant dès lors pédagogiquement en exemple, le « sain d'esprit » « heureux » s'opposant ainsi (comme le veut la tradition psychiatrique) au « malade mental », c'est-à-dire à celui qui a pour fonction d'occuper la place du fou.

Pour moi, la « normalité » ce n'est rien d'autre que l'état d'aliénation d'un individu, aliénation portée à son maximum. C'est ce stéréotype de personnalité « bien équilibrée » qui se trouve valorisé dans tout un système bourgeois et néo bourgeois décrit sous le nom de socialisme dans le deuxième monde (c'est-à-dire l'U.R.S.S. et les pays socialistes est-européen)
Ainsi, je ne puis rien pour ceux qui viennent à moi sous le déguisement social de « malade mental », si moi je les accueille sous mon déguisement de psychiatre analyste. Ceci veut dire que je ne puis être efficace que dans la mesure où je puis au cœur de moi-même entendre la révolte qui traverse le « malade mental », ceci suppose que je renonce à toute fin de réadaptation. Ce que je vise n'est rien d'autre que la libération de celui qui vient me trouver. Cette libération peut prendre des formes très diverses et trouver un sens dans des engagements politiques, c'est-à-dire dans une transposition sociale d'un problème personnel. On peut dès lors se libérer en se joignant aux guerres de libération, qu'elles soient au Viet-Nam, en Amérique Latine ou ailleurs, selon la ligne tracée par Che Guevara et Régis Debray. Il s'agit de maintenir à travers la révolte une forme de prise de conscience qui se soutienne d'un combat à mener.

La santé mentale telle que je la conçois, c'est la possibilité pour tout être humain de s'engager non seulement jusqu'au cœur de la folie, mais encore au cœur de toute révolution trouvant dans cette voie là une solution à la préservation du « moi ».

Metanoia: some experiences at Kingsley Hall*, London

par R.D. LAING**

At this Conference I was asked to give rather than two improvisations a formal presentations. What follows is an edited transcription.

Here are two hypotheses.

1. Whatever it is that clinically is diagnosed as acute schizophrenia or schizophreniform breakdown, may itself be a resource a human being calls upon when all else seems impossible.***

2. If the *set* and the *setting* can be changed (from the mental hospital model), the experience may be so transformed, that it no longer need be regarded as „psychotic" at all. Let me make an analogy.

LSD-25 was originally regarded as a psychoticomimetic substance. I propose that this biochemically induced 6-12 hour trip has its natural analogue in what I suggest be called a *metanoiac* voyage (from metanoia : change of mind). The nature of the metanoiac voyage may be „good" or „bad", largely depending on the *set* and the *setting*. Mental hospitals define this voyage as *ipso facto* madness *per se*, and treat it accordingly. The *setting* of a psychiatric clinic and mental hospital promotes in staff and patients the *set* best designed to turn the metanoiac voyage from a voyage of discovery into self of a potentially revolutionary nature and with a potentially liberating outcome, into a catastrophe : into a pathological process from which the person requires to be cured. We asked : what would happen if we began by changing our set and setting, to regard what was happening as a potential healing process through which the person ideally may be guided,

* Kingsley Hall is a settlement in the East End of London. Mahatma Ghandi stayed there in 1933. The Trustees of the Hall were gracious enough to allow us (The Philadelphia assoc. Ltd.) to use it for the purpose described here, from June, 1966, and have supported our work financially.

** Dr. R. D. Laing was a Fellow of the Foundations Fund for Research in Psychiatry (Grant No. 64-297), (1964-1967).

Currently he is Chairman of the Philadelphia Association Ltd. The Founder members of the Association were : Sidney Briskin, Dr. David Cooper, Joan Cunnold, Dr. Aaron Esterson, Dr. R. D. Laing, Clancy Sigal, Raymond Wilkinson.

*** See : Laing, R. D. and Esterson, A. (1965) *Sanity, Madness and the Family:* Vol. I *Families of Schizophrenics*. London : Tavistock Publications.

and during which he is guarded? Essentially it is as simple as that. In practice, however such are the prevailing taboos in our culture, that it is very difficult to set up and to keep going any place where the above hypotheses can be tested. To a limited extent we have succeeded in establishing three such places in London in the last three years. I am not aware of any comparable places anywhere else. The theory however, is „in the air". A significant number of our contemporaries are thinking along the same lines. Do not mistake the lack of a review of contemporary literature for any claim to theoretical priority*.

*
* *

Where is schizophrenia? The traditional answer is that schizophrenia is *in* some people rather than others, in their minds or in their bodies or in their style of life. This answer, however, may be part of a social process that itself generates the schizophrenia we are purporting to cure." Schizophrenia", to adopt a nominalist position, is a set of attributions that some people who are experts in making this set of attributions make about other people. Those people who make this set of attributions have to prove that it refers to something real. My summary of the evidence to date, is that they have not done so.

Meantime we can ask certain questions. Under what circumstances do these people bring this set of attributions into play in relationship to other people? The aetiology of "schizophrenia", comes to be the aetiology of this set of attributions. Since *psychiatrists* in particular make this set of attributions, it appears that *they* suffer from „schizophrenia", at least as much as the people to whom that set of attributions is made. In what social situations, mediating what personal relationships, is this set of attributions reinvented? Psychiatrists and psychoanalysts usually say that it (schizophrenia) is seen to be present *in* a „patient", when another person starts to behave in a way that exhibits those symptoms of schizophrenia that lead the psychiatrists to make that diagnosis. This is a completely circular argument. It begs the question as soon as the question has been raised. The question is, under what circumstances does a psychiatrist think that someone else is suffering from that condition which this set of attributions defines? For us, on the contrary, the aetiology of schizophrenia has come to be sought through studies of social situations, of the social circumstances under which this attribution is brought into play. It is brought into play when a peculiar disjunction has arisen whereby, eventually, at least two human beings, one a psychiatrist, one a patient, confront each other across a very complex failure, or set of failures, of communication.

It is not possible within the scope of this presentation to go into the details of what this failure of communication is. I shall mention only one or two aspects of it. By the time someone, whether child or adult, has come to see one of us, this person has already become perceived by a number of people as manifesting some sort of deviance, or alienation, or disturbance ; something or other which is supposed to be wrong with him. By

* The following three sources give between them most of the relevant recent references :
Bowers, M. B., Freedman, D.X. : „Psychedelic' Experiences in Acute Psychosis", *Archives of General Psychiatry, 15*, 240-248, 1966.
Laing, R. D. (1967) *The Politics of Experience & The Bird of Paradise*, London : Penguin Books ; New York : Pantheon ; Milan : Feltrinelli ; Germany : Suhrkamp.
Silverman, J. : "Shamans and accute schizophrenia" amer. Anthropol. 1967-69 : 21-31.

the time he comes to us, there is already an enormous gulf across which we witness an individual who moves rather too quickly or too slowly, or too much or too little, or says too much or too little, or uses a manner of speaking which appears peculiar to others. By this time this other person is liable to be trying to tell us something which is not what we expect a sane person to be saying. For instance, he may seem to us „ill" in some way, and he himself is often trying to tell us that he is not. This becomes a further manifestation of his illness, namely, that he lacks the insight to know he is ill.

If you are ill from our point of view, and you do not think you are from your point of view, that is a further token of how ill you are. If you have lost your mind, then you have not got the mind whereby you can appreciate the loss of it. So a further indication of the fact that you have lost your mind, is that you do not think you have. You do not feel you want any treatment, since you have not lost your mind. But this means you have. That you do feel ill, means you are. Treatment for a condition that, from your own point of view as a schizophrenic, is non-existent, will be to you intrusion, infringement on your integrity, persecution. You will perceive as persecution our well-intentioned efforts at benevolence ; our kindness as a conspiracy or an elaborate hoax. You will then either be paranoid, in that you are construing the best intentioned efforts of those who are only trying to help as a particularly insidious plot to destroy you. You will be admitted to hospital for a non-existent illness ; put to bed when you feel quite well. Your height is taken (no doubt to measure you for your coffin), your weight is taken, and then you are asked to take 7 from 100, to which you answer „I don't beleive in doing things backwards". You then get the interpretation that you are a homosexual and obviously you must be subject to some affective-cognitive symbolic deficit if you do not say 93. By this time, the multiple disjunctions between the two or more sets of people are enormous and we have a typical early schizophrenic with flatteneapproorin-d parite affect. who either laughs at this very serious business because he thinks it an elaborate joke, or takes it deadly seriously with considerable trepidation because he thinks it is probably a deadly conspiracy against him ; who lacks insight into the fact that he is ill, and shows no gratitude etc., for all that has been done for him.

What can we do about this situation? Some of us in London have set up a number of households where we do not play our part in the game of saying we are not one of them, or one of you. We have changed the paradigm. Someone is involved in a desperate strategy of liberation within the micro-social situation he finds himself. We try to follow and assist the movement of what is called „an acute schizophrenic episode", instead of arresting it.

There are a number of such movements which our society reacts to with little short of terror, and often with horror. The most obvious one is the movement of regression. One can „go forward", be „beside oneself", be high or low, go round in circles, or even stand in the same position ; but if somebody, in an existential sense, has to turn round and go then there is pratically no place he can be. I do not know if in France there is any place where you can go if you simply want to flip out, to collapse back into undiffe-

rentiated-unintegrated state, where this movement would be respected and would not be regarded necessarily as pathological ; where people would attempt to guide you through that movement if you needed guidance, and to guard you whilst this journey was being undertaken.

I have seen a number of people go through different degrees of such a journey in the places that we have in London.

I shall attempt to develop a little further the concept of transformation of a potentially liberatory kind. I have suggested the term *metanoia.* It is a traditional term. It is the Greek New Testament term, translated in English as repentance in French as conversion. Literally, it means : a change of mind.

Some changes of mind are forbidden. The person is given „treatment". It would be less confusing to say he is punished by „treatment". If we are to allow such changes to happen, we know that we have to consent to changes of a complementary or reciprocal nature within ourselves. A change in one person changes the relation between that person and others, and hence the others, unless they resist change by institutionalising themselves in a congealed professional posture. It is not sufficient to think simply of one person alone going into a regressive movement, for instance. Psychoanalytic theorising is much given to isolating movements inside one person alone. Any such change in one person is both occasioned by and in turn occasions events in the social field. Any transformation of one person invites accommodating transformations in others. But we have highly developed strategies of exclusion and isolation to forestall such eventualities. It threatens a micro-revolution. These possibilities of revolution are occurring all the time and the forces of counter-revolution and reaction are very strong. Most of the micro-social revolutions of this order are „nipped in the bud".

The movement of going back (regression) is one of the most forbidden. In London, in the United Kingdom and in the United States, there is practically nowhere someone can go back (regress) without at best perhaps this being uneasily tolerated, as a pathological development which we may be prepared to indulge for a little if it is ",in the service of the ego". It is practically always regarded as fundamentally a defect, a defence, a retreat, some failure of courage, a withdrawal from the present to the past. What may happen if we let a person go back? Here is one example.

One lady who is staying at Kingsley Hall came there about 2 1/2 years ago. She was an assistant matron in a general hospital ; a type of female regimental sergeant-major : an efficient, rigid, organised, nursing tutor in a general hospital, devoted to her work. She had begun to feel, as she put it, that she had lost herself some time in her life. She did not know exactly when, but felt that it had been a long time ago. She felt she had to go back to where she had lost herself in order to find herself again, and that *only* by going back might she possibily find herself and be able to live in a way that was not false. A few days after coming to Kingsley Hall, she was going back quite considerably, in a way

that I have never seen anyone do. She still retained her job in the hospital which was about an hour away. She would go to work, come back, take off her clothes and lie on a mattress on the floor and be incontinent, in urine and faeces, in the course of the night ; get up, have a bath and go into work again in the morning at six o'clock and carry out her duties as an assistant matron. She kept this up for a few weeks and then wrote a perfectly conventional letter saying that she required to take leave of absence from her duties for a time. This was accepted. She stayed on at Kingsley Hall and quickly went completely into a very full regression. As she went back, she became completely helpless to the extent that she had to be fed with a baby's bottle every two or three hours. This was the only food she would take. She covered herself with her own faeces and looked in an extraordinary mess. This is easy to talk about, but it was not easy to live through it.

She became thin, down to almost a bundle of bones. She stopped talking and she could not stand. When already extremely weak, she had a uterine haemorrhage for which she was required to go into hospital. No one found out why this had happened. In hospital she developed impacted faeces. Her faeces had to be digitally removed. She herself, when we asked her if it was alright, said yes, she wanted to continue. Dr. Berke, who is here today, saw her regularly for about 2 years and, along with other people, helped to take care of her. He could give you this afternoon if it is appropriate to do so, more of the details. According to her own account, she went back to before she was born. She said indeed that she wanted to go back to before she was even incarnated. At the most extreme point she went back to, she wanted us to take over her body completely, to hand her body over to us, so that we would see that food got in, faeces came out. She did not want even to have to defaecate. She wanted to abandon her body completely. Looking at her at that time, it seemed as though she had done so to a considerable extent. Her body at times was very cold. She looked as though she was approaching a state very near actual physical death. If one is going to allow this sort of thing to happen, one may have to take the risk, of the person approaching very close to physical death, as well as death in a symbolic sense. According to her and to others, this movement back can go not only to childhood, not only to prebirth, but to pre-incarnation. In what sense such expressions are to be understood, I leave for the moment. Regression may certainly be felt by people to be a return to conception, (not merely to the first few years or months of extra-uterine existence, or even to birth), before they can turn round again and once more come forward.

One might call the movement forward *neo-genesis*, a new movement forward whose principles and regularities we know very little about. It seems to be on the whole much quicker than the regression : I have seen persons come back across years in hours, days, weeks. This woman came back over a period of five to six weeks. Each day she was a little older and more organised. While a person is coming back, they can regress again.

This can be an oscillating movement : the graph can go up and down : it need not be a smooth parabola back and forward. On the way back there may be regressions within

regressions, or there may be regressions in the course of the neogenetic movement forward. If we knew more about these things, we would be able to assist more effectively. As it is in our present state of knowledge we would be wise to be essentially on-lookers and guardians. Only in very restricted respects can we presume to offer any informed guidance.

They are making the voyage. I have never made that voyage myself and possibly none of us here have. Since in practically all Psychiatric Units this journey is not allowed to take place we can be sure that very few of us have ever seen it. None of us is in a position to do more than trust this process. Since coming back from it this woman has done a great deal of painting sculpting modelling and writing. I shall read at the end of this talk, a typical short story that she wrote a year ago.

***

Another way of potential transformation that is usually forbidden and disparaged in therapeutic communities is any form of what is unpleasantly called, in the jargon, "acting out". This *may* be an exploration of possibilities that one seldom allows oneself or is allowed by others. For instance. One young man of 25, living at Kingsley Hall, had been terrified of being seen. He felt his body to be dead, and in addition that on his left side he was feminine and on his right side masculine. He felt he was both a very old man and a very young woman, and that in some way he was not a human being at all but a non-human monster. The structure of his bodily experience was very complicated and I shall not attempt now to elaborate upon it. It could be regarded as a graveyard, in which the family dead of several generations had been buried. Both his parents had lost their parents when they, his parents, were children, and they had, in a sense, projected them into him. He had had two operations for inguinal hernia and he was terrified of being castrated. So he was dead, a woman, a man, different ages, like a collapsed harlequin, terrified of castration, and of being looked at. While living at Kingsley Hall he decided to try to do, in the building, what he most feared. He thought out a "counter phobic" strategy, which he proceeded to „act out". He took his clothes off and went around naked. He started to paint himself, paint his face and his body. He transformed his face into faces of very queer creatures : for instance, an old prostitute whose gestures, intonations, etc., he assumed. Some of these transformations were quite demonic and frightening to others. He was trying to get people to see how he felt, and to translate into dramatic shared reality the inner „objects" he had always both been terrified lest people know, and wanted people to know. The impact of this form of communications was a hundred times more than saying "I feel evil", or „I feel I am a whore".

While this man was there, another young man of 19 came who had been in a mental hospital for a year. He went around with a big bird tied on his head, on a flat hat. The two had not met. I was sitting in the kitchen and Jack (the ghost) was at the sink, naked, painted up. He had a tin of talcum powder and was dusting his genitals with the powder. He was accustomed to go around with a tin of powder dusting his genitals for a while.

Because he was very frightened of anything happening to his genitals, he tried to walk very straight, in contrast to his usual gait. Before his counter-phobic nakedness, he had habitually kept himself at all times wrapped in many layers of clothes, a raincoat and on top of it all a big, heavy coat several times too large for him. All this so that his genitals would be completely safe behind the padding. He walked like an old man. But now he was trying to do just the opposite, exposing himself rather than concealing himself. Well, into the kitchen came the chap with the bird on his head. He was very quick to size up the gist of the situation as soon as he saw David, and very quickly pulled out a Luger pistol and shot him with a loud bang, right on his genitals. The worst had happened. For a fraction of a second neither David nor I had any idea whether the gun was loaded or not. It was a realistic pistol and it made a realistic sound. In fact it was not loaded. David looked down and saw his genitals were still there. In the next few seconds, he lost about 50 % of his castration anxiety. He has never ever been so terrified again. He lost as much of his castration anxiety in that incident as he had done in the four years that I had been seeing him in analysis. No interpretations could be as primitive as that dramatic action, completely unpredictable and unrepeatable. At Kingsley Hall we have hoped to have a place where such encounters could occur.

I am aware that the brevity of this communication raises far more questions than it answers. It may be virtually unintelligible without reference to the publications of Cooper, Esterson and myself in the last eight years. We are all aware that enormous work lies ahead in both theoretical and practical respects.

I shall conclude with a very short story written by the lady I mentioned earlier : a birthday present to me last year, and called :

THE HOLLOW TREE

There was once a tree in the forest who felt very sad and lonely because her trunk was hollow and her head was lost in mist. Sometimes the mist seemed so thick that her head felt divided from her trunk. To the other trees, she appeared quite strong, but rather aloof, for no wind ever sent her branches to them. She felt if she bent she would break, yet she grew so tired of standing straight. So it was with relief that in a mighty storm she was thrown to the ground. The tree was split, her branches scattered, her roots torn up and her bark was charred and blackened. She felt stunned, and though her head was clear of the mist, she felt her sap dry and she felt her deadness revealed when the hollow of her trunk was open to the sky. The other trees looked down and gasped, and didn't quite know whether to turn their branches politely away or whether to try to cover her emptiness and blackness with their green and brown. The tree mourned for her own life and feared to be suffocated by theirs. She felt she wanted to lay bare and open to the wind and the sun, and that in time she would grown up again, full and brown, from the ground. So it was that with the wetness of the rain she put down new roots, and by the warmth of the sun she stretched forth new wood. In the wind her branches bent to other trees, and as their leaves rustled and whispered in the dark, she felt loved, and laugh with life."

Résumé en français

par O. MANNONI

Dans son exposé, le Dr Laing met en question l'entité nosographique décrite comme schizophrénie. La crise initiale de ce trouble — la schizophrénie aiguë — ne prend son aspect psychotique définitif qu'en devenant chronique dans le milieu psychiatrique.

Laing fonde ses convictions sur une expérience, et non sur une théorie. De son avis, nos connaissances théoriques dans ce domaine sont encore insuffisantes, et nous ne pouvons guère qu'assister avec le minimum d'intervention à ce qui se passe quand la crise se déroule sans que personne cherche à l'arrêter.

Pour cela il a suffi d'établir (à Londres) un certain nombre de « homes » où ce déroulement de la crise — qui ne serait tolérée en aucun autre milieu, psychiatrique ou non — puisse se poursuivre jusqu'à son terme, généralement sous une forme « régressive ».

La schizophrénie ne peut être définie que comme une condition qui est imputée à quelqu'un par quelqu'un d'autre censé qualifié pour porter de telles imputations. Pour en comprendre la signification, il faut examiner la situation dans laquelle un psychiatre et un patient s'affrontent dans un échec de la communication. Cette situation est déterminée par la condition de la société où ils vivent l'un et l'autre.

* Laing nous a donné un texte écrit résumant l'essentiel des thèmes développés dans ses deux brillantes improvisations du samedi 21 et dimanche 22 octobre 1967. Nous renvoyons le lecteur français aux commentaires de J. Schotte publiés Page... 21 Page... 60

Cherchant un terme pour dénommer la crise par où passe le patient, Laing propose celui de metanoia (grec μετανοια qui se trouve dans l'Evangile avec le sens de *repentir*, de regret, mais aussi de *conversion*, de *transformation spirituelle*), L'exposé de Laing se termine par le compte-rendu de deux expériences de *metanoia*, et par un texte écrit par une patiente qui a passé par la plus longue et la plus sévère des deux expériences.
