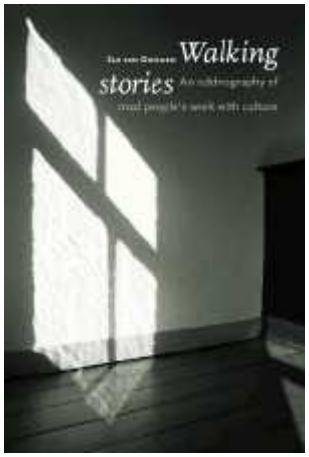
Walking Stories



Lisa, a fragile Indonesian woman, walked along the paths of Saint Anthony's park. Saint Anthony is a mental hospital. Lisa was dressed in red, yellow and blue; I was looking at a painting of Mondriaan, of which the colours could cheer someone up on a grey Dutch day. She had put on all her clothes and she carried the rest of her belongings in a grey garbagebag. She looked like she was being hunted, mumbling formulas to avert the evil or the devils. I could not understand her words, but she repeated them with the rustling of her garbage bag on the pebbles of the path.

When she arrived at an intersection of two paths where low rose hips were blossoming, she stopped and went into the bushes. She lifted all her skirts and urinated; standing as a colourful flower amidst the green of the bushes and staring into the sky. A passer-by from the village where Saint Anthony's has its headquarters would probably have pretended not to see her, knowing that Lisa was one of the 'chronic mental patients' of the wards. Or, urinating so openly in the park may be experienced as a 'situational improperty', but as many villagers told me: 'They do odd things, but they cannot help it.' The passer-by would not have known that Lisa was a 'walking story', that she had ritualised her walks in order to control the powers that lie beyond her control. Lisa was diagnosed with 'schizophrenia' and she suffered from delusions. When she had an acute psychosis, she needed medication to relieve her anxiety. Her personal story was considered as a symptom of her illness. That was, in a nutshell, the story of the psychiatrists of the mental hospital. Her own story was different. Lisa was the queen of the Indies and she had to have offspring to ensure that her dynasty would be preserved. She believed at that day that she was pregnant and that the magicians would come and would take away her unborn baby with a needle. To prevent the abortion, she had to take refuge in the park and carry all her belongings with her.

However, queens also have to heed nature's call and thus she went to the best place she could find: the rose hips. Lisa is indeed a 'walking story'. She has her story and she lives it. Her behaviour acquires its meaning when one knows the story. The story acquires meaning when one observes her behaviour. Saint Anthony's is a place full of walking stories. For many people their behaviour is odd. Writing about them may be odd ethnography. However, beyond the oddity lie meanings that reveal the often taken-for-granted cultural knowledge and understandings.

What to do with Walking Stories?

Mad stories are evocative and metaphoric. They are full of symbols, but we think that those symbols are used in very personal, even idiosyncratic ways. We consider them incoherent and incomprehensible. They are not 'rational' and do not represent any 'normal' logic. They do not fit into categories. They escape every classification, save that of 'psychotic stories' or 'mad stories'. They are matters out of place. They are viewed as signs of madness and therefore show how much we should value health and normality. Yet, mad stories are attractive. The many studies and literature on the topic which fill the shelves of bookstores and are so eagerly bought are the best proof of this attraction. Why then put another book on the shelves?

De-pathologising mad stories

Psychiatry kidnaps the stories of mad people. This means that the stories are often transformed and re-interpreted into medical stories. They become 'pathographies'. By describing others as 'schizophrenic', they are incorporated into the cultural scheme of things. At the same time mad people are made into potentially 'normal' people. The madness can be overcome by conversion; they can be re-socialised into normality by therapies and pharmaceutical treatment. If they remain 'mad' this can be fought by higher doses. The greater part of scientific research on schizophrenia is blind to the possible different socio-cultural meanings of madness. The stories and behaviour are described in similar terms as used for 'normal' ones: expressions of experience, idioms of suffering. What the medical world sees as a disease has little to do with what people may experience. International, epidemiological studies leave out atypical cases to get better possibilities for cross-cultural comparison of onset and prognosis of the disease. One of the consequences of this practice is that the original stories

disappear, taking on the meaning of a symptom, a sign of mental illness. In the clinic, during the intake process, the patient has to tell the story to enable the psychiatrist to provide good diagnosis. Clinical storytelling relies on a chronology of bodily and social events. The sick person experiences altered states of being and tells this to the psychiatrist or the therapist. The therapist renders the sick person's story into narrative sequences to produce a diagnosis. The clinician brings the past to the present to locate causes of the sickness. The sick person, family members, friends and all relevant others have to recall the past to give meaning to the present state of the afflicted person. Reasons for misfortune are sought in the personal life of the sick person and his/her immediate social environment.

Yet, the stories themselves are thought to be important. This is stressed in the latest version of the Diagnostic and Statistical Manual of the American Psychiatric Association, DSM-IV. The story has to provide the diagnostician with a better understanding of the cultural background and explanations of the patient. Although cultural concerns are represented in a significant way in the text of the DSM-IV, members of the culture and diagnosis task force heavily criticise the text. Good (1996) discusses the task force's critiques. They view psychopathology as social and cultural. One of the criticisms is that the DSM-text makes too sharp a distinction between disease and illness, wherein diseases are viewed as universal biological entities, while illness consists of forms of experience and cultural interpretations of the experiences of the individual and cultural groups (Good 1996: 129). Another criticism is that particular forms of science are hegemonic and that 'the reluctance to incorporate knowledge generated at the social margins, are issues of power and what the French social theorist calls 'symbolic violence'' (Good 1996: 130).
This means that the stories are still transformed into the hegemonic explanations and that the people who tell them are further marginalized. Diagnosis is not the only reason for bringing the past into the present. The story has to be told in therapy. Thus the patient becomes an observer of himself. He has to objectify himself and to distance himself from the problem. He has to develop the capacity to reconstruct the story in a special way. Together with the therapist, it is transformed into a 'new' past with a different meaning and a 'new' sense so that people can live with it in the future. He has to cut himself off from the past and to look at it as if he were a stranger. He will become a stranger to his own story because it is transformed into the therapeutic myth and acquires the meaning of a

symptom of severe mental illness. The result may be that, depending on the therapist's and others' position and strategy, which is linked to their interests, the story may offer either 'victim blaming', 'madness' or be a source of continued confrontation with and reflection about the past (Friedlander 1993: ix).

I do not want to show that psychiatry is a conspiracy against everything that is considered as odd, abnormal or awkward. Therapists sometimes understand stories as intelligible individual symbolic ways to signify feelings and experiences, but the stories always will remain idiosyncratic and do not have meaning to others. This may easily lead to the conclusion that the stories are outside the cultural realm and thus cannot tell about 'the work of culture'.
However, Littlewood and Lipsedge, both psychiatrists, say that it is 'particularly difficult to decide whether a person's belief is a delusion or not relative to the usual beliefs in his community when its culture is changing or when it contains a variety of conflicting belief systems' (Littlewood & Lipsedge 1989: 207). The authors give many examples which show that under certain circumstances, unusual beliefs are accepted or explicable. They argue that the community can use the stories of the psychotic as metaphors for their own experiences. They show that 'psychic epidemics' will occur when large parts of a population undergo experiences that they would be considered abnormal in other times. 'Mass hysteria' is an example.
The phenomenon of school girls in South Africa, who insist that they were sexually abused, or female labourers in Malaysia who said to be possessed, or that of parents in a small Dutch village, who insist that their children were sexually abused, becomes 'hysterical'. Their stories show that the concept of mass hysteria (or conversion, as it is now named) is a useful term for disempowering dangerous forces and undesired movements or resistance and protest. I agree with the authors when they say that mad people do not become sane when we tolerate and accept their stories. Their stories should be taken as they are. When such stories are told, cultural symbols and myths, rules, morality, values and norms are tested, violated, constrained and turned upside down. This draws attention to their deviant nature, but also to the discomfiture of culture.

Chronic Stories
What about the 'chronic stories'? What about the stories that never change? It is suggested that people with long-lasting mental illness cannot cut themselves off from the past. They lack the capacity to 'locate the self as actor within a seamless

unity of past, present and future' (Adam 1992: 159). The past and future are mixed and they leave no room for reality constructing in the present (Ibid.). This is a strong belief which has been discussed at length in the literature (cf. Rosenwald and Ochberg 1992) and brought into the daily clinical reality. Rosenwald and Ochberg even suggest that the reason to tell stories is to liberate the stories and therefore the lives of the people who tell them, because the stories relate to critical insight and engagement. They see stories as reflections on social conventions and telling a story as a means to make a 'better story', which means that people re-signify life and change it.

Storytelling is empowering for disadvantaged people and protects them against moral judgement. Storytelling is 'politics', or as the subtitle of their book tells us, 'politics of self-understanding'. Although I basically agree with the authors' arguments, I do not believe that storytelling is always liberating, emancipating and empowering. The idea of empowerment and liberation in science is a cultural belief, based on the creation myth of western religions: 'In the beginning was the word…' The word created the world. Although words are powerful, their power in itself is overrated. The power of the words depends on who speaks the words, when, why and to whom. The words of mad people alone have no power. They need more. To make others listen, words and deeds are needed. The words must become flesh and blood to be effective and convincing.

Re-anthropologising mad stories may provide a different knowledge. Illness experiences have become an area of interest in the social sciences. Medical anthropology focuses on 'the lived experience' of what is going on in bodies and lives. Studies of illness narratives, like those of Kleinman (1988), Csordas (1994) and Good (1994), see illnesses as polysemic and multivocal. Meanings of illness are personal, social and cultural. They reveal what it means to be ill. Illness cannot be separated from the life course. Anthropologists have argued that stories are the forms 'in which experience is represented and recounted' (Good 1994: 139). Actually, we cannot directly obtain access to people's experiences. Just like in psychiatric practices, life stories in anthropology are used as sources of information about the human condition. Psychiatrists agree that the life story has a potential for providing insight. Thus, psychiatry (at least part of the discipline) and anthropology have much in common.
However, anthropology may have a different approach to life stories. They provide a different sort of insight. Anthropologists often collect life stories in

order to obtain information about cultural practices. The study of stories questions the relationships between experience, symbols and culture. We need to approach stories from a variety of directions in order to understand illness and suffering because all too often, suffering resists language and cannot be given a name (Good 1994: 129). We have to understand culture and its work in order to formulate a perspective on the interplay of cognition and emotion, rationality and irrationality, morality and immorality, fantasy and reality, and body and psyche as human features that play their part in the story and life, and people's struggle to find a meaningful niche in society. But what will be the aim of understanding? Medical anthropologists differ in their opinions. Kleinman (1988) combined the anthropological and clinical traditions and opts for a more human relationship between the doctor and the patient. He sees experience as a mediator between persons. He argues for an ethnography of interpersonal experience, which gives room to 'the local context that organizes experience through the moral resounding and reinforcing of popular cultural categories about what life means and what is at stake in living' (Kleinman 1991: 293). Good comes to a similar conclusion: 'Narratives are the source of contested judgements … a rupture of the moral order' (Good 1994: 134). He suggests that we should investigate the 'experiential dimensions of human suffering' (Ibid.).

The problem is that human suffering escapes any category, whether it is ethical, political, medical or spiritual (Connolly 1996). Sometimes, suffering is a catalyst of more suffering. When people suffer, their relatives, friends and relevant others suffer too. Therapy with traumatised refugees often reveals that to tell a story may mean suffering again for the person who tells and for the listener. In my field experiences, this was the case with schizophrenic people. 'Interpersonal suffering' may relieve the pain and give a deeper understanding, but what do we do with this understanding when we only consider it 'interpersonal' or intersubjective?

The anthropology of illness narratives provides a preponderant number of studies that focus on the individual level, which is seen as the observable ethnographic reality. Health studies often ignore the active role of people who shape the broader context. Stories are not only stories: they come into life and are 'acted out'. People actively shape their lives and are shaped by social and cultural structures. Stories are responses to conditions that the people have to face. This means that suffering is not only an experience, but also a social product

‘constructed and reconstructed in the action arena between socially constituted categories of meaning and the political-economic forces that shape the contexts of daily life’ (Singer and Baer 1995: 101).

Morality plays an important role in stories of misery. It is closely linked with emotions and passions. Anthropology has studied the relationship between what Scheper-Hughes and Lock (1987) call the individual body, the social body and the body politic. These authors discuss emotions and show how anthropology has always dealt with emotions when they were public, ritual or formal, leaving the more private emotions to psychoanalysis and psychobiology. Scheper-Hughes and Lock see these private emotions as ‘a bridge’ between the ‘three bodies’. Emotions, they argue, are signs that illness makes and unmakes the world. However, it is not clear in their argument how exactly emotions are ‘a bridge’ and how they are linked with morality. Morality mostly is understood as a set of interpretations of goodness, badness and obligation (Connolly 1996: 252). Taped conversations of the therapists and the patients made clear that those interpretations were contested and that both the teller and the listener judged each other (Van Dongen 1994). Without doubt, one may say that the power to define the situation of the sufferer lies in the hands of others.

The stories contain expressions of love, hate, contempt, disgust, anger, and fear. These passions are considered very dangerous and threatening to the social world and should therefore be controlled and channelled into culturally appropriate outlets. For example, the stories of Rosa, one of the people in the book *Walking Stories*, are full of hate and jealousy toward her mother (and vice versa). For example, she tells that both she and her mother fell in love with the family doctor. Rosa became so envious that she wanted to kill her mother. Those feelings are considered morally improper, but ‘natural’. Therefore, they must be expressed, preferably verbally, to a mediator: the therapist who has to resignify them. Maybe the therapist would judge the behaviour of both women, but the ‘badness’ would be considered as innocent because both women were ill. The problem will be followed by a ‘charity model of obligation, in which… helpers are pulled by the helplessness of the needy’ (Connolly 1996: 255). Connolly argues that sick people do not need help; rather they need engagement in what is called the politics of becoming: the right to form a new identity, which is formed out of old cultural

possibilities.

However, this idea of 'becoming' is based in a strong cultural belief that also forms the foundation of the therapeutic myth: the belief in progress and change by reflection and hard work, which are – according to some authors – rooted in a 'disenchanted worldview', deriving from the Protestant Reformation (Gaines 1984: 179). 'Becoming' can be achieved 'by action in this world, not by the intercession of preternatural forces and beings into this life. Action in this world is caused by physical factors, not by fate, immaterial saints, genies […], devils or miracles …' (Gaines 1984: 179). However, illness by itself does not lead to 'becoming'. In all those years I never heard people make the claim that they 'have grown' or 'became' by their illness. Those who made such claims and have written their stories are by no means the people in *Walking Stories* and in my ethnographic work. People like Artaud and Wolfi, both with mental illness, would have written anyway because they were writers. The people of *Walking Stories* are neither artists nor writers. They are 'common' people who have to struggle to find words for their stories.

Morality is also linked to the specific nature of the illness. In her paper on chronic illness, disability and schizophrenia, Estroff (1993) analyses how sceptical we are about chronically ill people. We cannot tolerate their presence on a large scale, but we also cannot punish or neglect those who are chronically sick. The author writes that our suspicion may increase regarding the role of will or individual unwillingness to become well. This is well illustrated by the mechanics at a garage nearby Saint Anthony's.

A cordon of experts

Anthropology has described and analysed the consequence of this scepticism with the concept of liminality. Chronically mentally ill people are in a 'frozen liminal state' argues Barrett (1998: 481), because the rites of reaggregation are vestigial or absent all together. There is a lack of resolution.

I do not totally agree. In a sense, schizophrenic people are not liminal in our society. They are of concern to policy makers, health care, and social work. They are the focus of scientific research, pharmaceutical industries and even the arts. They are surrounded by a cordon of experts. Estroff (1993) argues by quoting other research, that among the factors that contribute to chronicity are the growing numbers of and the demand for jobs by mental health professions, the widespread belief (fuelled by public and political advocacy) that the people need

medical care, and income maintenance resources that are illness-tested and bound to deservedness through disability. We may conclude that it is in the interest of many to keep chronically ill people in a 'frozen liminal state'. Thus, we may listen to the stories as attempts to free oneself from this state.

Several authors have 'de-medicalised' mad stories. For example, Perry (1976) found that there were common themes and personalities in the stories of psychotic people which were typically cultural/archaic: the hero, the victim, the God, the queen or the king. Perry describes the common structures of the stories. Each story is 'an inner journey' with one or more of the following components: establishing a world centre as the locus, undergoing death, return to the beginning of time and creation, cosmic conflict when opposites clash, apotheosis as king or messianic hero, sacred marriage as a union of opposites, new birth as a reconciliation of opposites, new society of the prophetic vision, and quadrated world forms (Perry 1976: 82). The author sees psychosis as a process of personal renewal with the help of cultural myths.

Others have described mad stories as stories that cross cultural and social borders (Foucault 1961). For example, it is often assumed that schizophrenic people violate social interaction rules and that they are 'out of reality'. This is too a general statement. Goffman (1961) describes a different picture. Working as an assistant physical therapist in a large mental hospital near Washington (D.C.), he was able to fraternise with the patients because he had a low staff status. He concluded that just as the patients' behaviour was bizarre to those who were not living in a mental hospital, it was natural for those who live in it. Goffman also shows that the odd behaviour of mental patients makes sense in such a situation and even is often a sign of sensitivity to social rules and norms. Through breaking the rules, people show their awareness of them and also how the rules work.

Some authors have described mad stories as 'ununderstandable'. For example, Jaspers (1974) argues that although people with schizophrenia are diverse, they all have the following in common: they are strange, they are enigmatic, they are alien, and they are bizarre. They are unknowable. You cannot empathise with them. Their symptoms lie beyond the realm of human meaning, beyond the possibility of human interpretation. They are, not to put too fine a point on it, 'ununderstandable' (quoted in Barrett 1998: 469).
Jaspers was trying to discover what it means to be human. For him, human is what is understandable and interpretable. Others have tried to bring

schizophrenic people back into the human community of understanding by arguing that mental illness is a myth (Sasz 1961), or by making sense of madness through a comparison with art (Laing 1967) and modernism (Sass 1992). These authors found striking parallels between art, modern society and madness. I agree substantively with Barrett (1998: 488), when he writes that the problem with the idea of the relationship between madness and art, or between madness and modern society, is that it may lead to restigmatising schizophrenic people because they represent symbolically much of what is going wrong in the modern world, while they also have to deal with horrors and pain. On the other hand, it is acknowledged world-wide that social factors contribute substantially to mental health problems. We should do in-depth research to study how exactly social and cultural factors do that.

Schizophrenia is a well-documented illness and considered 'a serious mental disorder of unknown cause characterized by delusions, hallucinations, associations of unrelated ideas, social withdrawal, and lack of emotional responsiveness and motivation' (Kleinman 1988: 34). It is increasingly assumed that schizophrenia has a pathological basis, that it is a brain disease (Boyle 1990: 171). The consequence is that the focus is less on stories of schizophrenic people and more on the refinement of diagnosis. Anthropology could make an important contribution, but to my knowledge, few anthropologists have studied the meanings and consequences of a life with severe mental illness, or the stories of mad people. Corin (1990) studied the life worlds of schizophrenic people and showed that the behaviour of these people is based in cultural norms and values and that their way of living makes sense in the social context. Estroff (1981) immersed herself in the lives of patients at a day treatment centre and describes a group of chronic patients as they attempt life outside the mental hospital. Rhodes (1991) wrote an ethnography of an acute psychiatric unit. Using a Foucauldian perspective, she describes how the staff manages briefly to treat and place often indigent emergency patients. She focuses on the strategies developed by the staff members to deal with dilemmas they have to face every day.
My own work (1994) focused for a great part on the interactions of schizophrenic people and therapists. I showed that the odd behaviour and speech of schizophrenic people is often not a consequence of their illness, but caused by the paradoxes, ambiguities and power of the therapists. Martínez Hernáez (2000) showed that there is not only a pathophysiological or psychopathological reality behind the symptom, but cultural manifestations, metaphors, etcetera. He says

that a symptom may be understood as a symbol which condenses social and political-economic conditions. This allows us to investigate the construction of meaning and the reality of suffering. Too many others have attempted to understand madness, to give meaning to it and make it 'reasonable'.
I will not attribute new meanings to schizophrenia, nor will I give a description of life in closed wards. I will focus the work with culture of schizophrenic people. Culture is not only something people can have, it is also something they can use, or something that happens to them. Agar writes: 'Culture starts when you realize that you've got a problem […], and the problem has to do with who you are' (Agar 1994: 20). Usually, people are not aware of culture; 'meanings usually float at the edge of awareness' (Agar 1994: 21). People simply assume that culture is an unequivocal whole of meanings and symbols, while they mostly are capable of dealing with the contradiction: the ambiguity and multiplicity of culture. However, meetings with 'walking stories' change that.

Learning about culture through mad stories: tricksters and buffoons

Across Saint Anthony's there is a garage. In the morning when the mechanics are working hard to get all the cars fixed, Vincent (one of the storytellers in *Walking Stories*; see below) comes from the hospital and leans against the wall of the garage with a bottle of beer in his hand. He observes the mechanics' hands and overalls becoming dirty from the lubricant. Some mechanics greet him; others just ignore the man against the wall. Vincent grins and takes a good gulp from his bottle. He challenges the mechanics, saying: 'You are crazy! You have to work to drink a beer! I don't! I get my money and I am free.' The atmosphere of benevolence changes into animosity. The tolerance of the mechanics becomes very low because Vincent touches on a sore spot in their feelings. Probably, they too want to be 'free', and drink beer in the morning sun. The image of the psychiatric patient, who is needy and with whom one should have compassion because he suffers changes into the image of someone who – in the Dutch Welfare State – gets his money from social security or insurance and seems satisfied and conceited. 'Go to hell! We have work to do.' Vincent smiles meaningfully and walks away, maybe to look for others with whom he can amuse himself.

This is one simple event out of the many I have jotted down in my field notes. Those events bring about the deeper layers of 'the work of culture' and the work

with culture. Obeyesekere describes the work of culture as 'the process whereby symbolic forms existing on the cultural level get created and recreated through the minds of people' (Obeye-sekere 1990: xix). However, work of (and with) culture is not only the creation and recreation of symbols. Symbols hide something that cannot be mediated or symbolised openly. Passions and emotions like jealousy, hatred, disgust, contempt, anger, and anxiety cannot easily be communicated and symbolised. Yet, it is suggested by Scheper-Hughes and Lock (1987) that they are the mediatrix between the individual, the social and the politic. Mad people, like Vincent, display emotions in a vivid way.

They are thought of as having lost their feelings of decorum and control over their emotions. A well-known and dreaded phenomenon in psychiatric practice is 'acting out'. Although psychoses may be overwhelming emotional experiences, I disagree with the idea that mad people have lost their feelings of decorum or control over emotions. Sometimes they may do, but often the 'mad behaviour' and 'situational improperties' are intentional. I do not see 'intentional' acts as wilful or purposeful and conscious, but as people's state of which the content of assumptions, ideas, commentaries or beliefs have to be made clear to others (cf. Sperber and Wilson 1986). The madness cannot be divorced from the social and the moral, because others react to it. Fabrega (1997: 36) speaks of 'emotional contagion', which refers to others' responses to emotional display. One may feel shocked and repelled when people talk so openly about rape, sex, violence, badness, incest and revenge in such an emotional way to everyone, certainly when one witnesses the story coming alive. One looks, and one probably looks twice… Miller (1997) argues that such paradoxical reactions to emotional stories and behaviour are both negative and positive, because they help to preserve dignity; they mark the boundaries between others and oneself, enabling one to overcome feelings of repulsion. However, those feelings go hand in hand with moral judgements of others and oneself, which one feels that one cannot make. Miller continues to explain that people are truly in the grip of norms and values, because once the emotional reactions are recognised, the results are often shame and guilt. This can be illustrated by an event in Saint Anthony's. Vincent, a colleague and I were chatting in the coffee shop. Suddenly, Vincent asked my colleague if she thought that he was crazy. Her answer was to pretend that there was nothing unusual about him. Vincent did not take that. He laughed and told her that he was really crazy and different from her and me. She should not lie to him. He said that he looked different and that he was not like others. My

colleague felt uncomfortable. Miller might have explained this with the following: *The stigmatized variously generate alarm, disgust, contempt, embarrassment, concern, pity, or fear. These emotions in turn confirm the stigmatized person as one who is properly stigmatized. […] Strangely enough, it has come to pass that one of the surer markers of our recognition of stigma is our guilt for having recognized it. The stigmatized make us feel that we are not properly according them civil inattention, for we are never certain what we are supposed to do in their presence (Miller 1997: 199-200).*

We cannot allow that moral emotions govern all situations, because people would be brutally and badly treated. Nevertheless, the emotions are there. We feel that there are sometimes instances that lie beyond our tolerance and decent treatment of crazy people and we feel guilty about it. Crazy people see through these behaviours and they will tell us so.

It is through the work of emotions and morality that one may compare mad people with tricksters. As one could see in the example of Vincent and the mechanics, mad people call attention to the ambiguity, ambivalence and instability of symbols, rules and morality. They deal with what Kerenyi (1972) calls 'the spirit of disorder, the enemy of boundaries'.

Tricksters have a double role. On the one hand, they have creative insight and serve human beings. On the other hand, they show compulsive and excessive behaviour, lust and greed for unsuitable objects and relationships (Basso 1996: 53). Mad people expose the forces behind social interaction and the instability of norms and values. Their emotions counter rationality; disruption is more common than integration. Their stories will show that phenomena of ambiguity and instability belong to the essence of social life. Carroll (1984) poses the question of whether one should regard the trickster as a cultural hero or as a (selfish) buffoon. The underlying question is what the implications of 'disorderly' actions are. Should we see mad people as 'free and uninhibited experimenters' who are exempt from moral responsibility? This is suggested by the 'mechanics story'. Vincent's challenge triggered hidden opinions and emotions of the mechanics. I could not overhear the words of the men in the garage (if there were any) afterwards, but I can imagine that they might have said what I usually heard when I talked to villagers. On the one hand, they might have said that Vincent was mad and thus not knowing what he did. On the other hand, somebody might have said something about 'injustice' and 'parasites who live on my tax money…',

not an uncommon banal accusation in a Welfare State. But there also might have been feelings of shame and guilt for one's own feelings, like in the episode with my colleague. Madness is such a negative stereotype that it inherently threatens and even destroys being a social being, but feelings of shame and guilt may prevent mad people from total social isolation and downfall.

Mad people resemble the trickster. But for mad people, the repetition of their stories and what they do is problematic. Basso (1996) suggests that a trickster is successful only when he does not repeat an action. In trickster stories repetition is an indication that the trickster is foolish, compulsive and stupid. Mad people repeat stories and actions endlessly. And when they do, one speaks of regression and chronic illness. One labels them as chronic patients. Basso's description of the trickster who fails is very similar to psychiatry's description of chronic mental patients: 'characters whose actions are stable and fall into a general pattern and whose goals and modes of orientation to goals seems not to vary are in danger of being regarded as *excessively compulsive and inflexible* and, ultimately, failing in imagination' (my emphasis).
However, it is not only words that make mad people similar to tricksters. To compare mad people with tricksters also means that one has to study the dramatic performance, because performance is an essential part of social interaction. Anthropologists have studied drama as 'social drama', which is considered by Turner as the 'social ground of many types of narratives' (Turner 1980: 145). However, the social drama in Turner's view is functional and cognitive. 'The drama moves towards crisis and ultimate solution' (Jules-Rosette 1988: 149). In mad stories and lives, especially those of 'chronic mental patients', there seems to be no 'solution', no finality or reintegration of members of the social group.

The assumption that contradictions and 'disturbing compulsive, excessive behaviour' can be transformed into socially acceptable forms is based on the functionalistic belief that order and consensus in society are norm-al (hyphen on purpose). It seems to me that the value of the performance of mad people cannot be measured with consensus and reintegration. It is by definition disturbing, shocking and jolting. Mad people's stories and lives are dramas which have dramatic and comic dimensions (Van Dongen 1994). Especially the way in which

the people involve others in their stories is an often humorous or ironic and intentional way to break social manners. By 'bizarre' connections of symbols of different domains (religion, science, art, sexuality, etcetera) and by suiting the action to the word, they make others laugh and – at the same time – they give others a fright about what is mostly hidden. It is extremely difficult to resist or ignore a man who comes very close to a therapist at the beginning of their conversation, touches him, opens his pants and shouts: 'It comes out again!' This is a 'ceremonial profanation', which is according to Goffman (1961) a token of sensitivity for rules, values and norms. This behaviour undermines power relationships and forces the therapist to reflect on those relationships. The man was saying: 'I fuck you.' The main characteristic of their performance is openness and reversal of taken-for-granted rules.

The meaning of the performance is in the performance itself. If the performance of mad people invites the reflection of others, it is the reflection in (social) daily practice (like in the event with the mechanics or the therapist). Besides, the idea of Schieffelin (1985: 707) that 'through performance, meanings are formulated in a social rather than cognitive space' fits very well in this case. However, mad people always run the risk that their performance turns against them. What keeps them from total exclusion? Ricoeur (1969: 219) noticed that tragic-comic persons amuse others, but also that ethical and moral accusations are essential in comedy. According to this author, the tragic person is protected against moral judgement and presented as an 'object' of pity. Tricksters and mad people both evoke double feelings in other people. Some of these feelings are pleasure, aversion, attraction, admiration, compassion and rejection. But others will never be indifferent to them. The difference between tricksters and mad people is that the latter succeed in letting others feel the stories they tell, because they do not stop to tell and because they perform so intrusively into others' space. Nobody can resist Vincent when he comes close and talks about the cosmos and the apocalypse; nobody can ignore Joris when he speaks so loudly. The taken-for-granted world is usually turned upside down. The difference between tricksters and mad people is that reversal, which is a common phenomenon in trickster stories, carnivals, theatres and festivals, is permanent in mad stories (Littlewood and Lipsedge 1989). One should seriously wonder if this condition is a problem of mad people, or a problem of others. When one hears the odd stories, one knows that there is too much meaning. Too much is the revelation of cultural reserves. Madness is not a trick to reveal hidden meanings; it shows extra and unforeseen dimensions of symbols

and myths. It shows that culture is a permanent unstable process.

Symbols, myths and magic in mad stories and lives

A general characteristic of the stories in *Walking Stories*, and all the other stories of the people in the wards, is that the tellers are 'hermitic thinkers'. Hermitic thinkers see correspondence between events, models, myths, meanings and symbols. Everything is meaningful and people play 'le jeu des ressemblances'. The world of the stories and subsequently the lives are 'a palace of mirrors in which everything reflects everything' (cf. Eco 1985). The stories rest on core models, myths and metaphors of the culture with which we all are familiar and which we take for granted.

These core tropes are used to make sense of lives. They also expose the basic building blocks of culture (Turner 1967: 110). They reaffirm and reinforce these blocks and they test, question and judge them. Anthropological studies of chronic illness have argued that stories often deal with the liminal state of people. From the perspective of those studies, chronic mental patients are in a permanent liminal state. It means that the final stages of the social drama as Turner has described does not take place. One of the reasons that those stages cannot take place is ascribed to the private, personal or even idiosyncratic use of symbols, myths and cultural models by schizophrenic people, which deviates so much from the way they 'should' be used that the stories are rendered incomprehensible. The problem is not how symbols, myths or models 'should' be used; close examination of mad stories makes it clear that they deal with the inherent indeterminate and ambiguous meanings of symbols, myths, models and metaphors.

Littlewood and Lipsedge (1989) discuss the relation between public and private symbols. They write: 'To express adequately our experiences to others in our community we have to be able to perceive the world symbolically in a standarized matter' (Littlewood & Lipsedge 1989: 219). The authors continue that when people have experiences for which there is no acceptable code, or when we are uncertain which is the proper code to use, confusion in communication may arise. The more uncommon the experiences are, the more difficult it is to communicate them to others. The authors write that schizophrenic people employ highly idiosyncratic symbolic communication. They write: 'It is difficult to explain the overwhelming hold symbols possess over us unless they were learnt in association with powerful personal experiences. …They [the symbols] appear both to have a personal emotional or sensory pole and also to articulate general culture and

social concerns' (Littlewood & Lipsedge 1989: 220-224). I think that the authors are referring to the 'combat zone of disputes over power…' (Taussig 1980: 9) because what is personal and what is public, is not as plain as it seems to be and may differ from situation to situation, from context to context, from interest to interest.

Devereux (1979) defines a symbol as a special form of fantasy, 'which as a rule, stands for something having, or alleged to have, an existence, and susceptible of being designated by a conventional and specific signifier' (p. 19). Thus, convention is an important aspect of a public symbol. Devereux tackles and questions the problem of the difference between private and public symbols, which was discussed by Firth (1973). Devereux concludes that the nature and genesis of private symbols does not differ from that of public symbols and that both can be decoded by recourse to identical methods and techniques. In the first Lewis Henry Morgan lecture in *The Work of Culture*, Obeyesekere (1990) also discusses the distinction between private and public symbols. The author revisits the story of Abdin, a psychotic Muslim ecstatic, who hangs himself on hooks and cuts his tongue, both known rituals in Hindu India. For Obeyesekere, Abdin was 'abreacting his past and using the pregiven cultural symbol system to express and bring some order to and control over his psychic conflicts' (p. 10). Abdin reverted from the level of the symbol to the level of the symptom, because he repeated his acts compulsively. For Obeyesekere, a symptom is characterised by an overdetermination of motive, while a symbol is characterised by a surplus of meaning. The difference between a psychotic person and a priestess would be that the psychotic person moves in a regressive direction as he acts out the symbol system, whereas the priestess does the reverse (p. 14). Obeyesekere sees the significance of this distinction in the notion that people express their ontological problems of existence and being through the available cultural repertoires. Personal symbols are cultural symbols, public and private at the same time, that make sense in relation to the personal history of the individual. Obeyesekere calls the distinction between public and private symbols a false distinction (p. 24).

I too believe that schizophrenic people do not use 'idiosyncratic or private symbols'. They use public symbols in such a way that others are alienated or become confused. The stories of mad people are full of (all too) well-known symbols which always have a surplus of meaning because cultural symbols are inherently ambivalent and ambiguous. For example, a chain may be the symbol of

captivity, but also of solidarity.

Culture is extremely powerful. Even when people are overwhelmed by psychosis and madness, culture does its work. The views, beliefs, assumptions and opinions that are expressed in myths and stories by symbols, claim a certain truth, which is always debatable, because their meanings depend on the context and the situation. Symbols claim truth, but one can never be sure what exactly their meaning is unless one understands the context. The conclusion has to be that symbols are perfectly suitable for manipulation and (power) play. I disagree with the idea that the repetitive, compulsive use of symbols by mad people is regressive. I maintain that the use of symbols is 'special'. It is related to a mimetic process. Mimesis is a normal human tendency and can be observed in education, schooling, cultivation, etcetera. It enables people to acquire certain cultural attitudes. It requires guidance and taboos. When no restrictions are accepted, it will manifest itself in every domain of human behaviour (Girard 1978). This is often the case in mad stories. The models and myths have a strong force. Models will be mimed. Often, this means that the symbols will be repeated, acquire unexpected meanings or will refer to additional meanings which we did not know existed.

One should do away with the traditional way of approaching mad stories and what they do, and presuppose heterogeneity between the stories of mad people and other types of stories. If those other types were to account for mad stories, they would make them say things that they do not say or that they do not signify. The known approaches to mad stories do not explain why the stories and behaviour remain the same over time.
I will try to explain my approach and I base my explanation on the work of José Gil's *Metamorphoses du corps* (1985), which takes an interest in 'forces' and power and focuses on the practical effects of signs and symbols. He takes the study of forces as the way to understand how signs and symbols function in their own right, sometimes in ways that may differ from the ways they are usually attached. Gil presupposes that phenomena in modern societies are quite similar to those that take place in bodies during magical ceremonies. Madness consists of extra-ordinary forces which drive people away from their community. The people of the wards told me that their psychotic experiences are fearful and incomprehensible for themselves. After they experienced their first episode of psychosis, they believed that their lives were profoundly changed, and that they

had to make sense of their intense experiences. However, intensity of experiences is not enough to drive people to give meaning. What drives people is the fact that two forces are set in opposition to each other: the people's struggle to signify their lives in a meaningful sense, and the social force to control that struggle.

Mad people try to get a grip on their lives and to influence their courses, which actually lie beyond their control. They do so through the use of myths and symbols, stories and models that 'inspire' their motivations and desires, and influence their emotions. Culture, as a collective of stories, is used to practise magic. The idea of magic in relationship with mad stories may be odd. Usually, magic is understood as something by which people influence the 'supernatural' powers of the world. Traditionally, anthropology sees magic in relation with religion. But the concept may be used in a broader sense without referring to religion directly. In this sense, magic is the human control of what actually lies beyond control, but, though there is strong belief that magic exists, it too must be controlled and signified. Magic is the ability of words to effect things.

On the one hand, madness is a power that exists and must be controlled by specialists. In this context, it is meaningful that psychiatry is sometimes seen as the 'new religion' of our society. People see psychiatry as a power that can control and manipulate the superpowers of irrationality through control of the powers of flesh and blood (i.e. mad people). On the other hand, culture itself is a powerful force to control the experienced powers in madness like devils, ghosts, voices from heaven, demons and spirits of the dead. Because the magic of psychiatry has more prestige than the magic of the mad, there is a gap between the two and mad stories will no longer relate to the former. It means to control and manipulate the powers of madness through the rituals of therapy and the use of medicines. However, in the case of chronic schizophrenic people it is difficult to control. Patients of Saint Anthony's know for example very well how to escape regimens or how to play with rules and how to influence the flux of daily life in the wards.

The idea that certain phenomena in modern societies are much similar to those that take place in bodies during magical ceremonies, is described by Gil (1985). This seems to be the case in stories of chronic schizophrenic people, who also try to control the powers of madness. Magic is the ability of words to effect things. Signs, symbols and myths are recycled, mixed, and put together in a way that alienates others, but that has power to manipulate the course of events and the

others' responsive actions. This was exactly what nurses in the closed wards of Saint Anthony's always complained about; their plans were thwarted by incarnate stories of their patients; they felt manipulated, and the daily routine was disturbed.

It is tempting and reasonable to describe the world of chronic schizophrenic-psychotic people as magical if one looks at core aspects of the affliction: 'reality testing' and the differentiation between logical and prelogical thinking. Generally, it is assumed that schizophrenic people live 'outside reality'. It is also suggested that the psychotic world is irrational. However, it can be misleading to contrast the world of normal and abnormal; reality and 'outside reality'. First, schizophrenic people also live in 'reality' (the normal) for a greater part of their time. Second, the magical world cannot be described in terms of the normal discourse. The mad world has its own universe of discourse, its own conception of reality and criteria of rationality, perhaps different from the nonpsychotic world. Until here, the argument is similar to Winch's argument that describes the scientific form and the magico-religious form of thinking as a distinct form of social life whose practices and beliefs are only intelligible in the context in which they are held (Winch 1958). This is precisely the argument of Goffman (1961), which I have described in the previous section of this paper. It is also true, but not surprising, that the psychotic world is often seen as 'savage'; that psychotic people are, to put it in Comte's not too fine words: 'slaves of the infinite variety of phenomena' and 'nebulous symbolisation' (Comte 1908, cited in Lévi-Strauss 1996). However, Winch insisted on the incommensurability of the two worlds (science and magic). That would mean that no communication is possible. As we have seen in the discussion on private and public symbols, the symbols used by mad people are known, public and private at the same time. The differences between the two worlds lie in the fact that non-schizophrenic people and chronic schizophrenic people live different forms of life. For this reason, the magic world of mad people demands its own discourse, logic and rationality. The problem is whether others will accept this discourse.

There is another fascinating parallel between the magic world of mad people and other magic worlds, in relation to power. Both Taussig (1987) and Lévi-Strauss (1955) discussed the magical power of the written word. To quote Taussig (1987: 262): 'what is in effect obtained through the purchase of magic books is the *magic of the printed word* as print has acquired this power in the exercise of colonial

domination with its fetishization of print, as in the Bible and the law. *Magica*, so it seems to me, does not so much magicalize colonising print as draw out the magic inherent in its rationality and monologic function in domination' (my emphasis). I see the parallel between the magical books of the Colombian Indians with mad stories in the idea of the power of written words.

Schizophrenic people also are very aware of the power the reports, files, judicial decisions – all written words, that determine and control their lives. The patients often counter them with letters to the board of the hospital, psychiatrists, judges, or other personnel of Saint Anthony's, repeatedly and in a ritualistic way, often with similar words. Lévi-Strauss (1955) described the case of chief Namikwara, who imitated the ethnographer's writing and in so doing gained prestige among his people, even if his writing was not understood. This example also shows a similarity with the patients' writings. For example, Rosemary, an older schizophrenic woman in one of Saint Anthony's wards, had a typewriter in her room with which she wrote letters about her life to staff members, to me, and to her mother. The typewriter gave her prestige in the ward; her room partly gave the impression of an office (she was a secretary at one of the Dutch multinationals), or a 'writer's room'. Besides, Rosemary tried to convince others with her letters that she, although 'mad', was capable of controlling her own life. Rosemary repeated her typewriting and her stories over and over again. It seemed, like the stories of other patients, a ritual performed with symbols, words, and attributes.

The repetitive and formulaic nature of the mad stories resembles the fixed rites in a liturgy, although this 'liturgy' is not, like for example the religious liturgy, in service of the community. But the mad stories have important liturgical characteristics in their repetition of the same symbols, words, and actions. Besides, like in a liturgy, they need answers from others (staff members, people in the streets, family members, the anthropologist). Mostly, it is assumed that the stories are about the past; the events of the past are constructed within the personal and social history of the patients. Thus seen, the stories are attempts to give meanings to the past. This is also the case in liturgy: what happened in the past – for example, the Last Supper – is re-given meaning and memorised.

However, mad stories are not so much attempts to remember the past or to give

meaning to it; they are attempts to master and control the future. This also resembles the liturgy; it means reunion of people (and gods) and renewing the bonds within the group. Mad stories reclaim the place of their tellers in the community. Mad people tell and live their stories in an almost ritualistic manner: they tell the same stories over and over again, they use the same symbols and they will live them again and again. They have to, because they have to practise double magic: the counter magic to control the powers of the healing system, and the magic to control the powers of the madness.

Remembrance and repetition are attempts to master not only the past, but also the future. During all the years that I heard the mad stories of the same persons in different periods of their lives, I discovered that the stories did not change. This discovery was confirmed by review of the patients' files and the stories of therapists and nurses. There was also something else. In anthropology, it is assumed that stories are about the past, about those parts of life which are already lived. Events of the past are constructed within the personal and social history. Thus seen, memories and repetitive compulsion are attempts to master the past and to give new meaning to it. However, we should not stress the reflexivity of people, the re-play of past actions, too much. In our studies of narration, we also should consider that stories may be a fore-play of what will happen in the future.

Having said that symbolisation and metaphorisation of mad people are not idiosyncratic or private, we still have a problem. This is the issue of distance and demetaphorisation. Usually, a metaphor or a symbol stands for something else, but mad people often are what they say they are. They tie the symbols directly to their body and life. Thus, there is no difference between the story and the life. Jim told me his story, as he insisted, for the last time in his life. Then, he told me that he was a rock. How can we understand this? We know that people can be 'steady as a rock', but this was not what Jim meant. He is a rock. Maybe, anthropology, and also psychoanalysis, would interpret the 'rock' as a symbol for insensitivity and closeness to the outer world and incapability to have inner feelings. Another interpretation is possible. The fantasy of the rock, a powerful cultural symbol, can be a mark in the process where a schizophrenic man closes his body for the forces which make him repeat his story vis-à-vis more powerful stories. The solution for his frustration and hopelessness may be to become a rock. The problem that others have with these kinds of stories is that such things are symbols for them,

whereas they are reality for mad people.

This leads me to the role and the weight of culture in the stories and lives of the people of the wards. Anthropology may see culture as a collective of beliefs, customs, symbols, etcetera. There are more than a hundred definitions of culture, but what is often lacking is that culture is also a force, an energy that is directed to something. Culture has power over people. It is even so strong that people become 'possessed' by symbols and stories and do everything to come close to, for example, an ideal model. The body model of the tiny, active and thus beautiful woman may have such a strong impact on girls, that they will go beyond a healthy life pattern, become taken over by the image, and become anorectic. But when they are, they are told that they are not healthy or beautiful at all.
Cultural ideals and images cannot be described as coherent. What to do with 'walking stories'? The stories will make clear, as we will see, that people are not helpless victims or scapegoats. They are active agents who have nothing else than what their culture provides them to combat. They reclaim more than their own lives. They also reclaim the right to be involved in moral and cultural matters. The symbols and myths are not used as metaphors for signifying illness. Rather, they are used by people to re-take their place within the culture. They have to tell their stories, and others should listen, because they are not about illness; they are about the human/cultural condition.

One of the stories from Walking Stories: Vincent, Morrison and the cosmic man

Desire and resistance of a schizophrenic man

Billy, are you completely crazy?
No, it's true. Really. This guy told me. It's true. I'm really gonna do it.
I bet only reason you won't come with me is because I ain't got any money. Well, listen, I'm telling you
I'm gonna go back up there and getme some money, lots of it, maybe
even ten thousand. And then I'm coming back for you. I'm coming back.
– Jim Morrison: the Hitchhiker

The story of Vincent is emblematic for my argument. I followed Vincent's well and woo for many years. In general, his story and his life remained the same over all those years. Vincent had a dream and this dream became his life. He lived his story and he still does. Obviously, the ideas and models which were so important

in our shared history were so strong for him that he could not resist them. His story shows the magic of culture and his struggle to resist and manipulate the world. How does this work?

Anthropologists have highlighted that 'human motivation' has to be understood as the product of interaction between events and things in the social world and interpretation of those events and things in people's psyche (Strauss 1992: 1). This approach stresses that motivation depends on cultural models, but that the motivation is not automatically derived from ideology, discourses or symbols in a culture. Cultural models have a 'directive force'; they set forth goals and include desire. Emotions and cognition are interrelated. According to Quinn (1992) an important way cultural models become goal-schemas is by supplying people with understanding of themselves. It often is assumed that mad people suffer from disturbances in the sense of self. These disturbances are attributed to a false incorporation into culture in the crucial stage of childhood, causing a semi-permanent identity-crisis and a repetitive desire to construct a self. This, in turn, results in continuous redefinitions or elaborations of an imaginative, 'unrealistic self'.

However, the sense of self or self-understanding may vary throughout one's lifetime and may even vary from situation to situation. We all have to deal with experiences which raise disturbing existential questions, with 'sequestration of experience' (Giddens 1991). Many of us are 'homeless minds' in an era in which old cultural boundaries are opened up and new ones are established. However, it is sufficiently shown that these disturbances and inconsistencies do not mean fragmentation or permanent disturbances in a person's self per se. In fact, Vincent's story is about a 'stable self': he remained the same 'self' over many years. The story of Vincent has to be interpreted differently; it is a reclaiming of his life and his story from psychiatric discourse and therefore is a form of resistance: against medical discourse, against moral ambiguities in his culture. Vincent's desire seems to be a positive force which produces resistance against the moral and ideologies, power and control. Above all, his story and his life form a resistance against 'settings of technical correction' (Giddens 1991: 160) and a plea for imagination and emotional 'play' with culture.

The story and the life of Vincent

Vincent was a forty year old schizophrenic man. Vincent looks like his famous namesake: Vincent van Gogh. He was red-haired. His face has also the tensed and restless expression that can be seen on Van Gogh's self portraits. As a result of extensive use of psychotropes his movements are sometimes slow and his tongue hangs out of his mouth. He has lived for more than twenty-four years in a mental hospital together with his brother, who is also diagnosed as schizophrenic. He is a well-known man in the hospital and in the nearby city. When a student came to see me for advice on her master's thesis on mental illness she saw the portrait of Vincent in my office. She recognised him and told me stories about his life in the city. Those stories were very similar to what I heard during my fieldwork!

When we ascribe an identity to another person it may summon resistance of that person. The resistance is comprehensible, but in clinical psychiatry it is made an issue. Consider the utterance of Vincent, who was involved in a conversation with his personal supervisor. The conversation was a part of my research project on schizophrenic and psychotic people (Van Dongen 1994). Therapists and nurses talked with their patients about the patients' lives. Contrary to most of Vincent's conversations, this one was a rather sad reflection on his situation. It was not like his usual wonderful stories of success, pop culture and cosmic life.

The nurse and Vincent recorded the conversation. The opening is as follows: *[Nurse: How long are you in psychiatry?] I want to undo my chocolate. [Nurse: Vincent?]* Vincent undoes his chocolate and does not say a word. *[Nurse: How long are you in psychiatry?]* Vincent does not answer. *[Nurse: Well, let me ask you in another way. How long are you taken in here?] Vincent: Twenty-one years!*

These utterances point to several things: the starting point of the nurse, Vincent's reluctance to answer the first question and the assumption that there is something special with psychiatry to Vincent. The nurse wanted to talk about Vincent's life in a linear chronological way: from the beginning of Vincent's admission to the hospital to the present. Vincent's reluctance to answer the question about his life in *psychiatry* is clear.

However, as soon as the nurse asked in a different way, Vincent responded. He

strongly disliked being identified with a mental inpatient. He had a totally different view on the hospital. For him, the hospital was a place to sleep, to eat and to get protection when the outside world had become too threatening. The hospital was a shelter for withdrawing and settling down after a turbulent evening out in the city. Vincent often remarked ironically that everyone had to work and yet could not be sure to have a home, good food and enough leisure time. He was sure to have such things. But he resisted being referred to as a psychiatric patient. This had a strong negative impact, as it did for most of the patients who participated in my research. The model of a mental patient had a negative moral dimension and a negative directive force. It did not fit into his self-perception, just as it did not fit most patients in my research. The model of madness was related to guilt and shame.

Popular ideas of madness in western cultures are less rational and biomedical than one may expect. Those ideas include different cultural models of the human mind, the brain, religion, etcetera. They also include models of the moral order. Popular models are vague and loosely constituted. However, they share one aspect. They explain when someone exceeds the limits of the social order. Exceeding limits is shameful and embarrassing, not only for the person who crosses the border, but even more for the members of the social group. By ascribing the responsibility for exceeding limits to individual failure and personal guilt the madness and shame become a matter of the individual who commits the 'crime'. Madness becomes badness. To be assigned as a psychiatric patient means a moral judgement for the person. Vincent shows this belief in a compact package of ideas which is related to his view of the social reality and self-identification (cf. Strauss 1992: 205-207). The hospital was for Vincent a 'place where strange and wild things happen' and 'fights are going on'. He went through 'mad things like scuffles and breaking windows and so on'. He said that he had not a 'psychiatric disease', but that he went to the institution 'to rest' and 'to become an adult'. For him, the hospital was a 'nunnery', which indeed it was twenty years ago. It had a protective meaning. His ideas about madness and the mental hospital belonged to an 'authorative discourse': 'sharply demarcated, compact and inert […] one must either totally affirm it, or totally reject it' (Bakhtin 1981: 343).

There is no doubt that Vincent rejected the model of madness and the connected intrinsic moral judgement. The consequence was a considerable inner and social conflict, since others identified him as 'mad' or 'schizophrenic'. His turmoil was

connected to conflicts with nurses, family and people in the town. In spite of his overt rejection of the madness model, Vincent was always involved in fights, quarrels, drinking, gambling, begging and exhibitionism. In short, he was involved in all the things, which he thought to have belonged to the mad-bad model. Vincent was very aware of the contradictions between his models and those of others, and of the difference between a part of his story and his actual behaviour. He knew that he was different. He said: 'I am unlike others, maybe because I am red-haired.' He knew that others rejected him and he cared about it: 'They always reject me. When I enter a pub, they will say ta-ta. In other words, they say: Piss off. I am hardly inside when they say: Ta-ta, piss off!'

How did he manage the contradictions for himself and in front of relevant others? First, he reversed the moral dimension of the popular madness-badness model. He was not mad, he was not bad: *God does not exist any longer, because the people are bad. The devil became a common human being. People destroy each other when they finish their plundering […]. All that I say wrong, are the thoughts of bad people. From my birth on I fight with bad people.*

The badness of others was directly fixed upon Vincent. He experienced 'the lives of others'. This sensation gave him 'troubled feelings', because 'people creep under his thoughts'. The badness of others had become a physical experience. Other subjects like death, education, fatherhood, psychiatry and sexuality were penetrated by the evil of other people. This had such a strong negative effect on Vincent that he wanted to be 'a cosmic man', stripped of all human qualities and possibilities to do any evil: *I want to be a cosmic man. Cosmic people don't die. They don't have an anus. They are very clean and wear white clothes. They have a kind of penis, but they don't masturbate or crap. […] Life in the cosmos is rough. You have to drink until you feel good.*

Sometimes he thought that he 'had to lay down shorn and naked' until he was transformed. The only way in which he would achieve his exalted goal was by a life in the hospital, where he could 'work' at his transformation. He said: 'I work at my standstill, to live at myself.' This higherlevel goal – the ultimate 'good' – was an echo of a Buddhist ideal of the seventies which told him to make his mind empty in order to achieve the absolute state of Nirvana. This ideal was mixed with other ideas of the seventies, when flower power, pop culture and alienation from the parental generation predominated the lives of adolescents. We hear wellknown cultural and psychological issues in Vincent's story of the cosmos:

human beings who are not imprisoned in lower desires like sexuality; white clothes could signify purity; the cosmos could be heaven: one feels good. Purifying oneself by removing everything that is dirty (clothes and hair): shaving could be symbolic castration. There exists an over-determination of meaning in Vincent's story. There are lots of symbols of different (cross)cultural domains. Shaving for example is also a symbol of castration in Buddhist India. One can recognise the angels in the people without anuses and the little virgin penis. Thus, this polysemy refers to the determination by the motives of evil and good, and the many symbols which Vincent used. The problem is that there is no distancing or disconnection between the desire and the cultural public domain of storytelling. The story's text remains close to Vincent. His story is perceived by others as 'fleurs du mal', an illusion, simply 'crazy', or personal symbolism. The assumption that crazy people tell through the use of personal symbols, which are cultural but not distanced from motives, desires or imagination, means that they are disempowered. The symbols are similar to the public symbols.

When Vincent was a young man he was very attracted by these ideas. He tried to get rid of an authoritarian father and he wanted to live like his idols Jim Morrison and The Doors. Vincent was the son of a factory worker. His mother was a housewife. He had left school when he was sixteen years old. He became a waiter in a second rate restaurant. He fell in love with a girl, whose parents were well-to-do. The young couple went out and made trips by taxis. The girl's parents were willing to pay for them. Vincent must have felt very successful in those days, because his family was not rich and he himself did not have the job that could afford him the desired lifestyle. However, the relationship came to an end.

Vincent wanted to continue the life to which he had become accustomed. He remained a regular visitor of the city's bars. He went for taxi rides and he took the train to Paris. His father paid these trips. When the father finally refused to pay, Vincent's lived dream of glamour and wealth collapsed. Vincent became psychotic and was admitted to the mental hospital in which he still lived at the time of my field work. But the dream remained alive and very strong. In the first years of his stay in the hospital he often lived in the locked wards. When his dream took over him, he broke the windows and escaped to the city or jumped on the train to Paris. He was imprisoned for some time, because his debts to the national railway company had risen to unacceptable heights. Seclusion and imprisonment could not prevent him from escaping again and again. What

Vincent experienced as ‘high life’ was irresistible for him.

The idea of ‘standstill’, his identification with Jim Morrison and The Doors gave force to a range of related goals. He wanted to be sociable, successful and well known. In a certain way, Vincent succeeded in achieving these goals. He was well known in the hospital. Personnel and patients knew his stories and imaginations about his travels with Jim Morrison. Sometimes Vincent felt repelled, but he could not convince others of this feeling. When he tried to explain his feeling to a nurse, the latter said: *When I see you in daytime… at night, well, everybody knows Vincent, and you set us on laughing. I don’t have the feeling that you are repelled…*

Jim Morrison 1969

Vincent was also well known in the nearby city. He liked to go to cafés, bars and night clubs and to talk to the people. Sometimes he travelled by train without paying. He still rode in taxis when he had the opportunity and the money. People would give him a blanket when he had to sleep in porticoes of a flat at night. However, as a psychiatric patient Vincent could not afford the lifestyle he desired. Social insurance paid him a little pocket money, not enough to cover his costs. He lamented: ‘How much does life cost to make it without begging?’ His passionate wish to be Jim Morrison or to be with the pop star was so strong that he had to go into the world, mixing with corruption and sin, dirtying [him]self with externals, having some trick with the despised forms, instead of worshipping the sacred mysteries of pure content (Douglas 1982: 155).

He felt frustrated, because he could not achieve the status of a ‘cosmic man’. He felt dirty and polluted. He had a strong but not unusual idea that money was a guarantee for success and happiness, which he saw as a bridge to the higher-level goal of the state of emptiness, Nirvana. Success was an intermediate station to cosmic existence. In his view earning money in the usual way was a sad thing to

do. He rejected the social value of 'working for your bread' by saying: 'Life is not for working, life has to be pleasant.' However, he had to supply his pocket money in order to keep his dream alive and to live his dream. He did so by gambling, begging and exhibitionism. These activities belonged to the evil, the polluting. He slept in the street or in porticoes of houses on a piece of cardboard when he had no money to pay the bus or a taxi. For others he was no different from the tramps that people the modern big cities nowadays.

For himself, dirtying was a necessary evil: he did so to achieve his goals. Each little amount of money he got by begging, gambling or exhibitionism permitted him to be like Morrison for a short time. To be like the pop star was a mark on the road to Nirvana. The ideas of the pop culture – fame, plenty of money, beverage, women, music and a 'flashy lifestyle' – were part of Vincent's success model. This model was a strong leading principle. But begging, gambling and other behaviour gave rise to conflicts with others. In the city Vincent was abused many times. The incidents that followed his exhibitionism illustrate this: *I show my penis. [Els: You do?] They say that I must do that and I get forty guilders. [Els: If you don't want to do it, you can refuse.] No, I must, otherwise they beat me up. It is like a rape when they beat me. They beat so heavily, it's like I am in a woman. [Els: Why are people so curious to see your penis?] I am red-haired and red-haired people are special. So, people want to see my penis with that red hair. That's special for them. [Els: Don't you think it's annoying for you?] Even the sportsmen do it when they take a shower. [Els: Is that the same?] Yes, they are naked.*

In this narrative Vincent related his exhibitionism with his otherness. He also stressed the role of others and his helplessness. His abnormality was transformed into the badness of others. The realisation of his dream clashed painfully with his madness, the evil and the limits of society. No matter how strong the motivational force of his success model was, in this case the bridge between money and success and the good was very insecure. The piers of this bridge were inadmissible behaviour and social taboos. Nevertheless, Vincent showed a certain obstinacy in his continuously repeated efforts to achieve success on his way to the cosmos. Vincent was an incarnated problem of the western consumer society. One the one hand, his life is an extreme example of the rat race: pursuing success and happiness. On the other hand, his life was a struggle between evil and good.

Desire and passion

Vincent's story may support the claim of certain psychiatric theories that the

process of becoming a ‘self’ in psychotic people is disturbed. Serious disorders as psychosis and schizophrenia have disturbances in the sense of identity and capacity for social relationships. However, to view psychosis or schizophrenia as a combination of ego-functions and deficiencies in parental education, family structure and communication show the cultural foundation of the approach. The cultural beliefs and values are manifest on the level of ideology, but also on the level of behaviour and social interaction. Prominent characteristics are self-reliance, selfdirection and verbal expression (Kirschner 1992). These notions persist in modern psychiatric ideas. Vincent’s story and life may support this view. He does not seem a person who is self-reliant, autonomous. His behaviour does not match the accepted social behaviour, his verbal expressions violate the rules of interaction. His life story suggests that the theory of a derailed self through disturbed identification and education is right. His hospital files tell about an indulgent mother and an authoritative father; an uncertain situation in childhood, due to which Vincent’s ego was not integrated in the cultural domain.

In psychosis the passage from the imaginary order to the symbolic order does not take place (Lacan 1966). The name of the Father (to be understood symbolically) is rejected (‘forclusion du nom-du-père’). This means that the configuration of differences and rules – the law of the Father – is also rejected. The child does not participate in the symbolic (linguistic-social) game. The ‘metaphore paternelle’ fails and the result is that the child stays subordinated to desire (of the mother). The child has no choice and no own identity. The child coincides with the other’s words. It has no possibility to take a symbolic marked identity from the symbolic order and therefore it has no distinguished position. His self is what others say it is. For Lacan the idea of an integrated ego is rejectable.
Every self is divided and fragmented. Desire is the inevitable result of division and fragmentation, and becomes the motor of human creations. Lacan’s idea is similar to Ewing’s notion. This anthropologist states that the presentation of the self may differ from context to context (Ewing 1991). Desire created Vincent’s ‘cosmic man’. The fulfilment of that desire (being first like Jim Morrison in order to become a cosmic man), however, could not be achieved through the life Vincent had since he was an adolescent. In a Lacanian view desire means only more desire. According to this view Vincent’s desire was a regressive process. His dream of success and the good leads him back to his starting point again and again. However, the dream and the subsequent stories are more than that: they are means to survive and to resist.

Plurality and anbiguity are to be studied in their context. Vincent's ideas about the self embody certain assumptions about the person which are characteristic of the culture in the south of the Netherlands. Here the self consists also of significant others. The self is partly composed of elements over which a person has no control. The self can change and is less unbound and autonomous. Vincent shows for example this awareness when he said: 'You have to live with other people in a social way.' Psychotic people frequently violate the cultural rules in order to satisfy their needs. Vincent was involved in an ongoing social conflict. Sometimes it seemed as if he did not experience an offence of a cultural prohibition when showing his genitals in town. However, rather than suggesting that there is no conflict, as some psychiatrists do, I suggest that Vincent's behaviour was intentional and conflictual. It is well known that when people learn different or conflicting assumptions about what is right or wrong, moral or natural, a possibility exists for resistance to cultural ideas and beliefs (Quinn 1992: 122). In Vincent's case the conflicting assumptions had their origin in childhood. His rigid assumptions about the evil and the good were not simply cultural models which had directive force because they were learned in childhood and experienced as 'natural'. Vincent's story suggests a long process, beginning in adolescence, in which his ideas about failure, success, evil, purity, etcetera became incorporated in Vincent's understanding of himself and led to the identification with Jim Morrison. His behaviour and his almost conscious will to behave like he did echoed, as I wrote before, ideals of the youth in the seventies: resistance against authority and the ideal of total personal freedom. In fact, it echoes resistance against the cultural law by a large 'peer group' of adolescents: the 'protest generation'.

Vincent's technique of resistance was that of parody and grotesque realism. He offended precisely those cultural norms of which he said that to offend was a bad thing to do. He did it very openly. Begging, drinking, and exhibitionism seemed to be what Goffman (1971) called 'ceremonial profanations', i.e. conscious offence that shows sensitivity for values and norms.

Anthropologists showed that the directive force of cultural models is 'over determined'. Social sanctions, pressure for conformity, reward and values act together to give a model its directive force (D'Andrade 1984: 98). In this sense the cultural models Vincent used seemed not very rewarding for him. His offence was chastised immediately, sometimes through beatings, sometimes in the

hospital by being prohibited from going out. The socialisation process seemed not to be very effective. Vincent was admitted to a psychiatric hospital and he lived in the margins of society. He offended the rules and violated cultural norms. No matter what therapists or other mental health workers did over the years to reinforce a moral and proper way to behave, he maintained his dream and thus his way of living for more than twenty years. Obviously, there was a strong force involved. Vincent knew the values and norms of his culture, but he had different feelings about them. For him norms and values were associated with strong negative feelings. His experiences with people in town, his resistance against the ascribed identity of psychiatric patient and his feelings about the 'hypocrisy' and 'badness' of people caused these feelings. To understand what motivated Vincent (and others as well) we must know the feelings that he associated with cultural models as the result of his specific life experience. They were his passions of life…

If culturally organized views of possibility and sense must figure centrally in the acquisition of a sense of self – providing images in terms of which we unselfconsciously connect ideas and actions – then culture makes a difference that concerns not simply *what* we think but how we feel about and live our lives. Affects, then, are no less cultural and no more private than beliefs (Rosaldo 1984: 140-141).

Desire and intentions

It is not so strange that Vincent wished for a completely different way of life when we know how he lived. The different life was situated in the cosmos. For other psychotic people the ideal way of being was in heaven or in some utopia. One may say that the 'real' life of psychotic people forms a negative force. Often, this particular kind of desire had not developed in childhood, but in adolescence. From my research data it became clear that most of the psychotic patients which expressed so plainly a desire for heaven, utopia, or cosmos, were the adolescents of the seventies.

They were involved in the counterculture of that era. This desire is not so very different from a general desire people express for example in religion, myths or ideologies. The problem is not that psychotic people desire heaven or so, but that they desire it too often and too 'loud', therewith showing that the desire for 'heaven' is ridiculous. For us, this is very uneasy, because that which we express and believe in religion or ideologies, we deny to madness.

Should we define desire as a force that is characterised by a lack of something? Or should we view it as a positive force? Lacan (1961) defines desire as a lack, but Deleuze and Guattari view desire as a presence and a productive force. According to these authors 'needs are derived from desire: they are counter products within the real that desire produces' (Deleuze & Guattari 1984: 27). In their theory an individual is not bound to be a slave of his desire nor is the desire always a repetition of the oedipal triad mother-father-ego, but a will-to-power, a will-to-become, while opposing the regular social discourse. The authors do not exclude Lacan's version of desire, but they see desire as discursive, that is, emanating from power and control, while the object of desire is created in social discourse. In their view desire is dual. I will explain this by Vincent's case.

On the one hand, when his desire to become a 'cosmic man' is seen as a lack, there is always something that is lost and has to become reinforced. In a psychiatric view, what is lost is his sense of self and his sense of reality. What has to be reinforced involves re-territorialisation of his ideas and beliefs within the common ideology. This is what psychiatry wants to do. On the other hand, when his desire is conceived as a willtobecome, Vincent would have room for resistance to the social and the cultural order. In this case re-territorialisation becomes an outcome of discursive practices. This means for example that the 'cosmic man' can be made into a central figure in conversations with Vincent.

However, there is still Vincent's desire to be like Jim Morrison. I explain this desire for identification as a bridge between his actual life and his life in the cosmos. This desire cannot be explained by repetition of an oedipal model or a familial model of authority. Morrison is for Vincent a model of anti-authority. It is possible to see the repetition of the 'Morrison'-desire as 'pursuing failure', as Shafer (1984) describes for clients in clinical psychiatry. These clients have failed in life tasks and their emotional patterns related to these failures seem to persist. Failures become goals with directive force and their pursuit is valorised. Embroiding this theme, failure can be a model of something that happens to vulnerable people and the model of a vulnerable self with elements over which one has no control might make failure a goal. Thus, powerful forces like marginality, moral judgement of others, exclusion or denial of worth on the basis of a position as a psychiatric in-patient can lead Vincent to take on some of these models. It can be argued that this is for example the case with marginality when Vincent sleeps on the streets, in porticoes, or even on a dung-hill. But the

Morrison-model – the desire to double Morrison – is more complicated than an intra-psychic model of free, individual choice (if there is any!). There are two important items related to Vincent's Morrison-model, which I would like to discuss. Firstly, desire as a positive intentional force of resistance, and secondly, desire as a 'political' and mimetic process.

Vincent was an active agent. He was the 'nomadic subject, able to become, to resist, to see that things can be otherwise' (Fox 1993: 86). The desire of Vincent to be Morrison soaked his life. Morrison was a model with a strong directive force for many years. 'Higher-level goals' clustered around this model: success, freedom and happiness. Morrison stood for all. Nothing is abnormal in the goals of success, freedom or happiness in the Anglo-American and Northern European cultures. D'Andrade (1984: 98) notes for example about the American emphasis on success: 'there are external sanctions involving money and employment, there are conformity pressure of many kinds, and there are the direct personal rewards and value satisfactions'.

However, for Vincent the achievement of these goals did not pass off by socially accepted employment, but precisely by the opposite. He tried to achieve the goals by begging, gambling or exhibitionism. These activities are not signs of madness per se, but in Vincent's case they are signified as symptoms of mental illness. However, they offered Vincent satisfaction and pleasure, because if he succeeded to win a couple of hundred guilders by tapping the buttons of a gambling machine his dream about 'good life' became reality. People would accept a drink and would even have a conversation with him. He would take a taxi and the chauffeur would be polite and open the door for him. This gave him 'the kick'.

The directive force of such models cannot be entirely explained by personal and social reward. According to D'Andrade there are two motivational systems involved with cultural meaning systems: one that satisfies personal needs and another that represents a self as proof of a particular set of values (D'Andrade 1984: 98). For example, what motivated Vincent to identify himself with Morrison may be rewarding because it satisfied his need for recognition and attention. The effect of this open identification was the constant attention and care of mental health workers, because this identification was conceived as a sign of madness. Ironically, mad people have to behave mad in order to stay in social contact with others. The identification also represented the 'free' self and this self came close to the cosmic man.

However, the need for success and related feelings of freedom and happiness was only temporarily satisfied. The ways in which Vincent tries to fulfil his desire often meant a social conflict. We can hardly speak of any form of reward in this case. What made Vincent do this again and again? To explain this, we need another dimension of desire, namely intentionality. From a psychological view intentions are mental representations capable of being realised in action. I do not mean a full conscious effort to make something clear or to satisfy a desire. Analogous to Sperber and Wilson (1986) who see a communicative intention not just as an intention to inform someone else of something, but as an intention to make an informative intention known to the one who communicates and the one who listens, intention of desire is a semi-conscious effort to make an intention clear or to make clear that there is an intention to everyone who is involved in social interaction. Desire is thus not only a positive force that takes place in the real, as Deleuze and Guattari see it, but also an intentional force, not only to fulfil needs but also a force that is effective and productive in the social domain. The desiring subject communicates an intention with the desire. The question is what effects it has, and what it produces.

Jim Morrison and especially his ideas of fame, a 'flashy' lifestyle, plenty of money, spirits, women and music, were strong leading principles for Vincent. The proceeds of begging, gambling and other business enabled Vincent to live like his model. He could buy drinks and ride in a taxi. This, in turn, gave him the idea that he was 'on the road with Jim'. Vincent told me: 'I think I am the fifth Doors.' This is a remarkable phenomenon. Vincent did exactly what Morrison did. Morrison was not only a 'success model' for young people. Essential components of his life were 'doing dirty', protest, nihilism, anti-materialism and death. It is striking that Vincent fitted almost perfectly in this double Morrison-model. But the dark side of the model, e.g. anti-social behaviour and death, was disregarded in Vincent's discourse. About Morrison's death, he said: *Is he still alive, Morrison? [Therapist: He is dead.] He is dead? But I never found out he is dead! [Therapist: No?] Never. Does it hurt? [Therapist: I don't know, I was never dying.] I don't know whether he is dead or not.*

When the movie on Morrison's life and death was shown in the nearby town, Vincent did not want to see it. When I took a photo of Morrison's grave at Père Lachaise in Paris, he did not want to see it. He said that he disliked 'the ugly images of Morrison', but I believe that seeing Morrison's grave or the film would

mean the end of Vincent's story and thus the end of his life. The most important thing in Morrison's life for Vincent was his glamour and success. Doing dirty, although it is an essential component of the star's life, was not a motivating force for Vincent, but an inevitable necessity. Vincent pointed therefore to the evil of others and the 'logic' of his own behaviour. He did dirty, but by doing so he was confronted with norms and values in his society. His behaviour was not tolerated. Complaints of his family, fights in the town, people making a fool of him and sending him away were the results. Yet, some of the things Vincent did are not uncommon in towns, where people 'celebrate the weekend' or have their parties. Carnivalesque ideas and a 'we-live-just-once' model could be seen. Vincent described this as follows: *They say: We live just once, when they walk around with a big glass of beer. Do you understand that? Who lives once? They say: When we are dead, we rot away, so let us drink! That is not possible. There is maybe a life after life. Incarnation? Rubbish! It is your world. You see so many people and then you may ask yourself: Why are you seeing that? Why are they destroyed like that?*

Vincent connected the carelessness of people, their badness, the evil and the consequent destruction. He contrasted these with the cosmos, the good and infinity: *My life is eternal. […] I don't reincarnate, I disappear. The universe is infinite. Life continues till the entire universe is filled up with cosiness. There is no end to my life.*

Vincent did 'bad things' to be in the 'scene' he despises. This was not simply copying Morrison's life. The proceeds of his 'jobs' guaranteed him not only fulfilling of a personal desire to be Morrison, but also meant (short-term) social relationships. This was the only way Vincent had. Alternative social institutions that could satisfy his social needs were missing. Through his madness and status of psychiatric patient he was marginal and lonely. So, social aspects created the conditions of the force of his models. The forbidden actions Vincent used to attain his goals belonged to these social factors. What he did openly, others did clandestine. He knew this: *I have to tell everything to my wife. Are you mine? [Els: No, I have already someone else. I am not yours, but I am listening. Tell me.] Well, if I tell my wife she falls asleep… [Els: I don't fall asleep. Do you have a friend?] Yes. She is a twin. [Els: Does she live here?] No, I meet her in town. She takes a gin from me and leaves it. Then my money is gone and she does not want anymore. If I had five thousand guilders, she would come with me, she said. She is so beautiful, she is a twin. I want to tell her anything, but she won't listen.*

He almost exactly copied a song of Morrison, i.e. 'The Hitchhiker' (the text is at the beginning of this part). This image suited Vincent. He was wandering about and he always tried to get some money so that he could buy love and a social relationship.

An older but still actual argument of Goffman (1971) in his 'Asylums' on intentionality of mad behaviour is that such behaviour is not so much a result of any violence, but an intentional offence of rules. The behaviour shows sensitivity for those rules. It is a profanation. According to Goffman the behaviour is of interest, because it shows us the common ritual order. In its offence the behaviour shows us rules of which we are hardly aware in our daily lives. Later (1971: 411), Goffman adds: 'In sum, mental symptoms are wilful situational improprieties.' It is not so difficult to see the intentionality of 'mad' acting here. Also the relation with Morrison's wilful offences of culture and social rules and norms is clear. The openness with which Vincent offended cultural norms brought him not only into conflict with people in town, but the offence ridiculed a double moral.

Norms of what people can do in public are ambivalent and ambiguous. This ambivalence and ambiguity offered to Vincent (and other psychotic people as well) different possibilities to withdraw himself from the obligations of 'social regulation' and cultural norms. Vincent's contempt of behaviour of the feasters in town was evoked in others by his own behaviour. Showing his genitals in town was to stage the hidden and secret perversity of people: 'They say I have to.' When Vincent would refuse to do what the drunken people asked, he was punished by abuse. When he did what was asked, because he wanted to earn some money and because people wanted to see his penis, he was punished by his supervisors in the hospital. This was a dilemma for him.

The question is then: who was bizarre? Vincent or the people in town? I would like to stress that I do not claim that Vincent's 'mad' behaviour is a fully conscious act to make people aware of the ambivalent morals and norms and the hidden passions in his society. I argue that desire has three positive intentional dimensions which motivate people to act the way they do. First, there is the intention to satisfy the need to feel well, to be happy or get 'a kick'. This is a personal intention. Second, there is the intention to satisfy social needs, for example to have social contacts or sympathy of others. Third, there is an intention to express displeasure or an awareness of hidden negative aspects of a moral

system within a society. These intentional dimensions are intertwined. For example to express displeasure of negative aspects in a moral system can be of personal worth because it satisfies personal needs for a certain achievement and because 'it represents the "good" self' (D'Andrade 1984: 98).

Desire, resistance and mimesis

In this section I want to explore the intentionality of a desire in relation with the effects of the behaviour that follows from that desire on other people in Vincent's culture. In other words, is desire a 'will-to-power' that has a positive social impact? Is it a political act? Vincent's caricatured mimesis of Morrison and 'wilful situational improprieties' had an enormous impact on social relationships for himself, but did they show the ambiguity of cultural values and norms? In other words, could Vincent be compared with the trickster figure? Vincent's life threw him into conflict with the cultural conceptions of a person, norms of behaviour and social rules, which are in force in the society. These are regulations that somebody is trained and educated to adhere to mainly in childhood. These regulations always enclose resistance, because individuals may differ in the degree to which they are committed to cultural ideas (D'Andrade 1992).* They can reject ideas totally or partially. [* *D'Andrade expands the ideas of Spiro (1987) by adding the motivational force of cultural models to Spiro's concept of internalisation. He writes: 'Spiro has pointed out that all parts of a culture are not held by people in the same way; that cultural propositions vary in the degree to which they are internalized (1987)' (1992: 36). Somewhat before he writes: 'Thus it could be said that the statements generated by cultural models had directive force for some people, that is, had a force which made people obligated to do what the statement said. However, the term "directive force" refers to a specific kind of motivation – the moral or quasi-moral sort, where one feels obligation' (1992: 39)*] Vincent's desire to become Morrison and finally become a cosmic man reflected intentional efforts to dismantle the cultural rhetoric on decency, autonomy, self-reliance, labour, and all other concepts which seem so important nowadays. He showed the 'ridiculous' and arbitrary use of these concepts. It was as if Vincent wanted to say: 'You want me to be mad or to violate norms and rules? I will give you want you want.' He did this by well-known mechanisms in our culture, i.e. 'desire', 'mimesis', 'identification'. The mime had the same effect as that of a clown.

Jim Morrison
(Graffiti Rosario)

The people in the centre of the city laughed and challenged him to behave 'crazier'. Two issues are important. First, the issue of flexibility and constraints of cultural ideas. Second, the related issue of power. Obviously, notions of what is, what can be and what must be done have thresholds. On the one hand there are infinite possibilities for people to explain themselves. The flexibility, or pandemonium as Gergen (1985) names it, is not as infinite as it sometimes seems to be in a post-modern society. When Vincent said 'I am Morrison' or 'I want to be a cosmic man', the social impact and force was large, but only because of the irony, 'exaggeration' and impossibility of what he did. We cannot gather information about the irony in Vincent's life from his texts as they are presented above. We canderive his ironical attitude from the tone in which he talked and from the rhythm of his behaviour. His stories were sometimes told in a Rabelian way.

They are of grotesque realism, using vulgarisms, puns, mockeries and benignant fabrications. His behaviour was also ironic. I happened to be a victim once of his way of begging. To illustrate this I quote a fragment from my diary: *There comes Vincent! His red hair flickers as a warning signal in the sun. Without knowing why, I feel something is going to happen.'Hey!', Vincent shouts. With his long thin legs he rushes at me, his hand held out. He laughs. 'How are you? What are you going to do?', he asks, while shaking my hand. 'I am going to work, Vincent.' 'Work? What work? Are you going to tell stories about the hospital?' 'Yes, I will.' 'That's great, that's very great. Are you doing this alone?' 'Yes, I do it alone.' Vincent tilts his feet. He gets a deep breath and then: 'Hey, do you have something for me? For buying a bottle of lemonade? You gave me something lately, but that is gone. It does not matter what: nickels, dimes. I pay you back, I pay you. I will tell you another story. I pay you back. Please?' Vincent held his hand. 'I am so thirsty, girl!' [To make a longer story a little shorter, I gave him some money.] 'I pay you back! Did you note down the dates of the coins?' Vincent*

comes very close to me and smiles. I can smell his body and see his brown teeth. 'Thanks, I pay you back!' Then he disappears to the café.

I have to admit that this encounter gave me mixed feelings. On the one hand I felt rather defenceless against Vincent's charms. I felt as if I had to laugh, which I did indeed. To note down the dates of the coins was ridiculous. On the other hand, I felt repelled by unwashed flesh and I also was embarrassed, because I did not like to be forced to give him money. The stories and behaviour of psychotic people are tragic and comic. Psychotic people amuse, but they are also accusing. The tragedy, which summons compassion of others, guards them from total rejection.

This resembles the reactions people have for the behaviour of the trickster. The effects of his behaviour may be compared to 'the drastic entertainment' of the tricksters' stories (Kerenyi 1972). Stories of such grotesque realism, imaginations or fabrications are mostly only permitted in childhood, in our silent thoughts, in a cabaret or as an artist. What Vincent did and said had to stay behind the curtains of the public stage. His madness offered him a possibility to resist cultural values and norms, or to challenge them. Desire became a 'political' process. In the story of Morrison and the cosmic man Vincent presented himself as a caricature of the ideal of a totally free man. This was an ideal that developed out of the youth culture in the seventies and seems to be accepted as normal in the nineties. He pointed to the 'good' and the 'evil' and their ambivalent character. He pointed for example to drinking and gambling, which belong to evil things in popular cultural ideas, but which are at the same time permitted during an evening out. With irony and caricature the psychotic man or woman is accusing: he or she points to and makes a mockery of cultural values and norms.

However, we have to be careful to take this resistance and protest as political acts that undercut power and ambiguity. We can learn from feminist studies on disease that hold that resistance and protest against gender domination do not undercut existing power relations, but are utilised in the maintenance and reproduction of these relations (Jaggar and Bordo 1992). For example, a study on eating disorders shows that transformations of meaning 'through which conditions that are "objectively" (and experientially) constraining, enslaving, and even murderous, come to be experienced as liberating, transforming, and life-giving' (Bordo 1992). The transformations appear to be non-liberating; they reproduce the existing models of femininity. How is this in the case of psychotic people, whose ideas are dominated by the culturally accepted ideas? Vincent's

protest and caricature appeared to be counterproductive. The symptoms of chronic psychotic diseases weaken people and turn the lives of patients into an all-absorbing desire. Because psychotic people are wedded to an obsessive desire, they are unable to make an effective change in their lives when others are not willing to acknowledge the social meaning of psychotic language. Vincent remained the 'reproducer' of the dependent person of the psychiatric in-patient. Employing the language of the moral through his own psychotic 'language' involved the ambiguity of that moral and suited perfectly the dilemmas of a culture's mores, but everything remained in its place because Vincent's language reproduced, rather than transforming what was protested and mocked. The fact that the psychotic world has been taken as the 'unreal' world during the history of psychiatry in spite of attempts within psychiatry to give this world its meaning, is significant. Psychotic symptoms and pathology as potential means for resistance and protest serve in the maintenance of established and generally accepted cultural order. How can Vincent's desire become implicated in the cultural order?

D'Andrade claims that the standard analysis ignores what organises the desires. Desires are not simple things in themselves or motives independent of culture. D'Andrade claims that desires are 'conscious interpretations of goals activated by other cultural schemas' (1992: 55), and he agrees with the claim of the standard analysis that 'idiosyncratic and cultural schemas (or models) are organised in complex hierarchies'. Which schema is at the top of a person's interpretative system, varies. Top-level models are 'master motives' and contain the most general goals. For Vincent these were things like success, happiness, and standstill.

Further down in his hierarchy of models there were things like money, social contacts, drinking, women, etcetera. According to D'Andrade there are two empirical issues involved. First, it is not clear how the notion of 'directive force' should be used. D'Andrade proposes a psychological description by organising the data around cultural models which have the greatest directive force. Second, which factors cause cultural models to be internalised? For example why did the cultural model of success affect Vincent so deeply, while others of his generation are not so much attracted by it? D'Andrade gives us a part of the answer. It is because others have already learned other models, which interfere with the success model. The author concludes: Each individual's life history can be viewed as the building of new schematic organizations through processes of

accommodating to experience and assimilating these experiences to previous schematic organizations. The final result is a complex layering and interpenetration of cultural and idiosyncratic schemas which always contains some degree of conflict (1992: 56).

D'Andrade's conclusion is valuable for Vincent's story. However, there is a mechanism involved, that Girard calls mimesis. This mechanism is related to the directive force and internalisation of models and has to do with the maintenance of a model despite the evidence that desires will never be fulfilled. This is what has happened in Vincent's life. Vincent was an adolescent in a critical historical period. It is suggested that the rivalry between youths and adults in western societies during the seventies was uniquely critical. The young were profoundly alienated from the parental generation. Two main forms of dissent were important in that time: the radicalism of European youths with significant social criticism,and an American experimental and flexible dissent from what Roszak called 'the technocracy' (1970: 4). Although the European radicalism was closer to the front door of the Netherlands, it limits itself to the intellectual young people at the universities. It seems that the experimental dissent had a greater impact on the young outside the universities in the Netherlands. Vincent was one of the latter. Flower power, hippy culture or pop culture flourished well with the youth. It offered them the impression of full freedom, with no binding loyalties, no personal attachments, no home, no family, no obligations, no authority. What Vincent, and many others with him, did not see was that the propagated 'leisure' of sunny beaches, luxurious hotels, big cars, cool drinks and drugs were adjuncts of the jet set and high income class, not of underpaid waiters in a small restaurant. Vincent was confronted with and opposing a 'technocratic society' which equipped the young with an 'anaemic superego', made possible by unrestricted pursuit of profit, commercialising and permissive education. Withdrawing from the family and becoming a beggar or a gambler for example was a formidable gesture of protest.

The culture of permissiveness ill prepared the young for life. Adolescence was no longer a passage to adulthood, but 'a status on its own and a prolongation of permissive infancy' (Roszak 1970: 32). Vincent demonstrated awareness of this status of the adolescence period, when he said: *At that time I could not care for myself. […] You are only an adult when you are forty. […] I am not a psychiatric patient. I stayed in the hospital because I got lessons, perhaps for becoming an*

adult.

Such a permissive culture as in the seventies smothered protest by saturation coverage. Strictly speaking, it was not the parental default, but the social conditions which caused problems. The counterculture of the seventies was not simply an expression of protest or cultural renewal. The essence of this culture was, as it is with all countercultures, to aggravate contradictions and conflicts which already existed (Abma 1990). These contradictions and conflicts were social conditions. One of these conditions was not the lack of models for mimesis, but the lack of someone in that time who told, for example, the adolescent Vincent that on the one hand, his identification with Morrison could be beneficial and rewarding sometimes, but, on the other hand, it could not continue life long. When he was young his fantasy was nourished by the indulgence of the parents of his friends and his mother. When he grew up he was left too long without restrictions. He did not adjust to prescribed patterns of an adult man. He continued to assert pleasure, freedom and doing dirty, just like Morrison. Originally developed as a resistance against authority and society, Vincent's model came to dominate his entire life.

It came to belong to his passions and it shows the magic of culture. His mimesis presented itself as a caricature of the ideal of a totally free man – a cosmic man – an ideal that developed in the seventies and seems to have a climax in the nineties' hyper individualism. Apparently, the model of freedom and standstill had not lost its force. On the contrary, Vincent mimed Morrison as much as he could. He was so fascinated by his model that he was warming up to it. Morrison was the embodiment of all 'master models' and the models lower in the hierarchy. The pop star became over the years Vincent's 'master's voice'. The mechanism that lied behind the exceptional manifestation of mimesis was that Vincent's being was no longer defined by a place in society. Motivation was stirred up instead of decreased (Girard 1978) and desire increased at the expense of differentiation between the model and Vincent. Being mad was being mesmerised by the models of desire. However, it is not fully correct to ascribe the mesmerising totally to Vincent's madness. It is also not fully correct to see Vincent as a scapegoat. Through intentional behaviour Vincent showed the conflict, rivalry and undermining of the cultural order which were joined together.

Vincent's behaviour did not transform the cultural ideas about a person or the cultural ideas of good and evil. On the contrary, it strengthened the cultural

models of madness. The ‘solutions’ offered by psychotic language, too excessively uttered, lead to their own undoing. Vincent remained a ‘docile body’ (Foucault 1979). He remained a locus of social control; a psychiatric inmate.

In conclusion

If Vincent’s story is perceived as a ‘fleur du mal’ and a fantasy, how is it related to his life? Normally, lives are storied. What keeps the stories from being odd is that they summarise and justify the work from which they arose, and that they do not become identical with the teller’s desire or motives. But, this is precisely what happens in odd stories: the lives are not storied, but the stories are lived. They are identical with the tellers.

Crazy people are disempowered by the fact that their story is perceived as odd and personal. The problem with odd stories is that they are very attractive for normal people. We suspect ‘deep meaning’ in them. This becomes clear in the literature on art and madness. In this literature it is assumed that madness enables a person to get access to the deeper domains of creation and ontology. Good examples are studies of Nietsche and Van Gogh, and many other artists. Crazy people are ‘createurs bruts’, who have access to an original pre-cultural world, which serves as a source of creativity. I do not want to argue that every crazy man or woman is an artist, but I agree with the opinion that crazy people are ontologists: they are engaged in a new way of experiencing fundamental categories, in experiencing new frames from which reality can be described and experienced. Craziness is thus a new way of experiencing, like art. But it is an involuntary way, sometimes fearful and certainly not comfortable. Mad people do not invent a new culture or a new frame. They unbolt normative frames and inverse the rules of social relationships.

Their stories and lives have sensational and shocking attributes and therefore they resemble the trickster. But, everything in the world has a deep meaning and that drives them crazy. Mad people test possible worlds in their stories to see if they are endurable. Their stories *must* come to life because it is often the only way to contact the social world. But the openness with which Vincent and the others offend cultural frames (values and norms) brings them into conflict and ridicules a double morality and the arbitrariness of the frames. Cultural norms of what people can do in public are fully alive to ambiguity and ambivalence.

One does not show his penis in public, but when one is drunk on a Saturday night, one asks someone else to show the willy. Vincent and his story are at the core of our culture. We witness the interplay of emotions and cognition, of rationality and irrationality, of calculation and raging passions, of morality and immorality. It is a struggle to fight the magic power of culture. Vincent's story is a sad one and he knows it. When the story comes to an end, his life will end too. His denial of Morrison's death has to be understood as his will to survive. But what will happen when he becomes old?

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In Memoriam

Els van Dongen (1946-2009)

By Sjaak van der Geest

In the evening of 4th February 2009, Els van Dongen, anthropologist, colleague and editor of this journal, died at the age of 62. Her death came after a long and painful sickness, a period of hope and desperation, of gratefulness for a rich life mixed with stubborn resistance to the unfairness of that same life.

Els was a gifted anthropologist and an unusual colleague. Students loved her teaching, original, sharp, concerned and full of entertainment. Colleagues admired her for her unbridled energy and productivity and her many talents. She was fast in everything she undertook and impatient if things went too slowly. She deeply disliked bureaucracy and its meetings.

Her anthropological life started late, at the age of 35. She first trained as primary school teacher, during which time she met her husband Leo Hulshof. From 1968 till 1978 she taught in two primary schools in the proximity of their beautiful house in the rural south of the Netherlands, near the Belgian border. In 1978 she decided to study geography. During that course she discovered anthropology, which she liked instantly.

In 1982 she decided to join the new part-time evening course anthropology at the University of Utrecht. She combined the role of student with the care of her

family. She completed her master's 'cum laude' in 1988 with a thesis on the semiotic approach in the study of illness [1988].

Six years later, in 1994, she defended her PhD thesis based on conversations with psychotic people in a psychiatric hospital. The title of her thesis 'Zwervers, knutselaars, strategen' (Tramps, handymen, strategists) betrayed her aversion to psychiatric labels: She regarded the people she met in her research first of all as people out of tune with the 'normal' society, but gifted with extraordinary skills and ideas. I am sure that she experienced 'kinship' with them in their common 'unusualness'. Provocative also was the quote from John L. Caughey that she chose as device for her book: "'Schizophrenic' is perhaps best kept in its traditional sense, as a pejorative label for deviants whose visions we do not like." A few years later she would write that 'madness' showed: "that otherness is present in all of us.The otherness we fear"

In her book, which ten years later was published in a slightly revised English version, she sought to describe and understand how psychiatric patients experienced their world. She did so from the patient's point of view, focusing on the fears and hopes that characterise the life in a clinical mental ward. Dilemmas in that life are: How to express subjectivity in an atmosphere designed to restrain demonstrative emotion? And how to maintain personal integrity in a completely ordered regime? She portrayed the psychiatric patients as 'wanderers' – homeless people, as it were – in an alien and hostile country, creating a 'bricolage' reality from materials at hand. Although she often positioned the therapists and psychiatrists as representatives of an oppressive regime, she did not doubt their integrity either.

In 1996 she joined the staff of the Medical Anthropology Unit at the University of Amsterdam and began to play her key-role as teacher and researcher in our team. She taught both general courses in anthropology and specific medical anthropology modules on themes such as 'anthropology and psychiatry', 'anthropology and chronic illness' and 'medical anthropological ethnography in Europe'.

She published a collection of six narratives by people she met in the closed wards of the mental hospital during her PhD research. The personal stories are alternated by her observations and comments. The book, she wrote in her prologue, was her debt to these people: "I became indebted because the people

shared with me what they had: their stories and (part of) their lives” .

A little further she reflects: “When I went into the hospital, my aim was to study how people deal with mental illness and how mental illness could be understood from the perspective of the people themselves. Now I must admit that madness taught me more about the power of culture and the power of people than about madness” .

The power of culture… In 2000 she co-edited a volume with contributions about the way Europe treated migrants in need of health care. A central theme in that volume is exclusion. It proved a recurrent theme in all her work: exclusion and marginalization of ‘others’, such as psychiatric patients, migrant, refugees, victims of violence and older people.

When she turned her attention to older people in South Africa, she came home with touching stories about the beauty and warmth of old age but also with horrifying data of older people being abused and maltreated by their own children and grandchildren. In one article she spoke of ‘social gerontocide’. Invisible dramas unfold in poor households where the young generation despise and reject their older relatives for their passive role in the Apartheid era and try to ‘kill’ them socially. But, she stressed, the older people are not helpless victims. They fight back and develop strategies to survive.

Research among older people drew her attention to remembrance. Being old consists of having many memories. Rejecting or silencing those memories, however, implies a rejection of the older people themselves. “It is almost as if the past never happened,” one person tells her. In one of her last published articles she quotes a common saying of the young silencing the old: “That was your time… This time is ours!” In other words: Shut up. The ‘culture of silence’ in which they were forced to live during Apartheid is thus prolonged into the post-Apartheid era. That awareness of muted memories inspired her and Monica Ferreira, with whom she collaborated throughout the South Africa years, to bring out a collection of ‘untold stories’ to give voice to the lives of older people in the new South African society.

Her last major publications were two edited books, one about lying and concealment in medical settings and one about distance and proximity during illness. The former, co-edited with her long-time friend and colleague Sylvie

Fainzang, argued that lying is a way of dealing with major crises that people encounter, particularly during illness. The theme connects with ideas she has been airing from the very beginning: health problems are not only about health; they are linked to shame, exclusion, suffering and social violence. Lying in such circumstances may be the most effective medicine to restore the damage. But lying is mutual; those with power in medical contexts may exploit the lie as well, to maintain their position in the medical hegemony.

Facing distress, co-edited with Ruth Kutalek, brought together papers of a conference of the European Association of Social Anthropology in Vienna. Distance and proximity constitute the ambiguity of the illness experience. On the one hand, illness leads to loss of independence and need of help and care by others; on the other hand, illness makes one lonely as it isolates the patient from normal social encounters and may scare others away. The pain of the sick body will thus be aggravated or replaced by the distress of ostracism.

In 1998 Els and I organized the first conference on 'Medical Anthropology at Home' (MAAH). For Els doing fieldwork 'at home' was a personal experience. For about ten years she had been doing research 'around the corner' in a psychiatric hospital. For me, it was – and remained – mainly a dream. For both of us it was an attempt to contribute to the de-exoticisation of (medical) anthropology. The theme and format (small-scale / intensive discussions) proved successful and since 1998 the MAAH conference has been held every second year, in The Netherlands, Spain, Italy, Finland and Denmark. Els, Sylvie Fainzang and Josep Comelles, became the driving forces. Els co-edited two voluminous special issues with conference proceedings and remained active as long as she could. She wrote a paper for the last conference in Denmark focusing on her personal sickness and suffering, but was unable to present it. We discussed her moving self-reflection in her absence.

In 1990 Els published her first article in Medische Antropologie. She described the social meaning of medicines in the psychiatric ward where she did her research. The medicines, she wrote, had a binding as well as an oppressive effect in the interaction between patients and staff. Relations between these two parties had the character of a combat in which medicines (taken or refused) replaced words. The article became a key-text in our work on 'pharmaceutical anthropology'.

In 1994 she helped as guest editor to make a special issue about Zintuigen (The Senses) and in that same year she joined the team of editors. She kept that position till the end of her life. Medische Antropologie has been the main outlet for her ideas on health, culture and violence, certainly in the first decade of her career. She wrote eighteen articles and comments and an uncounted number of book reviews for this journal and (co-)edited five special issues on 'the senses', 'older people, wellbeing and care', 'shit, culture and well-being', 'medical technology and the body' and 'violence and human rights'. We, the editors, will miss her fast and sharp judgment in the evaluation of manuscripts, her invaluable editorial suggestions to the authors and her cheerful directness during our discussions.

Another journal favourite journal for her was Anthropology & Medicine, in which she published about the creation of cultural difference, lying and illness, and bodywork in nursing.

From the beginning in 1994 she has also been one of the editors of the book series 'Health, Culture and Society' which has brought out sixteen titles so far.

Els was a person with many talents. She took lessons in drawing and painting and produced beautiful canvasses with symbolic objects and portraits of relatives, friends, and people she met during fieldwork. Many of her productions can still be viewed on her website. She was also a filmmaker and photographer. The topics she chose for her photographs and films were sometimes from her anthropological research but often focused also on other things such as nature, everyday life and unexpected details such as the movements of hands during a conference.

Els has lived a very full life and accomplished more than most of us will be able to achieve in a life twice as long as hers. Even so, she was not always a happy scholar, perhaps feeling that her close colleagues did not fully understand or appreciate what she was doing. Close colleagues are sometimes more distant than those who are far away. Nevertheless, in this space, she carried on with her own strong and positive energy, becoming a popular guest lecturer in universities abroad and serving on various international scientific committees. When her sickness grew more serious, about two months before her death, we decided to make a book of friends for her. Thirtyeight people, colleagues from Amsterdam, from other Dutch universities and from abroad, plus students and friends

contributed brief essays (and one poem) that dealt with the themes that had been prominent during her academic life. They focused on people who are excluded or marginalised, because of their age, their illness, their 'madness' or because they are living in violent circumstances. Other contributions were about people who are oppressed because they do not fit in the dominant discourse: people with HIV/AIDS, victims of (sexual) violence, refugees and migrants.

The title of the book 'Theory and Action', was the name of a famous core module that Els taught in the Master's of Medical Anthropology and Sociology. In one of her papers she stressed that theory and action are closely connected in medical anthropology. "Theory helps us to bear our ignorance of facts," she quoted George Santayana. Facts, she continued, acquire their meaning from what people do to them, in this case anthropologists and the people they are working with. Theory provides a way of finding pertinent meanings and making intelligent interpretations that open the door to relevant action. She then cited the famous line from Kurt Lewin that there is nothing so practical as a good theory. A good theory is practical because it enhances understanding and produces the questions that really matter in medical anthropological research. In her module, Els discussed with the students that problems of ill-health and suffering should be regarded in their historical, political and economic contexts and how larger social and political forces shape relations and actions and cultural imagination at the local level. The necessary – but often difficult – cooperation between anthropology and health workers received special attention. Questions that were addressed during the course included: Why do we need theory? Which theories are relevant? How can we link macro, meso en micro theories with practical work?

'Theory and Action' constitutes both medical anthropology's ambition and its weakness. The frequent criticism that medical anthropology receives from those who work in the heat of the day confirms that, unfortunately, much academic work remains largely or totally useless to 'actors' in health care. Nearly every contributor in the book struggled in one way or the other with this dilemma and with the challenge of proving the practical relevance of theory.

When her condition became critical, we decided to tell her about the book and gave her the list of authors and the titles of their contributions. She was overwhelmed and deeply moved when she saw the list of so many friends. She gave us one of her paintings for the cover of the book and allowed us to include one of her last essays that dealt with her own illness and the way people express

their connectedness in times of suffering and uncertainty. Four weeks later we brought the book. I held a short speech and she responded directly and with humour. She was almost too weak to open the paper wrapped around the book. We drank a glass of wine and had a lovely lunch while she observed us from the sofa. She read the essays and reacted personally to many of the authors. Ten days later she died. On the 9th February we said farewell to her in a ceremony full of music and words of comfort.

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