OFFSTAGE: MADNESS, THE OB-SCENE, AND COMMON SENSE[1]

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Abstract: Throughout European history, madness has been associated with two states: movement and confinement. These apparently contradictory states converge in an ob-scene state, in the etymological sense of the word: offstage. In this chapter, based on data from ethnographic work in the Catalan mental health care network, it is argued that "being ob-scene" results when madness challenges hegemonic social processes of inculcation and persuasion that induce acceptance of behavioural patterns considered appropriate and lead patients to identify with the interests of therapists. Madness defies not reason, as it is widely supposed, but common sense understood as a cultural system. Its refractory nature leads to the management of madness by expert systems that seek to subsume the experience of affected persons in predictable nosological categories.

Key words: madness, ob-scenity, common sense, ethnography, biopolitics

Fuera de escena: la locura, lo obsceno y el sentido común

Resumen: En la historia de Europa, la locura ha estado asociada con dos estados: el movimiento y el confinamiento. Estos estados, aunque aparentemente contradictorios, convergen en un estado obs-ceno, en su sentido etimológico de fuera de escena. En este capítulo, y tomando como base mi trabajo etnográfico en la red de salud mental de Cataluña, se argumenta que esta "obs-cenidad" deviene cuando la locura desafía los procesos sociales hegemónicos de inculcación y persuasión que inducen a la aceptación de los modelos de comportamiento que son considerados apropiados y que promueven que los pacientes se identifiquen con los intereses de los terapeutas. La locura no desafía la razón, como

1 This is a translated and slightly shortened version of previous publications in Portuguese (Martínez-Hernáez, 2012; 2013a) and Spanish (Martínez-Hernáez, 2013b).

2 Translation: Susan M. DiGiacomo and Mary Savage

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generalmente se indica, sino el sentido común entendido como un sistema cultural. Su naturaleza refractaria conduce a una gestión de la vida por los sistemas expertos que busca subsumir la experiencia de los afectados en categorías nosológicas predecibles.

Palabras clave: locura, obs-cenidad, sentido común, etnografía, biopolítica

In European history madness has always been associated with two social practices: movement and confinement. Movement receives one of its finest depictions in *Don Quixote*, in which the witless hero wanders endlessly in search of something at once so near and so remote as his own fantasy. Among other modalities, confinement includes the insane asylum as a means of containing…what, precisely? Unreason, chaos, lack of common sense, disorder, fear, difference, dissidence? In any case, confinement has persisted for centuries as a form of social control. Although apparently contradictory, movement and confinement as related social practices define an *ob-scene* condition in the etymological sense of being "offstage." While movement becomes a departure, either voluntary or forced, from the play of social life, confinement annuls the civil rights of those affected (Martínez Hernáez, 2000).

As we might expect, what links movement and confinement is the same thing that joins madness to psychiatry, a profession that, in its early years, was considered "special" (Campos Marín, 2001; Comelles, 1988). Psychiatry is a body of knowledge and practice whose object is alterity, although with the passage of time this otherness has come to constitute a diffuse and weakly formulated terrain of abnormal states that include depression and anxiety; being at risk for mental illness; disconcerting or unsettling behaviours associated with aggressivity, gambling, or sexuality; discomfiting social interactions; and minor memory loss. Among many others, all of the foregoing have been transformed into psychiatrically treatable conditions, as historical work (Caponi, 2009, 2012) and the most recent versions of DSM-IV-TR (American Psychiatric Association, 2000) and DSM-V (American Psychiatric Association, 2013) have shown. If the biopolitics of psychosis were an exercise in concealment, the new biopolitics of neurosis and minor mental disturbances require persuasion in order to resolve a supposed anomaly considered to be reversible, and put in its place a hyper-normality that links the subject to a consumer culture and political economy (Martínez Hernáez, 2013c).

By contrast, "madness" does not appear to be responsive to persuasion, or at least not initially (Goffman, 1988 [1961]; Caudill, 1958; Dunham & Winberg, 1960; Foucault, 1999; Rosen, 1974 [1968]). In the biomedical tradition, psychosis is not seen as susceptible to understanding and still less to dialogue, perhaps because it is considered to be the simple expression of disordered judgement and thought, as Kraepelin (1907) believed. Instead, what it tends to generate is a monologue in which therapists, family members and the supposedly sane find what they were looking for: unreason, the inability of the affected person to maintain social connection, and diagnostic categories understood as absolute truths that generate the idea of the "total patient" in need of "total therapy"[3].

Why the need to locate madness offstage? What is being concealed in the very act of hiding it from view, and what is revealed by the attempt to render abnormal states invisible? Is it something as simple as the Kraepelinian axiom that delusions are the expression of disordered judgment, or does it involve other dysfunctions and short-circuits between madness and culturally defined forms of power-knowledge? The aim of this chapter is to reflect on the social construction of madness as an *ob-scene* object that does not deserve a hearing, but should be located off the social stage because it disrupts the logic of common sense in the Geertzian sense of the word, as the naturalization of cultural convention.

3 Total nosology takes as its point of departure a definition of the patient self as a predetermined entity incompatible with the possibility of a subjective self formed through social action, including the professional cultures of mental health care. In this way, the damaged self is perceived as a psychopathological island, a stable and naturalized entity that responds to therapeutic interventions that are also stable and naturalized: total therapy. This model manages distress in terms of a self-referential expert system and its personified world of disorders and treatments more than in terms of human needs. Centred more on mental illness than on mental health, it is organized through treatment protocols rather than as the outcome of a clinical reflexivity that recognizes in affected persons knowledge born of experience, and is oriented more toward a politics *of* life than toward a politics *for* life. For an analysis of the idea of the "total patient", see Correa-Urquiza (2010). For more on the concept of "total therapy," see Martínez-Hernáez (2009).

Common sense and ob-scene sense

Over the course of approximately one year, I interviewed Babu two days a week with the idea of writing his life history.[4] At that time Babu was an inpatient in a Barcelona residential treatment centre for chronic psychotics, along with some 20 other patients who were also my informants, although to a lesser degree. Among the resources available for the treatment of mentally ill persons, residential treatment centres, along with supportive housing, are understood to be one of the levels closest to reintegration into the community, although no one defines what this "community" consists of; it often appears to be an idealized entity that has little to do with pragmatism based on empirical knowledge of social reality.[5] In this context, Babu and his companions enjoyed greater freedom of movement than would have been possible in other institutional settings.

Babu divided his time between the residential home where he lived and a psychosocial rehabilitation workshop, run by the same foundation that managed the residential home, where he spent a few hours each day. The workshop's activities included painting, bookbinding and some small assembly jobs; it also had a newsagent and stationer's shop that was open to the general public where Babu was usually in charge of the till. Most of our conversations took place in the shop, in a small office adapted for therapy-related interviews, or during long walks around the neighbourhood.

Babu told me he was from the Konkani people who belonged to India's Catholic minority, and that his family had aristocratic roots. He related how his childhood had been marked by the continuous torture perpetrated by his alcoholic father. Each night his father would fire an unloaded shotgun at the child's head, and inflict corporal punishments on the boy that the next day would be dismissed or ignored by the entire

4 These interviews were carried out in the context of a broader research project on the mental health care service network in Catalonia that included both observation and in-depth interviews. Fieldwork was mainly carried out between 1990 and 1993 in different institutions in the city of Barcelona that included inpatient treatment, outpatient treatment, and psychosocial rehabilitation. Since then, I have continued to follow processes of mental health care in this network as both a researcher and an expert consultant. For reasons of confidentiality pseudonyms have been used, and the names of institutions do not appear in this chapter.

5 See Canals (1994) for a detailed discussion of the concept of community and its use in medical contexts.

domestic group as though nothing had happened. As in the logic Taussig (1995) has explored in his writings on the role of silence and the denial of torture in the amplification and management of terror, Babu, his siblings and his mother lived with the unpredictability of torture and the torture of unpredictability. He said he had been a diligent child at school until he became ill with typhus at the age of fifteen, that he found relations with women difficult because of his shyness, and that as soon as he was able he left to study in London. There he met his wife with whom he came to live and work in a city close to Barcelona. He was an executive for a well-known American multinational.

According to Babu's account, his problem began unexpectedly in Barcelona. He suddenly found it difficult to concentrate at work. This difficulty was followed, he explained, by an intense feeling of "depression" and a "need to stay at home" away from all social contact, repeatedly going over his childhood problems of torture. What happened next is best explained in his own words:

> I remembered the nights of torture with my father. The time that he whipped my brother and the shots to the head, always hoping that he would kill me once and for all, and that he would not kill me. I thought that because I had suffered so much, I was Jesus Christ. I had sometimes had fantasies when I was a child, like being a great footballer or tennis player and being cheered by the crowds. Or I was a great scientist and I had made a great discovery, or that I was Swedish and I had been adopted by some dirty Indians. Now too I thought I was very important. Things were not going well at work. I was very anxious and my brain was paralysed, I couldn't work and I had to stay behind longer than everyone else. I knew I would lose my job, but I made myself ill with nerves before that and took sick leave.
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> During my last days at work silly ideas were going through my head, like the North American bosses would come to Barcelona and appoint me director. My boss would then fall at my feet and beg my forgiveness. Everyone was praising me. And the truth is that when I went past the office I thought I heard voices saying [cheering] 'boss, boss'. Then I thought I was the president of all the foreign multinationals in Barcelona and they would come to ask me for work and favours. When I was walking in the street I thought all the women wearing blue and white wanted to be my lovers and all the men dressed in those colours, my collaborators. President Bush had stood down to give me an opportunity because I was more intelligent. When I saw American satellite television I thought they were talking about me because they had put an electronic device in my house to protect me against attacks. But by then president of the USA wasn't enough, and I had to be king of the whole world,

> and as I had suffered so much as a child it was as though I had been crucified by my father, because I had never heard another story like mine anywhere else. That was terrible, continuous torture. Then I had come back to life to help everybody. I had stopped being Babu to be Jesus Christ.

Babu's experience, although private and personal, had a major impact on his relationship with his work colleagues. Anyone who is convinced he is president of the United States of America or Jesus Christ will not easily go unnoticed in the work environment. Straight away, Babu met first with perplexity from his colleagues, and was then completely ostracised until his sick leave and the start of psychiatric treatment. So why did this exclusion from the social stage happen? Babu's experience clearly takes on forms that are not accepted socially, but what threat does it represent?

Madness is often regarded as the antithesis of reason or even rationality, the first being understood as a quality and the second as the systematisation of that quality. The opposite of an idea of "reason", which supposedly allows things to be evaluated in the right way, would be defective judgement, confusion of internal and external reality; in sum, madness as unreason, and its manifestation in delusions. However, the problem is that a therapeutic context can hardly be understood as the embodiment of rationality. What is more, analysis of the practices of containment, rehabilitation and treatment I observed during my fieldwork shows that, rather than this abstract entity called reason, madness seems to be the opposite of the more day-to-day level of common sense, understood in the terms Clifford Geertz uses in his essay as a "cultural system" (Geertz, 1983:73-93).

Geertz defines common sense as a cultural system characterised by the following attributes or "quasi-qualities:" "naturalness," "practicalness," "thinness," "immethodicalness," and "accessibleness" (Geertz, 1983:85). Although it may seem obvious, it is worth emphasising that these qualities are not attributes of things, but rather qualities attributed to things by common sense. And it is precisely in the interplay of these attributes and attributions, and interpretations of their presence or absence, that I believe the social construction of madness takes shape.

Geertz stresses that the most defining quality of common sense is naturalness, understood as its meaning of "of-courseness" and a sense of "it figures." As would be expected, this idea of naturalness is not applied to the sphere of all things and representations, but rather centres on matters that appear self-evidently obvious. Although Geertz does not say so, one

does not have to be very perceptive to see that naturalness is essentially an attribute of any cultural system because it is what allows the construction of what he defines as an aura of factuality (Geertz 1973:91): the condition by which representations appear unmistakably real for social actors. One way of defining this condition is the cultural principle that things are as they are because they correspond to a pre-established "natural" logic that legitimises them.

If we analyse Babu's story, we can observe two distinct registers. In the first, events occur following a logic similar to the elementality of common sense: if Babu had been tortured by his father, from this perspective it stands to reason that he would be affected by it, would have problems concentrating, or that he would have childhood fantasies that he was an adopted Swedish boy. Ultimately, this type of fantasy that Freud once called the "family romance" (*Familienroman*) of the neurotic (1981:1361) —thinking that one is the child of other parents, one has been adopted and on that basis, imagining a whole other world of family relationships— is probably inherent in everyone's imaginative and performative capacity. But this naturalness in Babu's story breaks down in a second register that begins with "During my last days at work silly ideas were going through my head," leading him to think he is the president of the USA and then Jesus Christ. Here, delusion emerges in opposition to the obviousness and naturalness of common sense. What alerts the family, friends and colleagues of a person like Babu to the fact that he has become disturbed is this lack of elementality, or put another way, the break with the aura of factuality. In certain circumstances, it is acceptable within the domain of common sense (or of alternative common senses) to see the Virgin Mary and hear the voice of God, or to imaginatively unmask hegemonic common sense and its naturalisation of the world, as some artistic movements do. However, if one thing characterises delusion it is a subjective rupture in which, paradoxically, the biographical and the outrageous combine to reveal the arbitrariness that underlies all naturalisation, to strip bare the artifices of a social world of conventions. Expressed in the language of structuralism, it is as though event and structure were entirely at odds.

The specific nature of Babu's experience also clearly threatens all the other attributes of common sense. His fictitious world in which he heads all the North American multinationals in Barcelona and later becomes president of the United States can hardly be consistent with the principle of practicalness (Geertz, 1983). Even less so can Babu's experience be

associated with the special connotations of sagacity and "ability to make projects thrive" which, according to Geertz, must be interpreted within this attribute (Geertz, 1983:87).

Babu's fantasising is also key to understanding the absence of other attributes of common sense, such as "thinness" (Geertz, 1983:83), in his narrative. If, as Geertz says, the common-sense view of the world can be summed up by the 18th-century English theologian and philosopher Joseph Butler's affirmation that "every thing is what it is and not another thing", then Babu's story is premised on the reverse: *every thing is not what it is but another thing*. This is evident in Babu's subjective world and his certainty that he is not who he is (an executive and engineer in a multinational corporation), but something else (president of the USA, Jesus Christ), but also in his interpretation of social reality because there, too, what is (passers-by dressed in blue and white) is obviously something else (the women are his lovers and the men, his collaborators).

The next attribute is asystematicity or "immethodicalness" (Geertz, 1983:90). Although Geertz does not put it quite in these terms, immethodicalness refers to the flexibility and elasticity of every assertion about the nature of things, to the inconsistency of experience —and this does come from Geertz— reflected in the American poet Walt Whitman's "I contradict myself, so I contradict myself. I contain multitudes": a principle that, in the acute phase of his illness, was the opposite of Babu's experience as he did not question his delusion but regarded it as a certainty, the only certainty. While this was not the case in his later reflection on his own experience once his delusion had abated, his account of that experience clearly conveys the absence of malleability, and therefore the rigidity, of the system of beliefs and convictions that characterised it.

Geertz's final quality is "accessibleness," which tells us that common sense is a general property of all social actors, or at least a majority of them, since as Geertz tells us "any person with faculties reasonably intact can grasp common-sense conclusions" (Geertz, 1983:91). It is no coincidence that Geertz himself commonsensically offers us this contrast between common sense and madness, although he does so almost in passing. Babu's experience, for example, shows how a largely inaccessible idiosyncrasy can contrast with commonly shared judgements.

In sum, in Babu's experiences we can see a narrative artificiality that contrasts with naturalness, a fantasy that counters practicalness, a codification that contradicts thinness, a rigidity that is a retort to the

flexibility and immethodicalness required to get by on a daily basis, and an idiosyncrasy that leans towards the inaccessible. Experiences like Babu's defy common sense, replacing it with a kind of "ob-scene" sense.

Refractions

The modification of this ob-scene sense is a basic, although tacit, objective of most care facilities charged with the treatment and rehabilitation of people diagnosed with a psychosis. During my fieldwork, and in subsequent research, I have observed how these facilities function as schools of common sense that set out to reconstruct the aura of factuality of social actions and representations in an attempt to turn affected persons into socially credible individuals; that is, reproducers of common sense (Martínez-Hernáez, 2000). These facilities cannot, therefore, avoid a moralising function, although paradoxically most therapies consider themselves to be unconnected to social and moral spheres, as their understanding of human afflictions is based on an individualistic epistemology and methodology. For this reason, mental health professionals tend not to seek out strategies that would allow affected persons to join their against-the-grain narratives to a critical and/or reflexive purpose, to a social function that emerges from their particular view of the world.

In the treatment context in which Babu found himself, affected persons were not encouraged to develop their own vision of the world, and much less to do so in a critical, creative and reflexive way. Rather, they were oriented toward adopting and participating in the most stereotypical and normative social conventions without questioning them, becoming what we might define as "good patients". Thus, it was considered inappropriate for patients to read books on esotericism, to join minority religious groups, or to reflect on abstract problems: resources and activities that are usually understood as amplifiers of delusion. In this vein I observed a curious discussion between a psychiatrist and her patient, who had been diagnosed with schizophrenia a year earlier and had begun to study philosophy at the local university. While the patient spoke about his interest in philosophical questions about the meaning of existence or the nature of things, the psychiatrist pressured him to abandon this course of study and switch to one more closely related to practical reality. The therapist thus reoriented her patient not to the sphere of rationality,

but to the more elemental, practical and supposedly accessible sphere of common sense. The conversations generally held in the group therapy sessions also show a risk-free preference for topics considered practical and elemental, such as public transport, how to find work, or the price of goods in the market. These and similar subjects are generally chosen because they link in with managing daily life and are therefore considered essential to the affected person's rehabilitation.

One of the aims of group therapy is to recreate a vision of common sense that can be shared by all those taking part in the session. This mechanism attempts to retrieve each participant's individual remnants of common sense and use them to build a collective common sense that each individual can then adopt. For example, one of the institutions in which I did fieldwork ran a session about public transport in which a participant, Emilio, said that he refused to travel on double-decker buses because they were not safe and were constantly overturning; his rejection of this form of transport was even stronger if the bus had an odd number because the day, month and year of his birth had even numbers and he reasoned that even numbers meant life and odd numbers, death. The therapist sought a critical response from the rest of the participants, who argued as a group that the bus manufacturers took safety requirements into account when designing double-decker buses, and that they had not noticed these vehicles overturning any more than others. But when the discussion turned to matters such as "fate is written in the numbers" or "who can guarantee that these buses will never turn over?", the therapist began to insist they must be practical and accept that if things are as they are, that is, if double-decker buses are being driven around cities, then there is a reason for it. The therapist thus guided Emilio to an attitude of assuming the aura of factuality of cultural representations and artefacts. Faced with Emilio's insistence on imploding cultural conventions, the therapist positioned himself as a bastion of common sense, pushing the dissenting voices to the margins of the stage.

During my fieldwork, I observed therapists using two mechanisms to reconstruct their patients' common sense. The first was an explicit system of negotiation and coercion dependent on a logic of rewards and punishments. In the second, the therapist encouraged the patient to identify with his or her own judgements. Neither strategy, however, met with more than limited success because of the patients' tendency to what has been called derealisation: an involuntary deconstruction of the

cultural codes that allow the world to be naturalised. The therapeutic stage thus became a scene of continuous struggle between common sense and its deconstruction by the patients: a deconstruction that reaffirmed the therapists' commitment to common sense, and a common sense whose arbitrariness was exposed by deconstruction.

In the group sessions the identification strategy entailed motivating the patients to respond to and contradict any statements that were not considered to be practical or commonsensical, such as the emphatic assertion that double-decker buses overturn or, as another informant stated, that the State pays for ships where homosexuals and dissidents are kept and then abandoned out at sea. A simple glance from the therapist to the patients considered to be more "recovered" could be enough to prompt them to comment in ways that corresponded to the therapist's expectations. In this way a hierarchy of proximity to the therapist that placed a premium on obedience and mimesis was established among the group participants. But for this to work, the therapist needed first to establish a relationship of transference or idealisation that was absolutely necessary for the affected person to identify with his or her interests – or perhaps "desires" would be more accurate – since without this connection the therapist would not easily be able to use his or her disappointment as a strategy when patients responded with bizarre judgements.

In the individual sessions, although the therapists did not have recourse to the other patients to act as their mouthpieces, they appealed to the patient's supposed remaining fragments of "common sense", and to their own position as the personification of this common sense. However, the trust between the two was easily broken. The therapists would insist that patients trust the treatment and let themselves be guided. The patients probably thought it highly unlikely that they would be able to trust someone who did not trust them. New patients tended to give more explicit accounts of their experiences, delusions or hallucinations, but they soon realised that this frankness came at a high cost in the form of increased medication, the therapist's distrust, and panic among close friends and family. And so the process would continue until the patient decided to offer what he or she thought the therapist wanted to hear: an impression of common sense performed by a domesticated individual who has purged any traces of *ob-scene* sense from their story and takes a critical view of the experience responsible for their being in treatment. This was Babu's strategy as he described it to me. There was no question of trust, only of

meeting the therapist's expectations; telling stories colonised by narrative conventions that concealed the outrageous and the unthinkable, and thus allowed him to reclaim a small place on the social stage or, at least, a more comfortable and tranquil day-to-day existence.

By way of conclusion

Madness is an offstage voice in both social and therapeutic contexts. As a narrative that must be domesticated, delusion is hidden psychopharmacologically and psychotherapeutically until it can re-emerge purified and adjusted to common sense. In many cases, however, this task leads to a series of failures, not only because madness is resistant to hegemony, inculcation and persuasion, but also because it implodes common sense by confronting it with opposing quasi-qualities: artificiality, impracticality, codification, rigidity, and inaccessibility. This is why managing afflictions of this kind is exhausting for affected persons, their families, and mental health professionals alike, who find themselves caught in the tension between common sense and idiosyncratically obscene sense.

Madness is feared because it reveals the contrived nature of common sense, including its most basic contrivance: its naturalisation. Madness is denied any social use or function; for example, as an instrument for rethinking the arbitrariness of our social world. Doing so would mean allowing madness onstage as a meaningful social resource. Most therapeutic strategies, however, do not seek to engage psychosis in dialogue or cede it social space but instead treat it as an anomaly to be domesticated, even though this mission seldom meets with success. The resulting reproduction of "total therapy" models of treatment reduces the possibility of dialogue and social communication, and this in turn facilitates an emphasis on management over narrative, nosology over experience, bureaucratic pigeonholing over lived identity. And finally, on the preeminent rhetoric of evidence, with its ability to objectify human affliction through nosologies, categories, diagnostic criteria, reductionistic hypotheses and possible treatments, over what, in the last instance, is the most evident: suffering.

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