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► **To cite this version:**

Baudouin Dupret, Louis Quéré. Error, Aberration, and Abnormality: Mental Disturbance as a Shift in Frameworks of Relevance. *Human Studies*, 2014, 38, pp.309-330. hal-02160961

HAL Id: hal-02160961

<https://hal.science/hal-02160961>

Submitted on 30 Sep 2019

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Error, aberration and abnormality: Mental disturbance as a shift in frameworks of relevance

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What leads us to deal with someone's "strange" behavior as though it is the result of mental disturbance rather than error or extravagant beliefs? There are no doubt cases where the difference is clear, and others where uncertainty prevails, in the absence of sufficient or incontrovertible evidence. But in general, in our ordinary life, we manage to make the difference. How do we do so, and against what background? What does context contribute?

Further, there are specialized contexts for evaluating whether certain types of behavior or discourse are normal or abnormal: courts of law and psychiatric hospitals are two examples, among others, of such contexts. Contrary to what happens in everyday life, judgments in these contexts are formed against a background of technical or scientific knowledge. At the same time, they result from epistemic means of evaluation – we could call these ethnomethods – that are extremely similar to those we habitually resort to.

We would like to highlight this similarity with respect to recognizing mental disturbance. We will start from the way Ludwig Wittgenstein attempted to apply a distinction, in *On Certainty*, between error and mental disturbance. We will attempt to extend it by drawing on notions of reciprocal perspectives, as developed by Alfred Schutz, and of judgments of incongruity, as developed by Harold Garfinkel. We will then document our investigation by analyzing sequences from Malek Bensmail's documentary, *Alienations*, which examines the treatment of mental suffering in contemporary Algeria¹.

Wittgenstein: error and mental disturbance

In *On Certainty*, a work devoted to reflections on doubt and certainty, knowledge and error, beliefs and their foundations, etc., Wittgenstein attempted to elucidate

what leads us, as “ordinary men,” to explain someone’s behavior by referring to mental disturbance rather than mere error:

71. If my friend were to imagine one day that he had been living for a long time past in such and such a place, etc., I should not call this a *mistake*, but rather a mental disturbance, perhaps a transient one.

72. Not every false belief of this sort is a mistake

73. But what is the difference between mistake and mental disturbance? Or what is the difference between my treating it as a mistake and my treating it as mental disturbance?

74. Can we say: a *mistake* doesn’t only have a cause, it also has a ground? i.e., roughly: when someone makes a mistake, this can be fitted into what he knows aright.

75. Would this be correct: If I merely believed wrongly that there is a table here in front of me, this might still be a mistake; but if I believe wrongly that I have seen this table, or one like it, every day for several months past, and have regularly used it, that isn’t a mistake? (Wittgenstein, 1969-75)

We may make several remarks regarding these reflections. The first, relative to the inflection introduced in paragraph 73, provides the motive for our investigation: the point is not to characterize two types of false belief on their own terms, but to distinguish them on the basis of the reaction or behavioral response that each one evokes. This is how we should interpret Wittgenstein’s correction of his initial formulation: “... *my treating it as a mistake [or] as mental disturbance*” (emphasis ours). The difference, and thus the characteristics, of both types are manifested through the form of behavior adopted or the way one carries on, probably because one grasps a situation, an event, or a behavior only through what it does, what it causes people to do, and how it does so.

When something is perceived as an error, one’s reaction is to attempt to correct it. An error is something that can be recognized by its author or by an observer, because it has a ground (*ibid.*: §74), which can be explained, or “for which, as it were, a place is prepared in the game”) (*ibid.*: §647). It is because one knows (or learns) the correct way of believing, doing, or saying, against a backdrop of belief, knowledge, and practice, that one can take responsibility for errors or mistakes, attribute them to others, and cause them to recognize these errors. Anyone who possesses knowledge or has mastered a certain number of techniques (according to

public criteria) can spot an error; and errors can be corrected, by using ordinary procedures for control and revision. Corrective practices, which draw attention to errors in order to make it possible to avoid them, are among the normative activities of our way of life.

At this point, we may point out that errors are not restricted to the domain of exactitude, but also extend to the domain of appropriateness. We can make mistakes of calculation or grammar, but also errors in judgment. The criterion for this second type of error results from the idea of “that which can’t be done” in a certain situation or a certain cultural and social context. In this regard, we might speak of a horizon of normality. The norm here may generally be perceived through its absence, at the moment when reasonable expectations are violated, during a disruptive experience that requires reparation of one kind or another (Garfinkel, 1967). Often, this consists of recognizing one’s judgment error or pointing out circumstances that justify the existence of a dislocation in perception or practice (Pollner, 1987). This is the case, for example, if one has reacted badly to a humorous remark because one took it seriously: one will recognize that one misunderstood and was wrong to get angry. Taking background expectations for granted and fulfilling them – in other words, giving credit to mores, ways of doing, and beliefs held to be legitimate, and taking them as grounds for inference and action without examining them – is what allows people to recognize their actions, beliefs, feelings, and aspirations as intelligible, normal, reasonable, etc. If we suspend the operative nature of these background expectations, we are forced to “normalize” the resulting incongruities to allow experience to organize itself on the basis of social routines.

From all the case studies in the literature, it emerges that error is located, as far as praxeology is concerned, in the trial by inexactitude or inappropriateness of the implementation of a rule (in the broad sense). It intervenes in the course of applying a rule, understood as an instructed action that is composed of an utterance and an implementation (Livingston, 1995). Error is the incongruity that slips between the first part (utterance) and the second (implementation). It exists only insofar as it is spotted and noted through (self-)criticism. It can be repaired or corrected:

correction is to error what an answer is to a question. At the same time, an error does not invoke the question of whether its author shares the same world as the one who identified the error. The implicit principle of reciprocity of perspectives (Schütz) is not flouted. In cases where implementation of the rule is incorrect or inadequate, there is no doubt that it constitutes an attempt to implement that rule. A failure to understand the rule (or lack of attention, etc.) can lead to the inability to apply it as it should be applied, but there is no doubt that we are speaking of the same form of life, the same world, and the same language.

The same may not be said of mental disturbance, which results more from a failure in the reciprocity of perspectives than from an incorrect answer. Error does not break reciprocity; disturbance does. Disturbance does not locate a reply in the same order of ideas as the question; it reveals a dislocation between worlds. One can draw attention to an error in judgment by pointing out that, in a shared world, the reply is inappropriate in relation to what might have been expected. In contrast, one may observe mental disturbance when the reply is massively irrelevant to the question, when the reply is so inappropriate that it is impossible to correct it, and when the dislocation is not a question of degree but of nature.

Observing mental disturbance constitutes a different type of response from that elicited by identifying an error. How so? In the initial approach, attributing mental disturbance can be a way of “normalizing” a form of behavior that appears unintelligible due to the incoherence of actions and words – a sort of dislocation between two forms of life.

If someone supposed that *all* our calculations were uncertain and that we could rely on none of them (justifying himself by saying that mistakes are always possible) perhaps we would say he was crazy. But can we say he is in error? Does he not just react differently? We rely on calculations, he doesn't; we are sure, he isn't (Wittgenstein, 1969-75: § 217).

In both cases, there is a gap. In the case of an error, there is a gap between what occurs and what one knows to be “correct” or “appropriate.” In the case of mental disturbance, as mentioned in the quote, the gap exists relative to a shared way of

reacting, an attitude anyone might adopt, which consists of not doubting more than is reasonable or logically possible, of not doubting things outside the appropriate circumstances, of not questioning certain truths, or of not extending unfounded doubt to that which normally escapes it. The second type of gap can have important repercussions. Thus, in the case of someone who doubts his own name, “there is no judgment I could be certain of if I started doubting about that” (*Ibid.*: § 490).

Extending doubt beyond what is reasonable can make it impossible to act, because, in order for action to be possible, it is important to rely on certainties that are accepted without question: “Why do I not satisfy myself that I have two feet when I want to get up from a chair? There is no why. I simply don’t. This is how I act”) (*Ibid.*: §148).

Judging that behavior is bizarre or abnormal relies heavily on what is seen as contextually inappropriate:

I am sitting with a philosopher in the garden; he says again and again “I know that that’s a tree”, pointing to a tree that is near us. Someone else arrives and hears this, and I tell him: “this fellow isn’t insane. We are only doing philosophy” (*Ibid.*: §467)

This example portrays behavior that an observer would spontaneously classify as resulting from mental disturbance, were that observer to have no knowledge of the activity being undertaken. It shows that it is possible to locate a gesture that seems strange at first sight within a descriptive context that renders it plausible, normal, and therefore intelligible.

Is it possible to find such a context for someone who believes that, every day for months, he has seen and constantly used a purely imaginary table? One might imagine this being part of a performance or a simulation. But it seems more difficult in the seriousness of everyday life. One might plausibly be led to deal with such a belief not as an error of perception, or as a false or extravagant belief, but rather as delirium, manifesting an important break: a possible change of the world; or a loss of the foundations for the sense of the world that we share with others. Someone professing such a delirious belief lives in a world whose ontology cannot be shared by just anyone, in large part because he has disconnected himself from our habitual ways of perceiving, thinking, judging, and acting; in sum, from the

“community’s standards” (Soles, 1982). This is certainly why it is pointless to draw his attention to his delirious belief in a bid to dissuade him from it.

Community standards are relatively vague if we are required to define them a priori, but it is easy to locate instances when they are violated.

“In certain circumstances a man cannot make a *mistake* (...). If Moore were to pronounce the opposite of those propositions which he declares certain [‘I have two hands’...], we should not just not share his opinion: we should regard him as demented” (Wittgenstein, 1969-75: §155).

It would therefore be impossible to attribute such words or behavior to an error or a difference in perception. Why? On one hand, because one cannot make a mistake when there is no point in speaking of knowledge, or when doubt does not seem reasonable. On the other hand, because when we are faced with someone who extends doubt beyond reason, and attempts to prove that his doubt is justified, we will refuse – in ordinary circumstances – to accept what he presents as evidence.

Note that the categories “mentally disturbed,” “mad,” or “demented” that appear in the quotes are very general, and can refer to very different cases and mental perturbations that are widely divergent in nature. Wittgenstein’s examples, which are situated in a series of reflections on questions of knowledge, doubt and certainty, ways of judging, the nature of objective beliefs, and the absence of ultimate grounds for these beliefs all refer to a certain type of capability – let us call them cognitive capabilities. The forms of mental disturbance that are evoked therefore concern mainly transgressions of the limits of meaning, and especially of publicly shared meaning, as well as departures from or transgressions of the certainties that serve a pivotal function in human activity. They do not relate, for example, to alterations in emotional behavior or affective disturbances, not to mention the whole set of psychic problems. Finally, note that the point here is not to look for causes for errors or disorders, but rather to point out the limits – which continually fluctuate, yet remain quite clear (if not precise) – that mark out what makes sense.

Every day, we meet people who strike us as having extravagant or aberrant beliefs (for instance, regarding the origin of humans or the universe, or the reason for the existence of a given phenomenon). Yet we do not treat them as though they were mentally disturbed. Why

not? First, because they do not extend doubt beyond the realm of what is reasonable: their doubt is still “one of the doubts in our game” (*ibid.*: §317). Second, their beliefs offer relatively simple answers to complex questions, when elucidating those questions would require advanced knowledge. Finally, when they act, they continue to take common-sense knowledge -- the familiar environment, of which knowledge is shared with others, or background expectations that constitute what Schütz and Garfinkel call “the daily life attitude” – as the basis for inference and action, as we do. Their aberrant beliefs remain isolated in the mass of their practical certainties, because they do not challenge those certainties overall. In sum, we continue to live in the same world and share our forms of life, despite this extravagance.

Still, it is not enough to invoke an infraction to “community standards” in order to qualify a type of behavior as resulting from mental disturbance. Some beliefs can appear aberrant because they fail to respect shared standards of coherence and rationality, or bizarre because they result from a different world-view, but it is still not possible to attribute them to madness. On the other hand, in a group, we can consider someone to be mentally disturbed if he believes things to be possible when, by common agreement, there are not; if he makes no distinction between what is possible and what can be imagined, and takes his imagination as a basis for action; or if his actions transgress hinge certainties of human behavior (Moyal-Sharrock, 2007). This is what would happen if someone acted on the basis of the certainty that humans could fly, that cars grow from the earth like plants, or that someone else’s thoughts could be implanted in his brain.

Doubt may also arise over a partner’s mental health in a case where his or her statements formulate the hinges of our linguistic activities and games, with no particular reason or outside a relevant context. This is the case of the forester imagined by Wittgenstein (1969-75: §353):

If a forester goes into a wood with his men and says “*This* tree has got to be cut down, and *this* one and *this* one” – what if he then observes “I *know* that that’s a tree”

Danièle Moyal-Sharrock sheds light on the status of such a hinge certainty. The certainty that ‘this is a tree’ inevitably underlies the actions of the forester and his

workers; but it does not need to be spoken out loud; it is manifested practically in the normal transactions that constitute this activity. To formulate it as knowledge or certainty, in the absence of any particular reason, is to transgress the limits of meaning and to block activity.

To *say* a hinge in an ordinary context is to suggest that it does not *go without saying*, that it needs support, grounding, context. To say a hinge within the language-game invariably *arrests* the game, produce a caesura, a hiatus in the game.(...) Our foundational certainty is operative only *in action*, not in words. (...) Hinges can manifest themselves only *in* what we say and do” (Moyal-Sharrock, 2007: 95-97)

An individual can cross the boundaries of meaning not only by formulating that which goes without saying, but also by transgressing or casting doubt – with actions and not only words – on commonly accepted hinge certainties, which Moyal-Sharrock refers to as “universal hinges” (for example, “human beings cannot fly unaided;” “someone else’s thoughts can’t be inserted into my mind.”). To found one’s actions on challenging such certainties is to behave in a pathological manner: “There is no *normal* transgression of a universal hinge” (*Ibid.*: 176).

Practices of accommodation, practices of remediation

What types of reactions occur when one is faced with mental disturbance? We find some answers in sociological works on mental problems (although an examination of this diverse and varied body of work is not possible in the framework of the present article). “Accommodation practices” (Lynch, 1983) are part of the ordinary behavior one is led to adopt when interacting with a person who manifests mental disturbance. These consist of the sum of procedures or techniques (avoiding, cutting short or diverting conversation, making allowances and using tact to prevent the emergence of situations that cannot be controlled, etc.) that people use, in everyday life, to manage interactions with people who seem like to cause trouble, “because there’s something not right about them.” These practices aim to confer a semblance of normality on an interaction with somebody who can no longer be credited with the ability to honor the expectations one might reasonably formulate of anyone:

The individual is relied upon both in commonsense reasoning and social theory as a source of compliance with the standards of the larger society. The normal individual successfully adapts to the constraints imposed by social structure. Troublemakers were viewed as persons who, for various reasons, could not be given full *responsibility* for maintaining normality. Instead, the burden of maintaining the individual's normal behavior and appearance was taken up by others. Troublemakers were not overtly sanctioned; instead, they were shaped and guided through the superficial performances of ordinary action. Their integration into society was not a cumulative mastery learned "from inside"; it was a constant project executed by others from the "outside" (Lynch, 1983: 161).

These accommodation practices are also present in psychiatric work, whether in interactions between physician and patient, or in the global treatment of the mentally ill in institutions. In particular, they may be found in psychiatric tests and caregiving, where prudence, discretion, and tact are predominant, with the aim of preventing emotional outbursts, uncontrollable impulses, or violent reactions. Jörg Bergman (1992) emphasizes this point with regard to psychiatric interviews, which are often characterized by an indirect mode of investigation and by the euphemization of the subject (through litotes or understatements, for example), because they demand prudence and discretion. This is because it is necessary to obtain information from the patient gently, without causing offense – and drawing attention to the patient's behavior or to an incident that took place during the interview could suggest "some improper, deviant, or morally questionable behavior" (*Ibid.*, p. 156). It is also because the patient is attached to an existence that is made up of continuities, not disruptions. In a word, the physician and the patient are united in wishing to produce a kind of coherence.

Accommodation practices are a response to the disruptive experience that arises when we are confronted with mental disturbance. By contrast, it teaches us what "individual normality" consists of (Lynch, 1983). In the ordinary world, we take a great deal of things for granted, without problematizing or interpreting them. Reciprocity of perspectives is not a principle in that world, but a fluid reality. It would be simply unbearable to have to question systematically all the hinge certainties that hold up our daily actions. We trust the ground beneath our feet, without putting it on trial, to all practical ends, without anticipating that it will

disappear before such an eventuality arises. To question that is to suspend trust as a social routine; this leads to generalized suspicion, which extends doubt beyond what is reasonable, or prevents hinge certainties from operating in practiceⁱⁱ.

In the world of psychiatry, however, communal worlds are problematic. On one hand, people base their communications on ordinary epistemic resources; on the other, at least the staff and families of patients assume partial or total non-reciprocity of perspectives and dislocation of frames of relevance. Two attitudes seem possible, in this regard, and are reminiscent of the attitude an anthropologist might have when faced with the exotic. Either the psychiatrist points out the patient's inability to deal with the rational order of things, and therefore seeks to produce a diagnosis oriented toward prescribing a therapyⁱⁱⁱ; or s/he attempts to reach a perspective and a register of relevance that s/he does not share, but that will allow rapprochement with the patient^{iv}.

Contrary to ordinary accommodation practices, therapeutic approaches are remedial. They aim to change the conditions of the phenomenon, affect its causes or regulate it. They are most often part of a specific range of actions, which may be very diverse: sending the patient to a physician or a healer, arranging a meeting with a psychiatrist, making him undergo a ritual, exorcising him, requesting hospitalization, locking him up, etc. These remedial practices are based on beliefs that are appropriate to a certain cultural and social context, or on motivated subscription to a certain type of "natural facts of social life." Because of these beliefs, phenomena that, in another context, would be seen as unlikely or outright impossible – like possession, enchantment, supernatural vision, direct contact with a divine being, miraculous cures, etc. – are seen as possible and even probable.

Ordinary accommodation practices and therapeutic remedial practices both result from a judgment of derangement, using the same epistemic toolbox. In that sense, it is possible to say that the ethnomethods of accommodation and remediation, including psychiatry, are identical when it comes to evaluating whether an individual's behavior is normal. They result from the same moral normativity whose

cursor distinguishes normal from abnormal, but also separates “acceptable” from “blameworthy.” Morality appears here as a fundamental epistemic resource that makes it possible to determine pathology based on the background moral normativity of a social group and its marker for normality. This marker can move and the framework can change: What was once dismissed as absurd may now be accepted; hard and fast certainties become dislodged and abandoned (Monk, 1990). Still, nothing can be said without any framework whatsoever; and, within any framework, there is a marker that makes it possible to distinguish appropriate utterances from those that overflow its bounds.

Practices relative to mental disturbance

We started with Wittgenstein’s idea that, to understand the difference between error, extravagant belief, and mental disturbance, one should not use predefined criteria, but rather investigate when an attitude, an expression, or a form of behavior contradicts not an utterance that we hold to be true, but rather the entire framework that gives meaning to our beliefs (*Ibid.*). This implies that we will restore ways of acting to their environment. It also implies that we will put different contexts in perspective. If we compare different life forms, we can understand how, for instance, mental disturbance is configured in each by partially different ranges of practices and operations, with ideas, concepts, and interpretations to animate them and vocabularies to articulate them. This is precisely what Malek Bensmaïl’s documentary on the treatment of mental illness in Algeria allows us to do.

One of the most striking aspects of this film is the way it shows two series of practices relative to mental disturbances coexisting in Algerian society today, one centered on rituals we could describe as traditional, and the other on psychiatric medicine. In these two series, the concepts of illness and healing are not the same; nor are those of patient and treatment. This does not mean, however, that we are dealing with two completely separate universes, but rather of universes that are partially juxtaposed or intertwined. The links between them raise very particular questions.

The film starts with a visit to the tomb of the director's father. It evokes a few memories of him, then cuts to a visit to the sanctuary of a local saint, venerated for his ability to help people suffering from all sorts of mental ailments. Finally it shows a popular ritual involving a trance. A rapid transition through Constantine's streets and surrounding landscape leads to a chair, which signals a new environment: a psychiatric hospital. This "introduction" shows that the narrative is pinned first on the director's father, a psychiatrist and the founder of Constantine's psychiatric hospital, and secondly on the "traditional" way of treating psychic issues. The documentary highlights the contrast between these practices, which have their own ways and places for operating, and those of the psychiatric hospital. The contrast also involves two conceptual worlds, two systems of ideas or forms of social life – to the degree that practices cannot be separated from the ideas that animate them and the concepts that articulate them^v. In one system, mental disturbance is due to alteration brought about by spirits, or the result of possession; in the other, it is caused by the disturbance of cognitive abilities and the alteration of an individual's emotional behavior. The disturbance and alteration are probably the result of physical, biochemical, or neurological processes; or destabilizing events or life situations which caused them. In one case, the treatment consists of acting, in one way or another, on spirits or supernatural forces, which it is necessary to identify or tame, or whose intervention will be provoked; in the other, the treatment consists of diagnosing and classifying the illness and of acting on its presumed causes, in particular the physical and chemical ones. In one case, a cure is brought about through an individual or collective ritual, including the mediation of sacred or sanctified objects; but a saint, a spirit, or God causes it. It consists essentially of restoring a state of peace in the coexistence between spirits and human beings. In the other, the aim is to remedy dysfunctions of body chemistry or regulate emotional processes, in order to restore an individual's "normal" capabilities, and in particular that individual's ability to order his or her own life, to situate words and deeds within the boundaries of reason, to manage emotions according to the prevalent "feeling rules," etc. Although they are formally isolated from one another,

we should note that these two worlds share an extremely porous frontier, as Bensmail's documentary shows clearly.

In the second part of the film, we shift from the domain of ritual to that of psychiatry. This part examines an interview between a psychiatrist, surrounded by her assistants, and a young woman, accompanied by her father, who brought her to the hospital. The patient presents herself as highly educated, as a physician in particular, and says she is still undertaking related studies; she claims to be endowed with "supernatural" powers with regard to academic learning, physical strength, and clairvoyance as well as the ability to see spirits. She also explains that she is constantly under attack by people who are jealous of the gifts she received from God. A little later, she says she was bewitched by a marabout she visited. She also claims to be in contact with beneficent jinn, to have visions, to hear God speaking to her, etc. In the terms understood by the patient, then, the problem is not due to her personal condition, but to the attitude of others, who "won't leave [her] in peace" and attack her. For her, a hospital stay has no therapeutic aim but rather aims to protect her from the outside world. The "metaphysical" world, in contrast, poses no threat to the patient, but rather has blessed her with exceptional talents and clairvoyance.

At no point does the physician show that she believes the patient is mistaken about her identity, her schooling, or what has happened to her; she does not indicate that she thinks the patient is hallucinating or lying. She lets the woman speak without correcting her, contradicting her, evaluating her statements, establishing facts, etc. She poses simple questions to induce her to explain her statements; she practices "explanatory amplification" (Dupret, 2011). Only the patient's father tries to correct his daughter at one point: "*but the imam told you they [the djinns possessing her] were gone.*" The interaction is utterly fluid, thanks to the doctor's deliberately discreet and tactful investigation (see above). She asks questions, the patient answers; the transitions are relatively coherent. The patient resumes the conversation after inserted scenes. She adapts perfectly to thematic changes. She

responds in a formally appropriate manner to the formation of a diagnosis and the issuing of a prescription.

Here are two excerpts showing the psychiatrist's tact, and the euphemistic turn of phrase she adopts:

Doctor: Ok. So I have the impression you've overworked yourself a little.

Patient: Yes, yes.

Doctor: Right, overwork, you've got to get some rest, I think you need a break.

Patient: From studying.

Doctor: But this is a request for the time being.

Patient: For the time being, yeah, because what I find irritating ...

The second excerpt occurs after a discussion of possession:

Doctor: Well, I'm going to suggest something, and I hope you'll accept.

Patient: Sure, sure, why not?

Doctor: That you spend some time here at the hospital.

Patient (laughing): That's why I'm here.

Doctor: Well, great, we're agreed.

Patient (enthusiastically): I want to spend a year here.

Doctor: No, not a year, just enough time to have a rest. Nobody is going to bother you.

Patient: Inshaallah.

Doctor: Ok.

Patient: Hopefully.

In the last part of the interview, the psychiatrist tries to find out more about the circumstances of the patient's "possession," her visions, her contact with "good" jinn, what God tells her; but here too, nothing indicates that she thinks the patient is wrong, since she does not seek to correct her statements at all. Nothing suggests that she takes the patient's utterances for aberrant beliefs. At the same time, it is clear that she never regards the patient's explanation as anything other than the basis for a diagnosis. The patient's narrative is taken seriously, not for its factual content, but for the criteria of psychiatric evaluation it offers. The doctor's point of view is not directly ironic, since it does not challenge the patient's factual assertions; but it is structurally ironic, since it is based on the hypothesis that the case is pathological, and it uses the narrative as a basis for reasoning that concludes with a diagnosis and medication^{vi}.

As she says later in conversation with the director of the documentary, included in the film, the psychiatrist takes into account the fact that Islam allows for this type of belief in jinn, possession, and clairvoyance. Still, she is forced to describe the patient's words and behavior as "pathological," as if they somehow transgressed the normal words and deeds of an ordinary Muslim in the framework of his legitimate beliefs. This description, uttered after the interview, is the verbal enunciation of a judgment that was already manifest throughout the conversation, through the behavior adopted towards someone who is clearly mentally disturbed (as indicated, for example, by the father's behavior during the interview). Indeed, the patient initially presented herself as a physician with many graduate degrees, fluent in seven languages, and in the process of studying several other specializations – all these claims reinforcing her conviction that she is "supernaturally strong." Next, she claimed to have suffered a nervous breakdown, presenting this as the reason for the consultation; and then she went on to speak about the insults, prejudice, attacks, and injuries she had supposedly suffered, expressing her conviction that people seek to provoke her wherever she goes. For this reason, it is likely that "mental disturbance" as an interpretive framework was not only applied from the beginning

of the interview, and maintained in what followed, but also that it was supported by new occurrences, according to the “documentary method of interpretation,” where each event retrospectively buttresses an earlier assessment, and lays the prospective groundwork for coming evaluations (Garfinkel, 1967, chapter 3). It is therefore unsurprising that this method was also applied to the patient’s mention of being bewitched, her relations with jinn and God, and her clairvoyance. In addition, this was clearly not her first contact with psychiatry, since at one point the physician asks her if she is still taking her medications.

When the physician asks the patient about being possessed and having visions, she gives the impression that she has returned to the common world: while her imaginary identity, her claim to possess supernatural powers, or her expressions of paranoia demonstrated a break with community standards of identity, mentioning possession, protection by jinn, and visions suggested a return to “normality.” But this impression is misleading. For Muslims in Algeria, to be under the influence of jinn, to converse with God, or to have visions might seem to correspond to a set of things that are accepted as possible and legitimate. Applying such possibilities to oneself, with the accompanying practices, does not necessarily imply mental disturbance. If God speaks and the believer hears His voice, this is with the realm of extraordinary, but conceivable, relations with God. In a social world that shares *this form of life*, there is nothing surprising in the fact that there are widespread beliefs equivalent to those many Christians might have regarding angels and demons. In neither case can we consider such beliefs as the sign of mental illness. Still, in the case discussed here, the physician concludes that the experiences the young woman claims to have had are “pathological” rather than the normal manifestation of a cultural fact:

Doctor: Because of our, um, Muslim culture, it’s part of Muslim culture, it’s also in the Quran; but this is pathological. Either it’s a psychosis, a case where there is – they really see things they interpret as, um, possession; or it’s cultural: there are women who accuse their neighbor of having bewitched them. To

explain a dispute or a misunderstanding, they might orient to witchcraft, but there are far more, um, personal interpretations.

The recognition of different registers and the transition from one to the other proceed in a contrasting manner. Clearly, the psychiatrist accepts as part of her worldview elements that come from surrounding popular beliefs as well as elements that come from her scientific training. But it is likely that she does not cling as firmly to both categories, as shown by her mention of uncertainty with regard to belief in possession:

Doctor: I don't know, as a Muslim, um, we believe in such things, but the frequency, it doesn't happen as often, or as quickly, there are many – it's pathological.

For others, beliefs seem more homogenous. In addition, one can observe great fluidity in shifting from a ritual treatment to a medical treatment, or vice versa, as shown by the statements that the father of the young woman made to the psychiatrist: he had shown his daughter to an imam for an exorcism before bringing her to the hospital. In a later scene, a patient at the hospital is shown consulting a traditional "healer."

Still, it is not insignificant that the adjective "pathological" should be used in "formulating" – after the fact – a judgment formed during the interview with the patient. Yet what was it in the interview that gave rise to the conviction that this was pathological, rather than cultural?

Patient: For now, yeah, because what irritates me is not school, because look, it was an attack, head trauma, the man who hit me, I have bruises all over me, look, people are out to get me wherever I go, it's not normal, because, um, it's paranormal, it's metaphysical.

Doctor: How so?

Patient: I was bewitched. The idiot, that stupid marabout sent djinns after me, so because I'm a practicing Muslim, Muslim djinns protected me. I have six Muslim djinns.

Doctor: Can you see them?

Patient: Yes.

Father: But the imam told you they were gone.

Patient: Please.

Doctor: Can you see them?

Patient: No, I can't see them, I feel them, they help me, I close my eyes, I wish for anything...and I get it. If someone gets on my nerves -

Doctor: Do they talk to you?

Patient: Yes.

Doctor: What do they say?

Patient: The future, I see things, at night when I'm sleeping, I have visions and they come true. I can even see humans, for instance, when I see a sick person, I can even see the hour of his death, yes or no, but I can't tell you that.

Doctor: According to you, why were you singled out to receive all these powers?

Patient: God. He gave me everything: beauty, everything, money

(Doctor makes inaudible remark) God, no

Doctor: Why did God choose you?

Patient: Can't say.

Doctor: No, you must tell us everything.

Patient: Yes, He spoke to me in a dream.

Doctor: What did He say?

Patient (laughs): Can't say, not allowed.

Doctor: You must trust us, you must tell us everything.

Patient: Yes, it's divine, it's a bit -- it's metaphysics.

Doctor: Give us a little sign.

Patient: A little sign. Hmm. I'm good, I'm a believer, I've seen several prophets, um, Solomon, Noah, who else, Joseph, so I've almost seen – and I have visions, visions of the past, before Jesus Christ, for example. Um, there are two djinns who are Jewish, one is named Marshall, he's 5,000 years old, he's, um, Israeli. I don't know the other one's name, he didn't tell me his name, he's a good guy.

In formal terms, the patient's words seem to correspond to widely shared beliefs – in possession, in the attributes of djinns, in clairvoyance, in the need for secrecy, in the ability to hear God, etc. Islam recognizes the existence of djinns, invisible spirits with supernatural powers who, like humans, were created to worship God. Some do good, others evil; illness and distress, even possession, may be attributed to the latter. There are Muslim, Jewish, Christian, and atheist djinns, just as there are Muslim, Jewish, Christian, or atheist humans. Muslims believe that only God can know what will happen in the future, but they think that a person who has made a pact with a djinn can acquire an enormous amount of knowledge; an alliance between a human and a djinn can give the human immense power, and is for instance the secret behind the strength of great magicians. Thus, when the patient refuses to divulge what God told her, in the name of her obligation to keep a secret, she is referring to an aspect of popular belief: discoveries that occur in the context of contact and exchanges with supernatural powers belong in the realm of secrecy. They must not be revealed, especially because the forces of evil could use them.

The question then is why these statements, which seem to conform to beliefs shared by many Muslims, appear so clearly “pathological” to the psychiatrist and the audience alike. In Bensmail’s film, “pathology” appears when the interpretive framework becomes idiosyncratic and is no longer shared, when interpretation is filtered through the patient’s “unhinged” cognitive universe. In that sense, the documentary gives us access to the process of psychiatric cognition, which proceeds via reasoning by incongruity. This consists, first, of identifying a gap between a situation as it is and as it should be in normal conditions; next, on the basis of this gap, of inferring causes and a solution that will make it possible to narrow the gap. The framework of normality is provided here by Muslim culture and the belief in djinns that it allows (“as a Muslim, um, we believe in such things”), and it is precisely against that backdrop that the doctor can present the patient’s statements as incongruous (“it doesn’t happen as often, or as quickly, there are many – it’s pathological”). The background of normality is presented here as relative to religion and culture, or in other words as specific to the local context: that which is accepted by the majority of people in a given place. For the doctor, then, what is normal somewhere might be considered abnormal elsewhere (she says as much laughingly, after having been asked about her own beliefs; initially she refrains from expressing an opinion, claiming ignorance, and then contextualizing what appears as her conviction). This relativistic point of view (normality is relative to place) does not preclude the existence of standards and criteria in each framework of normality, according to which behavior and discourse are evaluated as normal or abnormal. In other words, it is not because the patient speaks about djinns that she should be considered mentally deranged, but because she speaks about djinns in a way that contradicts the local, normal, standard pattern of belief, or because she speaks about them in a way that is dislocated from the normal way of speaking about them.

Thus, the gap, no matter how vague, between publicly shared interpretation schemes, shared criteria of perception and evaluation, or culturally established (and therefore socially approved) ways of speaking about God, djinns, and possession – on one hand – and the patient’s discourse and behavior – on the other – is one of the

indications of pathology. Although very intimate religious experiences are possible and acknowledged, as in mysticism, the fact remains that the way of speaking about all these entities, and conceiving of their presence in everyday life, is part of a shared ontology. As Jean- Noël Ferrié explains in a text analyzing the familiar relations humans have with supernatural beings, cultural devices are what make the latter the types of creatures that they are; the organization of their world is copied from our own:

God is an article of culture even before He is an article of faith, which means that, like all articles of culture, He has a public existence...that places Him in reciprocal games of perspective...[We] may speak of God by basing ourselves on the fact that what we say of Him is known to most people, so that our statements, or what is made of them, need not be justified or even entirely accomplished in order to be recognized and understood (Ferrié, 2013).

Still, mental disturbance is not part of a sort of private language. The patient's interpretive systems are not inaccessible; the language she uses and the background of understanding on which she bases herself are shared. The patient knows she is in a psychiatric hospital, and that she is dealing with a psychiatrist; she still has concrete knowledge about university education and curricula, what it means to go to the United States, how to move around the city, the kinds of corruption people engage in, the protection afforded by the hospital, and the beliefs and practices of Islam. She can also recognize her father's anguish, etc. Still, there is something "off" in the exercise of her abilities and skills. The reference framework is dislocated, so that psychiatric work must access the patient's world with identical epistemic resources. Truth be told, the condition making psychiatric work possible (and effective) is precisely that it shares a background (language, categories and categorizations, practical epistemology, etc.) with the patient's language. On the basis of his common-sense knowledge of the social and cultural environment, and of shared criteria for evaluating the normality or abnormality of words and deeds, the physician attempts to enter a framework that is not her own to try and identify its outlines, and thus work not on correcting errors but on restoring congruence. It is as an "ordinary man" – like any other, resorting to lived experience -- that she

recognizes transgressions of common sense that indicate mental disturbance. This is so even though the doctor's psychiatric training and knowledge are what enable her to categorize the problem, make conjectures about its causes, and contemplate the appropriate treatment.

Culture, beyond error and illusion

There is a final dimension we must note in the physician's diagnosis. It does not occur to her that her patient might be wrong (about her identity, her diplomas, encounters, visions, etc.), or might simply have extravagant beliefs; in the same way, she never thinks of characterizing the popular beliefs that constitute the cultural environment as errors, resulting from ignorance or misunderstanding, or of dealing the ritual practices that seek to treat mental suffering as though they were illusions or necessarily ineffective because they represent a false understanding of medicine, based on the erroneous character of the ideas and concepts that animate it. Nor does she consider that either of these is stupid. The physician has therefore not taken the corrective attitude adopted by Frazer in *The Golden Bough*, who explained certain primitive practices by reference to the inaccuracy that characterized the proto-scientific knowledge available to the relevant populations. Wittgenstein criticized Frazer's explanations, emphasizing that they were "much cruder than the sense of the observances themselves" (Wittgenstein, 1979: 1):

Frazer's account of the magical and religious notions of men is unsatisfactory: it makes these notions appear as *mistakes*.

Was Augustine mistaken then when he called on God on every page of the *Confessions* ?

Well--one might say--if he was not mistaken, then the Buddhist holy man, or some other, whose religion expresses quite different notions, surely was. But none of them was making a mistake except where he was putting forward a theory.

Frazer considered a primitive society's magical practices as based on grotesque, erroneous explanations of phenomena, explanations provoked by ignorance, especially when it came to physics, nature, and the cause of disease. But by treating a people's magical or religious concepts and practices as erroneous and stupid, he himself was gravely mistaken, according

to Wittgenstein, because error occurs only where there is knowledge or theory. These magical and religious ideas, in contrast, are not theories and do not belong to the realm of knowledge, any more than do the ideas behind the practices. If one were dealing only with errors, in order to correct them one would only have to draw people's attention to the error in their beliefs, or to remedy their ignorance, or their simplistic representations of things and events, to turn them away from their usual practices. Yet Wittgenstein points out that this is not at all the case:

This is not how it is in connection with the religious practices of a people; and what we have here is not an error (*ibid.*: 2).

But never does it become plausible that people do all this out of sheer stupidity (*ibid.*: 1).

If the adoption of a child is carried out by the mother pulling the child from beneath her clothes, then it is crazy to think that there is an error in this and that she believes she has borne the child (*ibid.*:4).

Wittgenstein compares Frazer's narrow-mindedness and inability "to understand a different way of life from the English one of his time" with an understanding based on the general level of natural human reactions, encouraging rapprochement:

One sees how misleading Frazer's explanations are – I believe – by noting that one could very easily invent primitive practices oneself, and it would be pure luck if they were not actually found somewhere. That is, the principle according to which these practices are arranged (geordnet) is a much more general one than in Frazer's explanation and it is present in our own soul, so that we ourselves could think up all the possibilities (*ibid.*)

Conclusion

Bensmail's documentary provides a glimpse of the articulation between social and mental spheres in contrasting contexts, where the identification and management of psychic disturbances are at stake. In particular, the film allows us to document the way in which mental disturbance is recognized, whether from the psychiatrist's point of view or from that of the "layman" (represented by the father who brings his daughter to the mental institution – from his behavior, it is clear that he realizes she is going completely "off the rails"). This takes place essentially as an exit from common sense, a transgression of the "hinge certainties" that are commonly accepted as a basis for reasoning and action, or as a loss of congruence of beliefs

and attitudes with the objective certainties manifested in the way people conceive of things and practices that go without saying. From this perspective, even specialists clearly use laymen's criteria and methods to differentiate normality from pathology, and they can only do so by acknowledging that they belong to a given social and cultural context. In other words, through this film, which offers a glimpse of how people actually judge mental health, we can see that the use of psychiatric categories is above all a pragmatic matter: when people, including psychiatrists, pass judgment on someone else's mental state, their judgment is based first and foremost on a socially accredited body of knowledge and expertise, which they use methodically (Blum, 1970: 38). In other words again, psychiatric classification practices are culturally and contextually contingent, which means not only that they are variable, but especially that they are based on a culturally shared foundation of knowledge and beliefs, and that they presuppose "common-sense" modes of reasoning and inference, which can be observed and described (Coulter, 1973). This does not minimize the specific skills of professionals – of course they have tools for the diagnosis, classification, and treatment of psychic disturbance to which lay people do not have access; they also have experience that lay people cannot have.

There is another conclusion to be drawn regarding the distinction between error and mental disturbance. As we saw, each of these entails different responses. A corrective attitude makes sense in the case of error, but not in the case of mental disturbance, which requires practices of accommodation or restoration of adequacy (and of course a remedy when possible). This is why it is unsatisfactory to say that a mentally disturbed person is simply hallucinating, if indeed hallucination signifies the perception of things for which the normal conditions of perception have not been realized. It might be useful here to recall John Searle's semiotic figure (Searle, 1995), which refines the distinction between objective and subjective by adding a distinction between epistemic (concerning judgment) and ontological (concerning modes of existence). Something may be epistemically or ontologically objective or subjective. For example, an epistemically objective judgment is a judgment on which almost everyone agrees because it concerns facts that are seen as external to

people's individual appreciation. To the contrary, an epistemically subjective judgment depends on its author's point of view. Similarly, something ontologically subjective is something that exists because of the point of view or mental state of an individual with discernment (a pain, for instance, as opposed to a mountain). This is why "we can make epistemically subjective statements about entities that are ontologically objective, and similarly, we can make epistemically objective statements about entities that are ontologically subjective" (*Ibid.*: 22).

In the excerpt studied in this article, we saw that, in a psychiatric context, a number of entities to which the protagonists orient (God, spirits, djinns, etc.) are epistemically objective. It is pointless, then, to attempt to correct perceptions of these entities. Because a number of people believe them to be objective realities rather than the result of hallucinations, i.e. errors in perception, it would be appropriate, as Ivan Leudar and Philip Thomas suggest, for those who perceive these entities and for others, to learn to "coexist" (Leudar & Thomas, 2000). By analyzing these excerpts from Bensmail's film, we have confirmed the practical implications of this re-specification of the context of normality, and the epistemically objective entities that populate it.

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ⁱ INA Editions put out the DVD in 2012, as part of a box set titled "Looking at Algeria Today." For a general presentation of the film, see Dupret, 2011.

ⁱⁱ On trust, see Garfinkel, Watson, and Quéré. Trust as evoked by Garfinkel is very close to Wittgenstein's concept of "Ur-trust," as described by Moyal-Sharrock: it is manifested by the "utter absence of distrust." This is an "excluder concept:" "Rather than affirm itself, it excludes something: 'distrust' or 'mistrust'" (Moyal-Sharrock, 2007, p. 197).

ⁱⁱⁱ This is in a way Frazer's attitude in *The Golden Bough*, and Evans-Pritchard's stance with regard to the Azande.

^{iv} This is the suggestion made by Wittgenstein, against Frazer, and by Winch, against Evans-Pritchard (see herein).

^v "It does not make sense to suppose that human beings might have been issuing commands and obeying them before they came to form the concept of command and obedience. For their performance of such acts is itself the chief manifestation of their possession of those concepts"(Winch, 1958, p. 125)

^{vi}