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Phil. Trans. R. Soc. Lond. B 1966 **251**, 331-335
doi: 10.1098/rstb.1966.0018

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Ritualization and abnormal behaviour

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In this paper I shall present evidence from my clinical psychiatric experience to support the view that some abnormalities of behaviour can appropriately be seen as, so to say, para-rituals or meta-rituals; the deritualization of normal human rituals.

Ritualization and abnormal are both terms that present some difficulty in a multi-disciplinary symposium. If ordinary human speech is an instance of ritualization of behaviour in the ethological sense, then 'schizophrenese' is a de-structuring, a deritualizing of the socially shared ritual structuration of those patterns of sound that have acquired symbolic functions and come to be a language. I shall, however, be using 'ritualization' here subsequently more in the manner employed by the anthropologists.

Within the social sciences, in particular sociology, anthropology and psychiatry, the concept of 'abnormal' is itself problematic. Without rehearsing here the different sides of the debate, I shall, for the purpose of this paper, regard abnormal behaviour as behaviour that is socially deviant within a given society. Socially deviant behaviour is simply behaviour that the majority of people regard as such. Some abnormal—that is socially deviant—behaviour is regarded as an expression of 'mental illness'. Again, the concept of 'mental illness' is extremely problematic and has recently been subject to searching criticism from within psychiatry itself (Szasz 1961), as well as by anthropologists and sociologists (Goffman 1961; Scheff 1963, 1964*a*, *b*). My examples are drawn from that subclass of socially deviant behaviour regarded as coming within the special domain of relevance and field of competence of psychiatry. I put in parentheses in this paper any question of 'aetiology' of such behaviour (see Laing & Esterson 1964, pp. 2–9).

It is unavoidable that I shall have to pick my way through terminology—ritualization, normal, abnormal, mental illness—which is riddled by ambiguous and disputed meanings. There is no option in a paper of this length but to employ the existing terms without further defining them.

Our least ambiguous starting-point then is to define abnormal behaviour as behaviour that most people regard as abnormal. We bear in mind that the demarcation line between normal and abnormal is constantly shifting as social norms shift, as they are doing at this stage of history, often very quickly.

Abnormal-sick behaviour in 'patients' is often behaviour that does not fit into the formal structure of certain social rituals. The psychiatrist employs the 'ceremonial' of the psychiatric consultation as his test situation.†

As a psychiatrist, one's observations are made in 'role' and 'context'. This is the nearest one comes to a controlled situation. For instance, the psychiatric consultation takes place

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† I use 'ceremonial' in the sense employed by Garfinkel (1956).

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at a time and place of the psychiatrist's choosing and is terminated by the psychiatrist. Within this framework certain conventional courtesies are usually observed.

One patient came to see me with a script which he handed me at the outset. The script was for *me*. He wanted me to promise that I would follow it word for word, and offer no words apart from what he had written for me. From this alone, any psychiatrist would conjecture that here was either a paranoid schizophrenic or a very severe obsessional.

Another man wrote me a letter inviting me to lunch with him. His letter was interesting and I agreed. When I arrived, he said that he presumed I was not frivolous enough to want to eat at lunch time and launched into a very negative criticism of some of my work. He went on solidly for an hour and then abruptly begged me to take him on as a patient. His behaviour was abnormal, not in what he said as such, which was intelligent and interesting, but in his subversion of the context, the disjunction between him and me as to the definition of the situation, his lack of regard for my signals of hunger, impatience, etc. By inviting a guest for a meal and by not feeding him, he was deritualizing the ritualization, in the anthropological sense, of the situation that arises when one invites a guest for a meal, found, I believe, in every society. His way of assuming patienthood, by subverting the usual ritual whereby one becomes a patient in our society, defined him thereby, in terms of our society, as potentially a patient. Similar behaviour to this led him to be admitted to a mental hospital shortly thereafter, diagnosed as 'manic'.

A person, that is to say, may induct the psychiatrist to induct him into the role of a patient by playing the prescribed role in the prescribed context. But he may do so also either by entering into the ritualized context and refusing to play the prescribed role; or by playing the role of a patient outside the ritualized context wherein that role is 'appropriate'. A person, by so doing *and by nothing else*, may place himself not only in the position of a patient, but as psychotic.

Another simple variation of the pararitual gambit of refusal of roles within ritual context, and thereby invalidating oneself by invalidating the ritual of invalidation, is by role reversal within the psychiatric consultation. Thus one patient showed me that the psychiatric label for him was hypomanic or manic by entering my office for the first time in a breezy style, sitting on my chair, crossing his legs, clasping his hands and saying: 'Now, Dr Laing, tell me what is troubling you today?'

Examples of such para- or anti-ritualization can be multiplied. The very polished, impeccably dressed young man in dark, double-breasted suit with rolled umbrella—perfect in all respects except that he is wearing no socks and dirty gym shoes with no laces. The man who ends a rather puzzling, dull interview with a handshake in which he has tucked his thumb inside his own palm; a handshake that suddenly throws, retrospectively, everything that has gone before into doubt—an elaborate hoax, a double double take, a charade? Probable diagnosis in either case: schizophrenia, *ipso facto*.

We can see many privately invented rituals in the light of deritualization of socially accepted rituals, the destructuring of the usual social structure of communication. In such private rituals socially shared signals are not used, or shared signals are used with private connotations. The ritual seems to be self-gratifying or self-rewarding; generally, self-directed whatever its function, e.g. anxiety reducing. On closer understanding, however,

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the ritual may be found not only to be self-directed but also to have a socially directed message, conveyed in a privately elaborated code. It becomes the psychotherapist's task to decode it. Sometimes, if the patient trusts one enough, he will decode his signals himself, or explain them retrospectively after he has given up his ritual.

This subject is complex. One of the fundamental contributions to it has been made by Bateson *et al.* (1956) in the theory of the 'double bind' based on the Russell–Whitehead theory of logical types.

The following example epitomizes the type of problem with which we are concerned.

An obsessional man comes into my office once a week for three years. He sits down. As he sits down he shuts his eyes, and opens and shuts his eyes at me seven times. He:

(i)	Shuts eyes	To avoid 'killing' me by 'looking' or 'staring' but in shuttering them he feels he offends me
(ii)	Opens eyes	To kill me and so as not to offend me
(iii)	Shuts eyes	To reassure me that he is not trying to kill me, but by doing so makes me (as he feels) angry
(iv)	Opens eyes	To make sure I am still there and not angry, but this kills me
(v)	Shuts eyes	To not kill me but....
(vi)	Opens eyes	To not offend me but....
(vii)	Shuts eyes and keeps them shut for the rest of the session	As seven is a magical number with for him a special quality of 'truce', temporary resolution, or at least suspension of conflict

He is living in a world in which he cannot do the right thing. He is in an endless regress of wrong-right-wrong-right, doing-undoing-doing-undoing, undoing his undoing, etc. Situations like this fill his life. He can be arrested for hours in respect of how he correctly-incorrectly crosses the street, washes his hands, takes a handkerchief out of his pocket, ties his shoe-laces, wipes his bottom, speaks in a proper tone of voice, etc.

Where possible he has foreclosed these regressions to infinity by finding a formalized pattern of behaviour that is discreet, and finite, and can 'clear' him as he puts it.

Opening and shutting his eyes is a formalized, stereotyped pattern. It can be interpreted psychoanalytically in terms of destruction and reparation, love and hate, in terms of its placatory and protective functions, preserving me and him from his own fear of his own destructiveness, and so on. It can be seen also (and not incompatably with the more traditional type of psychoanalytic constructions) as an attempt to resolve an impossible internal system of contradictory injunctions, whereby he cannot do the right thing. He is right and wrong at once if he opens, and he is right and wrong if he shuts, his eyes. Long before he could make any verbal metacommunication about this, he was communicating to me his dilemma in this cryptic, kinetic behavioural idiom. As we began to translate the kinetic ritual into words, the ritual became more and more perfunctory. Cursory rapid blinks were enough, and finally even they became unnecessary.

Behaviour is usually seen as deviant not just because the content *as such* is strange, but because it is out of context. We are not arrested when someone scratches his head, picks

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his nose, moves his fingers, blinks his eyes, unless he does so 'inappropriately', for instance in order to communicate with another person—since such movements are not usual elements in conventional communications.

Much of so called psychotic behaviour consists in the use of conventionally non-communicative behaviour in order to communicate. A mistake made by many psychiatrists in the first part of this century was to take behaviour woven out of the fabric of conventionally non-communicative action at its face value, that is, as having no communicative function. We know now that some people, for reasons we shall not explore here, have come to form a tapestry of communicative patterns out of just those kinetic and sonic materials that are the 'left overs', as it were, from the communicational conventions that move within common sense, consensus, the domain of shared denotations and connotations.

Such a tapestry woven out of other people's 'leavings' is often highly formalized. If a person who uses this 'out of bounds' code is out of reciprocal communication long enough, his signals become more and more stereotyped and repetitious. The extremes of such ex-communication, ultimate despair at the possibility of communicating, are seen among the chronic inmates of mental hospitals.

This type of communication has its own rules: it is highly formalized; it is limited in temporal sequence; it is resistant to change; it is cryptic.

A woman patient who has been a patient in a mental hospital for over twenty years, approaches me at the same time each day, curtsies and hands me a piece of cardboard on which is stuck a small effigy. I take it, appraise it, smile, say 'thank you', bow, hand it back. She takes it back, smiles, curtsies, walks away. Almost every day for about eighteen months the same scene is repeated.

The effigy is surrounded by captions with arrows directing the reader to different sections:

'These limbs are made with wax from my ear and hair from my armpit.'

'The genital area is made with my menstrual blood and my pubic hair.'

'The face is made with my tears, my saliva, my catarrh, and hair from my head.'

'The body is made with my shit, my sweat, and my blood.'

I played my part in this ritual to humour her, somewhat patronizing and embarrassed. I might have taken the palms of her hands and licked her sweat. I might have drunk her blood, swallowed her tears. But I was a psychiatrist.

Might I now be able to show her as she showed me, how I, as she, needed to be accepted? Can I confess my tears, that I too want them to be confirmed and blessed. This patient's schizophrenic behaviour was woven out of the snot, shit, saliva, the tears and the sweat and the blood of a suffering and desire she chose to express in her way. What is our way? By giving and receiving papers at the Royal Society, perhaps. If we are normal, are we more direct or honest?

I hope these examples have succeeded in conveying something both of the extraordinary complexity of the rituals and pararituals known to psychiatrists, and the fundamental *simple* fear of and longing for communication that underlies them.

Ritualization is a formal patterning of the encounter, the meeting of human beings.

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Behaviour as parody, a pararitual or deritualization of normal ritual, is first regarded as abnormal, next as ill, and finally may be excommunicated. Thereafter, in clinical psychiatric terminology, it 'deteriorates'. It becomes more and more rigid, repetitious, telegrammatic, and cryptic. But by then, we have not only an aberration of normal ritual, but an aberration of an aberration.

References (Laing)

Bateson, G., Jackson, D. D., Haley, J. & Weakland, J. 1956 Toward a theory of schizophrenia. *Behav. Sci.* **1**, 251–264.

Garfinkle, H. 1956 Conditions of successful degradation ceremonies. *Amer. J. Sociol.* **61**, 420–424.

Goffman, E. 1961 *Asylums*. New York: Doubleday-Anchor.

Laing & Esterson. 1964 *Sanity, madness, and the family*. London: Tavistock; New York: Basic Books (1965).

Scheff, T. J. 1963 Decision rules, types of error, and their consequences in medical diagnosis. *Behav. Sci.* **8**, 97–107.

Scheff, T. J. 1964*a* Social conditions for rationality: how urban and rural courts deal with the mentally ill. *Amer. Behav. Scient.* **7**, 21–24.

Scheff, T. J. 1964*b* 'The societal reaction to deviants ascriptive elements in the psychiatric screening of mental patients in a mid-western state'. *Social Problems* **11**, 401–413.

Szasz, T. 1961 *The myth of mental illness*. New York: Harper; London: Secker and Warburg.

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