

# Psychosis and its conceptualisations: a journey from pathology to difference

*Adam Aronovich*

Màster en Antropologia Mèdica i Salut Global,  
Universitat Rovira i Virgili  
dolp55@gmail.com

**Abstract:** Various conceptualizations of psychotic experience are evaluated on the basis of a year-long extra-therapeutic relationship between the author and a 15-year-old teen diagnosed with a psychotic disorder. Perspectives ranging from the clinician's sign-based neo-Kraepelinian classification of ideational pathologies to the ethnographer's hermeneutic interpretations of symptoms are considered, providing ethnographic and auto-ethnographic data to argue that crystallized explanatory systems fail to account for all instances of psychotic experience. Reductionist approaches thus perpetuate the mystification of socio-economic and cultural aspects of madness and social control, further limiting the range of the sanctioned discourses on normalcy and sanity. Recovering the narrative voices of the afflicted is highlighted as a necessary step to help redefine concepts of madness beyond the dominant biologicist/psychologicist stigmatizing labels, emphasizing the need to construct and facilitate supportive environments rooted in reciprocity, horizontality and peer-to-peer guidance in which expert and popular knowledge can be better integrated and command equal weight.

**Key Words:** schizophrenia; madness; extra-therapeutic; reciprocity; ethnography; peer-to peer.

**Resumen:** Diferentes conceptualizaciones de la psicosis son evaluadas a través de una relación extra terapéutica, a lo largo de un año, entre el autor y un adolescente de 15 años diagnosticado con un trastorno psicótico. Perspectivas clínicas como la clasificación neo-Kraepeliniana de patologías ideacionales basadas en signos y perspectivas etnográficas basadas en la interpretación hermenéutica de síntomas son consideradas, ofreciendo datos etnográficos y auto-etnográficos para argumentar que sistemas explicativos cristalizados no logran encapsular la

totalidad de experiencias psicóticas. Aproximaciones reduccionistas perpetúan así la mistificación de los aspectos socioeconómicos y culturales de la locura y control social, limitando aún más el alcance de los discursos sancionados sobre la normalidad y cordura. Resaltamos la recuperación de las voces narrativas de los afectados como un paso necesario hacia la redefinición de la locura más allá de las etiquetas estigmatizadoras de los discursos biologicistas / psicologicistas dominantes, enfatizando la necesidad de construir y facilitar entornos de apoyo enraizados en reciprocidad, horizontalidad y ayuda *peer-to-peer* donde una mejor integración de saberes expertos y populares pueda ocurrir.

**Palabras clave:** esquizofrenia; locura; extra-terapéutico; reciprocidad; etnografía; de igual a igual.

## 1. Introduction

Structured more or less like a case-study from the perspective of a young psychology student tutoring a teenager diagnosed and treated for childhood-onset schizophrenia, this auto-ethnography should be read on two different levels. It is, of course, the story of a year-long interaction between its protagonists —Or and me—, but it is primarily the story of how my own understanding of Or's experience (and, accordingly, my behavior) evolved during the time we spent together. The meta-narrative is thus a retrospective gaze that attempts to trace the development of my own understanding of what psychosis is, or —perhaps more accurately— what psychosis is not.

The general outline is an examination of my relationship with Or from a variety of perspectives, building towards the conclusion that his experience ultimately escapes a fully satisfactory conceptualization under any one crystallized explanatory system. The examinations are, in chronological order, as follows: Or's schizophrenia understood through the biologicist lens of neo-Kraepelinian discourse, Or's diagnosis understood as the result of complex mechanisms of social control, the influence of social, economic and cultural factors on his affliction and subsequent diagnosis and treatment and, lastly, Or's narrative and symptoms examined retrospectively (remaining conscious of all the methodological faults implied by that asynchronicity). The interpretive

ethnographic approach borrowed from Martínez-Hernández (2000). However partially valid for some cases, I conclude that all of these approaches and explanations are limited in their power to extrapolate from the particular to the general as far as they are all inextricably bound by an underlying ideology and a specific methodology, and they have different goals.

On a more personal level —it is an auto-ethnography after all— this is also the story of how I began to become aware of my own arrogance and prejudices, and how I unmasked along the way the scientific hubris of institutions and professionals who claim to have authority over experience. My story reflects the stories of many honest and well-meaning professionals who, working under ideologically-loaded assumptions and assimilated dogmas are ultimately bound to reproduce hierarchical power relations and hence perpetuate the pervasive personal and social suffering they aim to ameliorate. Hence, I argue, for anybody earnestly and honestly interested in understanding consciousness in general and madness —psychosis, schizophrenia, mania, whatever it is called— in particular (and more importantly, in alleviating the inherent suffering attached to it), it is first imperative to climb down from the authoritative pedestal of *knowing*, opting instead for *listening* to the voices and stories of those who are experts of their own experience.

## 2. “Here be Dragons”: social control and the neo-Kraepelinian cartography of mind

I first met Or in his family’s house, a tiny two-bedroom apartment in the heart of *Shkhubnat Gimel* (or simply, “Neighborhood Three” in Hebrew), one of the poorest and most neglected parts of Beer Sheva, a city with a population of some 200,000 inhabitants in southern Israel. For the last year of my bachelor’s degree in Psychology, I had been awarded a social scholarship on the condition that I committed to a tutoring project that paired children from underprivileged backgrounds with university students. The goal was to offer the child often-needed personal attention, and help them to succeed at school despite their harsh life circumstances. When I arrived for the first interview, the coordinator of the program asked me to tutor a “special” kid. Intrigued, I enquired what

was so special about him. Or was an unusual candidate because he was well beyond the eligible age for tutorship in the program, and —she said— he was also a “schizophrenic”. His inclusion depended on finding a suitable tutor for him, preferably a physically strong, male, final-year psychology student, a description that I apparently met.

Working with Or afforded me the opportunity to experience firsthand what it means to build a relationship with a young psychotic person, and get to know the “positive symptoms” that are often considered the mainstays of psychosis<sup>1</sup> (the delusions, hallucinations, disorganized thought which I found fascinating). Although I had already been working with psychiatric patients for a couple of years, all of the people I had met up to that point were much older who had been in and out of psychiatric institutions, sometimes for decades, kept throughout on a steady diet of neuroleptics, sedatives and other psychopharmaceuticals. Most of them had been diagnosed with chronic schizophrenia, and almost exclusively exhibited what are known as “negative symptoms” (Andreasen & Olsen, 1982): flat expression and little emotion, poverty of speech and an overwhelming apathy and lack of will in which even the simplest of chores become an insurmountable burden.

In the place where I worked, even the word “rehabilitation” had become a euphemism, and all of the personnel knew that even though our goals were to eventually help people move on to an independent, more fulfilling life, none of the 30 or so residents that lived there —a gated compound that encompassed three houses in the heart of Beer Sheva, a privatized “midway home” — was going anywhere except the occasional hospitalization for acute or subacute psychotic episodes. Or was my first glimpse into the inner-world and behavior of a young person going through the early stages of mental illness, a person who perceived reality and responded to it quite differently from how I did, and was still young enough and perhaps naive enough to trust me and share his stories with me.

Sitting at a tiny table in the modest family home, Or smiled and introduced himself; he said he was pleased to meet me and that he hoped we would be friends and go for long walks in the city. Although it was obvious to me that the

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1 The Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association and now in its fifth edition, separates “positive” symptoms from “negative” symptoms, the former usually being associated with psychotic episodes and the latter being the emotional and cognitive deficits usually experienced over time (APA, 2013).

introduction was well-rehearsed and he was following the script dictated by his well-meaning parents, it didn't feel unauthentic or forced. He seemed genuinely excited and after a few minutes of conversation, he left the kitchen to go back to his usual activity, fumbling around the internet looking for information on his favorite pop-culture icons. He was obsessed, I would later discover, with reality shows and gossip programs, and often fantasized about being a participant in one. After he left for his room, his mother proceeded to tell me the story of Or and his illness, as perceived by the parents. They, too, were very happy and excited to meet me. Very soon I understood why they were so anxious and hopeful about our tutorship: they were terrified that Or would be taken away again by force.

"When Or was 12", the mother said, "His school teacher called us, once again. She said that Or continued to be a disruptive influence on his classmates and, after a meeting with the school's psychologist, they had decided that Or should go and see a child psychiatrist. We weren't being consulted, we were being told. The psychiatrist saw him once, and on the basis of the information given by the school he diagnosed Or with a disease". Naturally, I wanted to know what exactly Or "was", but his parents were reluctant to share his exact diagnosis with me. Looking back, I now believe that they were afraid that if they labeled him, I would treat Or not as a child with a distinct biography with all of its idiosyncrasies, but rather as a clinical case.

When I met him, Or was 14 and taking a steady diet of neuroleptics (quetiapine) and sedatives —mostly benzodipines—, in addition to the methylphenidate he had been taking for years, presumably to treat another diagnosis of ADHD. His parents, very religious (although not orthodox) Jews from a very traditional background, initially refused to follow the psychiatrist's indication as they didn't consider Or to be sick; "He is a very good kid", his mother would tell me, "he's different than the other kids and has trouble adjusting to his school, but we have never considered him to be sick. He doesn't really need to take those medicines."

At the time that Or was first diagnosed, a couple of years before we met, his parents decided not to comply with the psychiatric authorities and the psychopharmaceutic prescription they were handed. According to his mother, a few weeks after Or's meeting with the psychiatrist, the school's principal called Or's parents to her office. It was an ultimatum: Or's behavior at school

was unacceptable, and if they refused to listen to the psychiatric authorities, they would have no choice but to get the social services involved. Devastated and impotent, the parents returned home hoping for the best, unwilling to accept and internalize the experts' unequivocal decision that Or was a mentally ill person who needed to be on drugs. A week later, a worker for the city's childhood welfare services knocked on the door. With her, a couple of policemen entered the house, serving Or's father with a warrant signed by the district's chief psychiatrist. Their "lack of cooperation" was perceived by the school—and the state—as child neglect: Or was being denied the proper treatment that he needed and the pertinent authorities had come to take him away from his home by force.

Or spent the next 18 months involuntarily committed to one of the 30 beds of the inpatient adolescent's ward of the *Ness Ziona* Psychiatric Hospital, a closed facility about an hour and a half's drive from his parents' house. According to the current Israeli mental health legislation,<sup>2</sup> the court can order involuntary hospitalization of a minor in one particular circumstance: the presence of a psychotic episode coupled with immediate and physical danger to self or others, as long as the perceived dangerousness of the patient is causally related to the presence of the mental illness (Jaworowsky and Zabow, 1995).

Israeli researchers Ajzenstadt *et alii* point out that "the definition of dangerousness is vague and its application to a particular situation remains totally within the province of an individual psychiatrist" (2001:649). The authors found that when asked to define which behaviors are considered dangerous and thus justify commitment, experts included "violence, clinical depression accompanied by a suicidal urge", "neglecting oneself" and "damaging property" alongside behaviors considered as "different" or "strange" such as "unlimited purchase of items and clothes, listening to music very loudly, and stockpiling garbage or 'throwing eggs at the Prime Minister'", while others mentioned "the 'danger' to the good reputation of a person" (Ajzenstadt *et alii*, 2001:648).

One of the main problems with this model is that signs of mental illness can be inferred by professionals merely from "a person's failure to behave according

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2 In 1991, this law replaced a heavily criticized previous provision, dating from 1955, and it has the explicit goal of improving Israel's system of mental health care by avoiding unnecessary institutionalization and improve the patients human rights by treating them as outpatients in a community setting (Ajzenstad *et alii*, 2001).

to specific expectations” (Ajzenstadt *et alii*, 2001:649). But it is not only the legal definitions and regulations that are ambiguous. Martínez-Hernández points out that the problem of ambiguity is found in the DSM itself (2000). Despite the a-theoretical pretension of its taxonomies and its purported objectivity and scientific neutrality, mental health experts face significant difficulty to neutralize moral judgments and cultural values, making it hard “to distinguish between what is behaviorally pathological and socially normative... between clinical work and the bias introduced by the moral judgments of the professional; and between objective classification and a sort of corporate ‘common sense’” (2000:72).

In more recent years authors such as Richard Gosden have addressed the controversial issue of preventive medicine programs, initiatives that seek to identify divergent behaviors in children and anticipate treatment before their supposed mental diseases develop (2001). Attempts to identify “pre-psychotic” adolescents, Gosden argues, are clear evidence of the use of psychiatry as a tool of social control, often failing to account for its policies with clinical evidence: not only is schizophrenia a very vague diagnosis with a very mysterious and contradictory etiology, but there are no clinical tests or biological markers that can confirm it (Gosden, 2001; Martínez-Hernández, 2000). For Gosden, beyond the purported organic origin of the disease, these initiatives violate patient’s human rights as they pathologize people who do not conform to social norms and expectations (social control) or others whose psychosis could be interpreted as a meaningful crisis which, if successfully resolved, could play a significant and beneficial role in the life of that person<sup>3</sup> (2001).

As well as the problematical ambiguity of legal and clinical terms that leave room for liberal interpretations based on individual and social prejudice in the prevention and diagnosis of psychosis, there are many other ideological and socio-economic forces and interests at play. In order to understand this better, it is important to understand the current ruling ideology in psychiatric practice: neo-Kraepelinism (Martínez-Hernández, 2000). In his book *What’s behind the symptom?*, anthropologist Angel Martínez-Hernández writes that there are two very different ways of understanding psychiatric symptomatology: the clinical approach, rooted in the neo-Kraepelinian project that reduces symptoms to

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<sup>3</sup> This possibility has been defined by Gosden (2001) and others following Grof (1980) as a spiritual emergency.

signs (understood as positive manifestations of organic abnormalities), and an anthropological approach rooted in dense descriptions that interprets symptoms as meaning (2000). In biomedical terminology, writes the author, “signs” are understood to be “objective evidence of disease which can be perceived by a professional” (2000:4), while symptoms are much more ambiguous and unreliable, emerging from the subjective perception, interpretation and expression of the patients themselves: “linguistic, cultural and semiotic realities which cannot be understood without considerable inference” (Martínez-Hernández, 2000:82). Signs and symptoms thus refer to thoroughly different orders of reality: signs are part of an observable natural reality while symptoms emerge as “a human expression that embodies meaning” (Martínez-Hernández, 2000:4).

An elucidating example given by Martínez-Hernández contrasts the self-evident reality of a case of eczema, and the numerous possible interpretations of a statement such as “my heart is upset” (2000:4). While an eczema is most probably always an eczema, a distressed heart can mean very different things when expressed by different people: for an Iranian woman it may be related to the problems of feminine sexuality in an oppressive climate while for a Nahuatl native of Huayapan, the heart is indispensable for the good digestion of food. Furthermore, a patient from Barcelona may suffer from heart disease and others symbolically perceive the heart as the center of romantic life (Martínez-Hernández, 2000:5). Unlike dermatologists, however, psychiatrists have to rely on symptoms: most psychiatric diagnoses lack the supporting evidence that is usually provided by clinical tests, and quests to find reliable biomarkers have proved mostly fruitless (Mills & Fernando, 2014; Whitaker, 2004). The diagnosis is then given on the basis of symptoms, which are reified as signs. As pointed out by Martínez-Hernández, biomedical discourse relies on a presupposed isomorphism between diagnostic categories (ideational) and pathological processes (real) (2000:80). From the perspective of the neo-Kraepelinian clinician, there is no distance between the word and the thing (Martínez-Hernández, 2000). The narrative of the person, as Foucault famously noted, is subordinated to a highly localized medical gaze, in which the emphasis is to look for medicable pathologies in the body instead of listening to the voices of the afflicted and the possible meaning they ascribe to their symptoms (2007). The individual manifestations of affliction are clumped into a universal



label that simplifies complex complaints to make them more manageable for professionals. This has been acknowledged by Dr. Allen Frances, lead editor of the fourth edition of the DSM, who unsurprisingly resorts to metaphor to explain the logic of descriptive psychiatry: “Diagnosis is part of the magic... you know those medieval maps? In the places where they didn’t know what was going on, they wrote ‘Dragons live here’...we have a dragon’s world here. But you wouldn’t want to be without the map.” (Frances, quoted in Greenberg, 2010).

However, the efforts of neo-Kraepelinian psychiatry to chart the dragons of the mind come at a price: there is a deliberate confusion between the map and the territory, and the topographical accidents that are uncomfortable for efficient, highly individualistic clinical practice are mystified. “This naturalist approach”, writes Martínez-Hernández, “denies us access to large or small worlds of meaning, to the cultural categories and political-economic relations that a complaint may contain” (2000:77). What we gain in clinical efficiency we lose in real understanding, as was stated decades ago by Judi Chamberlin, a political activist and leader in the “Psychiatric Survivors Movement”:

In the medical model of mental illness, human emotions are transformed into symptoms. Behavior has meaning in the context of people’s lives; psychiatric labeling separates out certain behaviors and calls them part of a disease process. It is impossible to understand what is going on in the life of a person in crisis if his or her behavior is discredited in this way. (1978:109)

### **3. Continents of the mind: schizophrenia and its conceptualizations**

I met Or twice a week for four hours over the course of the following year. When we first met, Or had been out of the psychiatric ward and back home for a few months and was attending a special school for teenagers with unspecified “special needs”. One of the first things that struck me after I got to know him was how sweet and intelligent he was. Not only did he not seem to be dangerous at all, but I could not detect a pinch of malice in his being. Or was very fond of human contact; he was very physical, and although a big, tall 14-year-old, he liked to clutch on to my hand as we walked through the city streets. He had

no social phobias or inhibitions; he was very extroverted and felt immediately comfortable and at ease with all the new people we met, readily hugging and shaking hands with strangers. Sometimes, it would be a little too much: he wouldn't let go of my hand even if I asked him to or sometimes he would keep hugging someone until they pushed him, occasionally making them feel a bit uncomfortable.

Since our time together was flexible and we did not have to follow a pre-determined script or program, Or and I would decide what to do and where to go. Besides his fascination with the virtual worlds of cathode rays and optic fibers, long walks in the city and frequent visits to the candy shop, he particularly liked spending time in my house. My friends and house-mates adored him, and kindly but quickly learnt to set boundaries for him, particularly the women: Or wasn't always aware of other people's "personal space", or did not perceive it in the same way as most of us did. The perplexingly naive disregard that he seemed to have for social conventions was fascinating, and sometimes frustrating. Often, during our long walks in the city we would enter the local supermarket, and pretty soon I discovered that he was stealing chocolate and candy bars. Initially surprised and subsequently puzzled, I discovered that no amount of reasoning and no appeals to obedience would make him behave any differently. No matter what strategy I chose, I rarely managed to convince him to leave the supermarket empty-handed. Rather than becoming angry or frustrated, I tried to make the best of an opportunity to observe what I considered to be recurring and bizarre compulsive behavior. Going to the local supermarket became an exercise for the both of us, and it usually ended in the exact same way: with me checking Or's pockets outside the store and him going back to return the unpaid-for items, looking more puzzled and disappointed than ashamed.

As time passed, I began to understand that behaviors such as compulsive shoplifting or excessive affection and physicality could have provided the school staff and district psychiatrist with enough reasons to have Or forcefully committed. However, something in the quality of our interaction, coupled with my knowledge of his socioeconomic background, suggested to me that Or might have been acting as he did for reasons other than a pathological compulsion and error that endangered him or others. Although undeniably extravagant in his behavior, prone to elaborate fantasies of self-reference and

utterly unable to adapt to his assigned social role (a middle-school student in a compulsory formal education system), I never perceived Or to be violent, towards himself or others. In fact, besides instances of shoplifting<sup>4</sup>, no other expression or behavior suggested “dangerousness” to me. I knew, from his own stories and his parents’ reports, that Or had been in trouble at school a few times for fighting, but from their narratives I was left with the impression that Or was being bullied by other kids at school and he was merely trying to stand his ground. He did, however, fit perfectly into the Israeli prevailing cultural stereotype of “dangerous”: he was a teenage male from a notoriously poor and crime-ridden neighborhood in a peripheral city, he was from a *mizrahi* (oriental) ethnic background,<sup>5</sup> and he was not particularly well suited to thriving in institutionalized school environments.

From a personal level, it was very interesting to observe how my own behavior was being affected by Or’s. After shoplifting became a fixture of our long walks, I started noticing that I was acting as an agent of social control. Unconsciously, I had been micro-managing Or’s disruptive behavior, educating him in the proper ways to pursue consumer-commodity relationships, and I wasn’t even completely sure why. Was I worried that Or would grow up to be a criminal, did I want to save myself the trouble of having to constantly return the unpaid-for items, or was I just unconsciously defending the profit-margins of a corporation? In principle, my youthful rebellious and transgressive disposition saw no ethical problems or objections to the notion of an unprivileged kid from a marginalized neighborhood taking food from a chain supermarket; quite the contrary. Yet, as a tutor (being in a position of authority, however friendly), I could not possibly allow him to do so. By repeatedly taking him back to

4 Shoplifting, although evidently illegal, seems to me to be a tricky situation, since the “danger” implicit in it is, of course, the personal legal repercussions, the “danger” of loss of profits for a chain-supermarket but also the danger of breaking with social norms that dictate that food is a commodity and in order to eat we must purchase it from specific for-profit outlets. The problem is evident in Israel, where 850,000 children (over one third of the children in the country) live below the poverty line, one of the highest rates in the developed world (Weiler-Polak, 2010). A child that shoplifts in order to eat could be conceptualized as “dangerous”, but we would be ignoring a lot of socioeconomic context: 75% of poor children in Israel forgo meals because of their economic status (Weiler-Polak, 2010).

5 Among the many polarizations inherent to modern Israeli society, one of the most prominent divides is found amongst descendants of Ashkenazi (Eastern and Central European) Jews and Mizrahi (Oriental) or Sepharadi (Spanish) Jews. In general, European Jews have dominated social, political and cultural circles since the creation of the state of Israel. It is curious —although not surprising— how the microcosmos of Israeli society reproduces the global power relations between the global “north” and “south”. For a classic review of this issue see Peres, 1971.

the supermarket and in a theatrically shameful manner making him take the chocolate out of his pocket and put it in the counter, I was indoctrinating him into social conventions, despite my own discomfort with and suspicion of those same norms. The difference, I soon realized, was that Or was not acting out of any subversive ideology, there was no appeal to social justice behind his acts; he wasn't making a point against neoliberal exploitation and consumerism by not paying for his candy. As far as I could see, he was ultimately acting from compulsion, a lack of understanding: an act of anarchy that was not based on a premeditated political philosophy but on a lack of capacity for self-restraint.

As a fascinating and intriguing fellow human being, I was obviously very much interested in Or. Until that point in our relationship, however, I had probably been much more interested in observing the symptoms of his disease to validate what I had learnt at school. As time passed, I became increasingly resistant to the idea that the enormous diversity, complexity and apparent idiosyncrasy of his behaviors and expressions were all reducible to the neo-Kraepelinian category of "schizophrenia". I also started noticing the unconscious damage that the scholarship program's coordinator had unintentionally done by immediately presenting Or to me as "a schizophrenic child": from the first moment, I had assumed that I was to interact primarily with a pathology that happened to be embodied within an actual person.

But besides becoming suspicious about a purely biologicist explanation for his symptoms, I couldn't find enough reasons to categorically single-out the oppressive edifices of neoliberalism and classism that drove a hungry kid to petty theft either, and although tempting to ascribe Or's behavior and delusions to an innate —if perhaps unconscious— romanticized rebellious and transgressive force within him, neither of these explanations was fully satisfactory, even when combined. I realized that if I wanted to understand his behavior, I might as well just ask him about it, instead of making my own inferences. Perhaps if I focused more on Or and less on his disease, we would be able to establish a more genuine, more reciprocal and less hierarchical relationship that would be more beneficial for the both of us.

"Why do you feel the need to steal candy from the shop?" I asked him one day. Or stared back at me with a puzzled smile: "Please promise that you won't tell my mother". "I can't promise you that. Besides, you haven't answered my

question”, I insisted. “Promise that you won’t tell her!” he said anxiously, his voice radically changing in pitch and tone. Although I tried to be as honest and transparent with him as I could, his parents were well aware of his shoplifting antics long before we even met, and sometimes we would talk about it after he had left the room. “Fine, I won’t tell”, I lied. “So why do you insist on taking things without paying for them?” Not once did Or give me an answer I considered useful, insightful or true. “Just let me take them. Can you pretend not to see this time?” he would ask. He was evasive, defensive and apparently uninterested in justifying his behavior to me. Perhaps there was nothing for him to justify. His only concerns in this regard were for his mother not to find out and for me to let him do as he wished. “Adam, today after we go to the supermarket, can you please promise me that you will not check my pockets?”, he asked once, with a hopeful and naive ingenuity that, more than anything, made me want to hug him.

#### 4. Ethnography as a vehicle of “near-experience”

Or had an obsession (if not clinical, at least in the colloquial use of the term) with pop culture and reality television personalities —particularly musical talent shows. He often talked about them as if he had met them and they were well acquainted with each other. He talked about their personal lives, intermingling his own narrative with the stories he heard on television or, I supposed, imagined in his mind. I had made a decision to always address Or as a mature, responsible adult and speak my own mind as if he was one of my friends, hoping that we could move beyond our pre-defined “tutorship” roles and eventually he would reciprocate in the same way. “Or”, —I would often say— “I’m really not interested in reality shows. I’m bored by cheap entertainment and I think there’s much better things to think about”. He would not get defensive, but he would smile as if he knew something that I did not, and make me promise that I would make an effort to watch if he ever made it to one of the myriad talent shows on TV. He was infatuated with appearing on live television. “Or, you cannot sing!”, I would tease him —he really could not, as I had already painfully confirmed many times— “How are you going to manage to get on that stage?”. Or would give me a look of complicity: “I have other talents, you know that already”.

Other than reality shows, time travel was his favorite subject. It seemed that Or had no doubt that time-travel was not only possible, but that he was actively coming and going, jumping and cruising the time-space matrix as easily as he would walk to school every morning. He never had answers to practical matters. “Do you use a machine?” I would often ask him. He would laugh. “No machine.” “Well?” I would smile. “You just don’t need a machine. Why do you keep asking me silly questions?” The more I insisted the more disappointed he became with my lack of understanding or, perhaps, lack of imagination. Time travel became my favorite subject to discuss with Or for various reasons. It was far more interesting than mainstream television programming, for one, but it was also a subject that was unique in a very particular way: although a recurring theme in science-fiction, a common fantasy of children and a fun thought experiment, common sense dictates that time travel is impossible. His delusions to the contrary, however, still afforded me some anchoring to a paradigmatic symptom of a disease whose ontological validity was gradually being dissolved in my own mind. There was, however, one more thing: although still in the realm of speculation, the mathematical substrate for the theoretical possibility of time travel, when looked at from the perspective of relativistic physics (Hawkins, 2010) or quantum mechanics (Deutsch, 1991), is there. It is a fantasy that, although contrary to our common-sense and lived experience, is still theoretically possible.

The mere possibility of it gave in an edge that set it apart—in my eyes—from the myriad other bizarre delusions I have heard in other interactions with psychiatric patients.<sup>6</sup> Or himself, beyond constant talk about time travel, was also fond of asking me bizarre, repetitive questions about elementary physics. He was not interested in equations or theorems, and as far as I knew—from the few times he agreed to do his homework with me—he had neither the patience nor the inclination to do even very basic math. He was very interested in seemingly simplistic questions of cause and effect: “If we throw an egg from the roof of your house, do you think it will break?” he would ask, smiling. By this point I already knew that he was fiercely intelligent, and I suspected that

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6 In the outpatient midway home where I worked, telepathic communications with Vladimir Putin, Benjamin Netanyahu and even Bob Dylan were normal occurrences for one resident while another was tormented by the voice of a childhood acquaintance who repeatedly made obscene comments regarding his genitals.

his questions were much more complex and loaded with hidden symbolical content and intention than I originally thought. I would think carefully about seemingly simple questions like this, trying to outsmart him. Most times, I wouldn't answer myself but reflect the question back to him: "What do you think? If you throw an egg from the roof, will it break?". "I think so, but can we check?" he asked grabbing into my arm. I laid a layer of old newspapers in the patio floor of my old house, and helped him up the ladder to the roof. "Go ahead". Contemplating the egg smash and splatter against the floor, I was mystified by his continuous need of reassurance that the laws of physics were stable and constant and I was sure that it was somehow inextricably connected with his time-travel fantasies.

I have no way of knowing what went on in Or's meetings with the psychiatrists of Beer Sheva or the Ness Ziona hospital, but it is quite certain that beyond his perceived "dangerous" behavior, improbable conversations with pop culture icons or talk about time travel were ticked off as hallucinations and delusions: positive symptoms reified as signs. Yet beyond the pathology-centered clinical approach, argues Martínez-Hernández, there are three ways in which a symptom can be read if we look through an ethnographic lens: it can be interpreted as figurative language, in which apparently nonsensical idioms are used as symbols or metaphors; it can be interpreted as deceit, in which the bizarre speech is deliberately used to lie and confuse the other; and it can be interpreted as telling the truth, however unlikely or bizarre it may appear based on the experience of the listener (2000). Since I never perceived or even suspected that Or was playing a role or that he was acting out an elaborate plan to deceive me, his family, his teachers and the mental health professionals, I will proceed now to analyze some of Or's narratives and behaviors according to the other two possible interpretations, starting from the literal one: Or's experience as true.

To pretend that Or was a time-traveler seeking fame and recognition in reality shows was fairly easy to dismiss. However, both for the sake of the argument, and the benefit of the doubt, I will attempt to take this possibility to its logical conclusion. Besides, I had already promised myself not to dismiss Or's narrative as mere delusions or hallucinations rooted in error, however farfetched his stories seemed. In order to make a true attempt to bridge the



apparent gap between our inner worlds, I needed to acknowledge that neither Or nor myself had authority over the experience of the other or ultimate knowledge concerning the ontology of reality.

The ethnographer does not focus on the pathology but on the phenomenological, narrative and psychosocial expressions of affliction, and aims to help people unearth their own resources to find the optimal way to address the experience according to their world of meanings. This does not necessarily mean that a possible pathological process is rejected. The social construction of “schizophrenia” does not negate an objective, underlying biological reality. Care must be taken not to reify and naturalize narratives and symptoms in much the same way that the natural must not be culturalized (Martinez-Hernaez, 2000:244). Here, the author points out, we also encounter the opposite paradox that arises from neo-Kraepelinian interpretations of winks as twitches: how far should we go in our efforts to interpret twitches as winks (2000)?

I do not think —and I never did— that Or was in fact a misunderstood stranded time-traveler or an inter-dimensional entity who happened to be stationed in the rough, crime-ridden neighborhoods of the Negev desert’s biggest urban center. The possible literal interpretation of Or’s symptom was easily discounted, even if perhaps for a short period of time I did try to romanticize him for embodying the archetype of the mad genius, the visionary who is so far ahead of his time that he is deemed a madman.<sup>7</sup> Perhaps — however unlikely it may seem— I hoped to gain, through a closer understanding of his experience, perspectives and information unavailable to me through the standard perceptual and cognitive channels of my own experience. Pretty soon, however, it became clear that the only constancy found in this particular narrative was incoherence. I resigned myself to the certainty that Or’s delusions of time travel were in fact delusions, yet it did not necessarily mean that his delusions were reducible to “signs” of his pathology. The next, obvious question was: is there any meaning hidden behind his delusions of time travel? A third reading of time travel as metaphor would probably be more pertinent.

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<sup>7</sup> One of the historical figures that caught my imagination at this time was Nikola Tesla (1856-1943), the Serbian American inventor of the modern alternating current (AC) electricity supply system, yet also well-known in popular alternative culture for his purported advances in the mythical field of free-energy (Tesla, 1900). Several authors have pointed out that Tesla’s extravagant (if revolutionary) ideas and behaviors could probably “earn” him a retrospective diagnosis of Schizophrenia (Cheney, 1989).



Perhaps the only part of Or's experience that was self-evident was that it had been greatly marked by suffering. Although generally happy and cheerful, the traumatic impact of coercive hospitalizations and being forcefully removed from his family and environment could easily explain his basic suspicion of a world that violently invalidated his experience. His imagined time-travel, I suppose, was a way for him to cope with the systematic oppression and lack of understanding he had to endure everywhere he went, much as kids invent elaborate imaginary friends to help them cope with social stress. A sort of escape valve into a different time and space where he would be able to fit in. The strength and clinginess in the manner in which he held my hand wherever we went also suggested immaturity or insecurity, but later I came to suspect that he was not so much clinging to me in particular but he was much more generally clinging to the material world based on a fundamental distrust of its permanence and solidity, as if at any moment gravity would be reversed and he would find himself flying upwards into the sky. He seemed to be lacking a grounding not only in the realm of social conventions but also in the physical world of causality and constancy, living in a much more fluid and oneiric world, lucid-dreaming his way through life and feeling persecuted for it.

Over the course of the next few months, I did everything in my power to extract meaning from Or's seemingly idiosyncratic, even if somewhat predictable, responses and behaviors. As time passed, however, and our relationship developed, I started to become increasingly worried that there was no way for me to penetrate what seemed to be a chaotic and disorganized local world of meanings (Martínez-Hernández, 2000). I got frustrated with myself for failing to make sense of it, and doubted whether my precarious hermeneutic abilities were good enough to communicate with Or. Even worse, I started to doubt that there was any meaning at all hidden beneath the layers of bizarre, disorganized thought. Time-travel intermingled with pop-culture, conversations about meaningful events in his life were tainted by unlikely interactions with Israeli reality television personas. Or he seemed to be inhabiting a hyperreal space, in which he unconsciously mistook someone else's version of reality (television writers and performers) as his own, fiction and fact indistinguishable from each other. Whenever I thought I held the end of a string, it unraveled into more and more incoherence. Trying to keep things

friendly, horizontal and reciprocal was always a big challenge, as I felt that I was not getting what I wanted from him: clear and definitive answers that would allow me to unequivocally understand his behavior. I felt like a stranded traveler, whose path has been blocked by a tricky and pseudo-omniscient sphinx, and the only way to make headway is to solve its riddle, with the added difficulty of harboring a strong suspicion that there may be no answer at all for that riddle, and instead of a sphinx I was facing a Zen Master handing me *kōans*<sup>8</sup> to show me the limits of rationality and systematically destroy my own internal logic. I understood that I was unable to make order from the disorder in a discourse that was making me feel uncomfortable. “No wonder”, I now realized, “that clinicians prefer to medicate and confine”. It is much easier and effective to suppress positive symptoms than to face the perplexing task of finding common ground between such seemingly different experiences.

The complexities and intricacies of the social control of the “mad” became self-evident as I experienced how risky that perceived lack of common ground can be to our carefully curated consensus-reality. In the words of Martínez-Hernández (the translation is mine), “The current social strategy is to negate the word of the mad, to invisibilize and hide abnormality by locating them outside the social scene. Its purpose is to protect society from madness, from its inherent capacity to ‘implode the logic of common sense’” (Martínez-Hernández, 2013:202). Furthermore, narratives of “mad” experience cause social refraction that places the individuals in the realm of the ob-scene, in the etymological sense of the word: offstage (Martínez-Hernández, 2013).

In retrospective, I realize that my own fixations with “understanding” Or or “making sense of his experience” prevented me from really approaching him as an equal; despite my best intentions, I never dislodged him from his role as a fascinating object of study for a young and inexperienced psychology student. I was always looking at Or through an inexperienced and inexperienced clinical lens, merely attempting to highlight our humanity throughout the interaction. Although I recognize that I did try to engage in a rudimentary hermeneutical approach to try and find meaning behind Or’s symptoms, I never truly went beyond my initial tendency to distinguish true from false or what is “real” from

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<sup>8</sup> In Zen practice, a *kōan* is a short story or statement that seems nonsensical or irrational and is traditionally used to demonstrate the limits of rationality and logic: “A monk asked Jōshū, ‘What is the meaning of the patriarch’s coming from the West?’ Jōshū said, ‘The oak tree there in the garden’” (Wick, 2005).

what is not. “This presence or absence of distinguishing the normal from the pathological”, argues Martínez-Hernández following Weber (1968), is precisely what separates these two different forms of understanding phenomena (2000:16).

Besides the fact that the primary goal of our relationship was tutorship and ethnographic approaches were foreign to me, to say that after 12 months of meeting Or twice a week I understood his internal experience a little better is saying too much. However, to say that after 12 months of meeting him twice a week, I understood myself a little better is much more accurate: our interaction managed to dissolve many of the projections I was forcing into him, trying desperately to make him fit into the categories I had conceptualized for him, whether that of the psychotic, the mad genius, the oppressed and hungry shoplifter or the logic-shattering *koan*. It allowed me to consider the fact that everything I had learnt so far about psychosis was useful up to a certain point, and that beyond that point, the truth is that we know very little about how our own mind works, let alone the mind of others. The inherent subjectivity of experience, argues R.D. Laing, makes it impossible to make any definitive assertions about somebody else’s (1967).

How close do we need to get to each other in order to understand our experiences well enough to make useful inferences? While it may be true that “one need not have been a Caesar in order to understand Caesar” (Weber, in Martínez-Hernández, 2000:15), we can still argue that it would be much easier to understand Caesar if one had been born and raised in a patrician family in Rome around the year 100 BC, participated in the Siege of Mytilene as a Roman soldier, kidnapped by pirates while crossing the Aegean sea or at some point of life appointed chief priest of the Roman state religion. Thus, one of the main insights of my early therapeutic interactions is the need for reciprocal peer-to-peer environments in which *experts of their own experience* can provide guidance, support and navigational maps to people going through similar episodes; spaces that are perhaps facilitated by the ethnographer (or other mental health experts or non-experts), who has the proper perspective needed to differentiate between the winks and the twitches, yet primarily run *by the natives for the natives*. There is a lot of value in being supported by people who have previous personal experience with non-ordinary states of

consciousness in order to build solid bridges built on shared-experience that potentiate empathy and the ability to relate on a deeper personal level with the experience of the other.<sup>9</sup>

Furthermore, although ethnography is evidently a vehicle for “experience-near” observation in comparison to the “experience-distant” gaze of clinicians (Martínez-Hernández, 2000), even the most diligent and professional ethnographic interpretation has obvious limitations: occasional failures to reveal autochthonous meanings, a lack of interest in the pathological meaning and a certain unwillingness to attempt an explanation that goes beyond the hermeneutic circle (Martínez-Hernández, 2000:243). However, as the author points out, while perfect interpretation of the other’s experience may in fact be unattainable this does not mean that a partial one cannot be of help. If on the one hand we refuse to reduce the stories of the afflicted to “an inventory of facts reshaped in terms of diagnostic criteria” (Martínez-Hernández, 2000), and on the other we understand the limits of ethnographic interpretation, we still have our best resources at hand: the experience and narrative voices of the afflicted themselves and the basic human qualities of empathy, compassion, reciprocity and mutual care. Yet, despite our best intentions, the ingrained ethics, ideology and economic policies by which our assistential systems are often driven to provide a disservice to the afflicted and their communities, because both users and professionals —speaking from my own experience— both users and professionals often feel dissatisfied with the level of care and attention that the current systems are able to provide.

Furthermore, ethnographic approaches allow us to disassociate between non-ordinary experience and pathology, at least momentarily. By doing so, we make it possible to merely accept the differences. The focus then is shifted to a radically inclusive approach that respects and acknowledges “the infinite diversity of human experience” (Icarus Project Mission Statement, n.d.), even in

<sup>9</sup> *Verstehen*, in Weber’s model, refers to the act of sociological understanding that is derived from the separation between the researcher’s position and the native’s perspective (Martínez-Hernández, 2000). In our example, a Roman soldier who participated with Caesar in the Siege of Mytilene would naturally have a very different perspective of Caesar than that of modern historians. The ethnographer who engages in participant-observation in an interaction with a “mad” person thus plays a double role: that of the observer, in a familiar world, and that of the native, in an unknown one; he oscillates between the two in order to make sense of the unknown through his rooting in the familiar, being able to ascribe meaning to the “twitches”. And yet, I argue, since he lacks the first-hand direct experience of “madness” and has not experienced the social repercussions it entails, he is still lacking in perspective and drive to really engage in a reciprocal relationship with the “mad”. Hence, the emphasis on *peer-to-peer* environments, in which articulation equals facilitation.

situations in which the hermeneutic circle fails. We are left with the possibility of allowing a social and cultural context unfold in which symptoms do not need to be misrepresented as signs of pathologies, nor only partially understood as local worlds of meaning but rather integrated into the fabric of reality, either as legitimate ways of experiencing the world or as expressions of deep affliction that may also hold within themselves the seeds for deep transformational change. Without ignoring the possibility of organic pathology in some cases, psychosis could regain its depoliticized dimensions as a manifestation of systemic oppression, of social imbalance, of repressed dissent; we could recover its transgressive potential as an agent of deep individual and social change. This does not mean that we are arguing for the total dismantling of psychiatry or for a categorical rejection of diagnostic constructs. In my experience, these claims are somewhat naive and limited, and are lacking a wider perspective of the pervasiveness and depth of human suffering. If we aim for radical inclusion, it may be wiser to strive towards better integrating all the tools, technologies and methodologies available so that individuals can be treated according to their own ordering cosmology and universe of meanings.

Despite strong proponents from different perspectives, it seems inadequate to reduce all instances of psychosis to one single explanatory system. It now seems that psychosis is not rooted only in abnormal neurobiology; it is not only a psychiatric fiction invented by pharmaceutical executives to sell more drugs, or by authoritarian politicians to pathologize dissent; it is not only a social or cultural construction, contingent to a certain social order; it is not only, as transpersonal psychologists argue, the natural wisdom of being manifesting as a spiritual emergency indispensable for personal growth; psychosis is not only a normal reaction to an extremely alienating and exploitative capitalist system. It is not only, as R.D. Laing argued, a normal reaction to the deep alienation inherent in our pathological societies (1967). It may sometimes be some of these, sometimes many of them together and sometimes just a natural expression of divergent yet equally valid experience.

In this regard, we should be careful not to impose new layers of ideology upon people who may not be interested in the social and cultural validation of their divergent experience but simply in better and more effective ways to treat symptoms, alleviate suffering and thus be able to lead “normal” lives to the best of their abilities. As an example, this is one of the main points of

conflict and controversy within the Autistic Neurodiversity movement, divided between those who see autism as the natural expression of a non-pathological and equally valid neural configuration and those who argue for more research and better psychopharmaceutical and therapeutic options for treatment (Ortega, 2009). The first and most important issue is and should always be to address the intense mental suffering and anxiety that are ubiquitous to mental affliction, not by superimposing ideology but by creating meaningful dialogues between expert knowledge and professionals and the afflicted individuals and collectives.

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