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On heritage pharmacology: Rethinking 'heritage pathologies' as tropes of care

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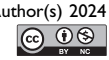

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Abstract

This article develops the concept of *heritage pharmacology* as an encompassing critical framework in order to radically recast the interactions and efficacies of heritage as a particularly potent pharmacology of care. I critically engage with Stiegler's philosophic reflections *On Pharmacology*, which builds on Derrida's work and recasts pharmacology – a term usually reserved for that branch of the biomedical sciences dealing with drugs and their interactions and efficacies – in order to draw out the 'curative-toxic' dimensions at play in wider care tropes. By placing core concepts and practices of heritage and pharmacology in critical dialogue, my aim as heritage critic is to gain mutual insights into 'care', as that which links together the two domains of heritage and health, as otherwise distinct discourses, concepts, technics, and practices. My specific intervention rethinks the crucial role of 'heritage pathologies' and the underpinning memory-work at play within these tropes while grounding these in a case study of Jerusalem Syndrome (JS). I argue that it is the dynamic of heritage pathologies, best crystallized in JS debates, that invests us in the wider Stieglerian quest/ion of 'pharmacology', as a concern with 'what makes life worth living'. Such quests ultimately take this article into the realpolitik of Palestine.

Keywords

care, heritage, Jerusalem Syndrome, Palestine, pathologies

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Introduction: On heritage pharmacology

> The question of the *pharmakon*, first arose in contemporary philosophy with Jacques Derrida's commentary on the *Phaedrus* in 'Plato's Pharmacy'.… The *pharmakon* is at once what *enables* care to be taken and that *of which* care must be taken.… [A] pharmacology – that is, of a discourse on the pharmakon understood *in the same gesture* in its curative and toxic dimensions. (Stiegler, 2013: 2–4; original emphasis)

In this article I develop the concept of *heritage pharmacology* as my encompassing critical framework in order to radically recast heritage in terms of its interactions and efficacies as a particularly potent pharmacology of care. By placing core concepts and practices of heritage and pharmacology (cf. Stiegler, 2013) in critical dialogue, my aim is to gain mutual insights into 'care', as that which links together the two domains of heritage and health, as otherwise distinct discourses, technics and practices. My theoretical point of departure is Stiegler's philosophic reflections *On Pharmacology* (ibid.), which builds on Derrida's work (2004) and recasts pharmacology – a term usually reserved for that branch of the biomedical sciences dealing with drugs and their interactions and efficacies – for the deconstructionist lexicon.

Stiegler's own pursuit of 'pharmacological questions' and their alternatively and/or simultaneously 'curative and toxic dimensions' takes in wider philosophical-political and cultural-psychological dynamics vis-à-vis health and care. What particularly interests me in Stiegler's subsequent recasting of 'pharmacology' as an alternative model of dynamic interactions and efficacies operative across diverse registers is the foundational role it has in terms of instituting care: thus, he identifies the *pharmakon* as precisely that which is 'at once what *enables* care to be taken and that *of which* care must be taken' (Stiegler, 2013: 4; original emphasis). As 'healthy' care tropes, these interactions have the ability to manifest as diverse energies of mind-spirit, creative lifeworlds, novel memory-work vitalities, and modalities of resilience, notably in terms of responding to experiences and feelings of loss. Heavily influenced by Winnicott's work, Stiegler argues that 'pharmacology' is ultimately led by the quest/ion of 'what makes life worth living' (ibid.: 1).

As a heritage critic, I am interested in positioning 'heritage' as that which emerges to concern itself with care in terms of its own responses to pharmakonic conditionalities of life. My specific intervention explores how a case study of Jerusalem Syndrome (JS) is capable of crystallizing the presence of diverse tropes of 'heritage care'. Through the lens of the psy-sciences, JS has been diagnosed as a mental 'disorder', with the city of Jerusalem itself regarded as 'pathogenic factor' and therefore as poison, contaminant, and toxin (Bar-El *et al.*, 2000). My concern is in recasting JS as a multivariant condition, and more particularly to gain new insights into 'heritage pathologies' as diverse modalities of care. I argue that this quest in turn invests heritage, as concept, techne, practice, further within the wider quest/ion of pharmacology, as a concern with 'what makes life worth living', and ultimately takes my article into the realpolitik of Palestine.

I outline my theoretical-methodological basis and introduce JS debates in more depth below, before embarking on our quest/critical journey proper.

Critical anatomies

> It is not simply that cultural particularities have been lost, becoming either objects for heritage museums or for the curiosity of tourists (that is, objects integrated into the methods of marketing), or symbols of struggles for so-called 'identity': it is also the most elementary *savoir-vivre*, and *savoir-faire* in the form of arts and skills [*métiers*] that are being dissolved, along with the academic and universalist forms of knowledge that result from processes of anamnesic transindividuation. The regression of local *savoir-vivre* and *savoir-faire* never leads to the progression of universal knowledge: it results in the complete opposite. (Stiegler, 2013: 30–1)

From the above passage, diverse forms and forces of heritage care can be discerned that combine Stiegler's interest in Derrida's critical recuperation of the ancient Greek etymology of *pharmakon* as 'at once' 'poison-cure' with that of Winnicott's work on 'object relations', while opening up pharmacological readings to the broader context of contemporary commodification and the accompanying 'generalized exclusion from cultural production' and depletion of 'local' memory transmission and its vital creative lifeways (Stiegler, 2013: 30–1). These have direct and profound implications for my recasting of heritage care as a response to the pharmakonic conditions of life and emerge as two key tropes that I pursue in this article: that of 'heritage as adoption' and 'heritage as adaptation'.

In terms of the former, for Stiegler, *savoir-faire* (as know-how) and *savoir-vivre* (as knowledge of how to live well), like that of anamnesis (as attentive transmission of collective 'living' memory), are synonymous with 'care as adoption'.[1] Taking forward Winnicott's work, Stiegler argues that the 'healthy pathway' to 'good' object relations is bound up in the need to 'adopt the pharmakon' and by these means 'to adopt … [one's] *transitional situation*' and learn to detach 'from the transitional object so as to engage with *other* transitional spaces, with which it will establish other relations' (Stiegler, 2013: 3–4). He emphases that 'care is a process of adoption' that is developed into adulthood as 'an art of living – that Winnicott called creativity' (ibid.: 21). Care, in turn, is linked to 'sublimation' as that which makes 'cultural experience' 'meaningful' and to the 'role of the *pharmaka* in the formation of desire' (ibid.) and in establishing 'a condition of keeping the psychic apparatus of the adult in good health' (ibid.:3). Moreover, Stiegler argues, '*pharmaka* form transitional objects of all kinds' (ibid.: 21) and, as 'good relations', variously establish 'mutuality', 'serenity, trust in life', and – via the *pharmakon* as the 'adoption of heteronomy' – determine 'autonomy' (ibid.: 1–3). It is precisely on this 'basis' that the *pharmakon* introduces 'us/the psyche/mental life' to social worlds, memory work vitalities, and 'cultural experience' and invests us in them. Writ larger still, Stiegler reiterates the vitalities of 'spirit', the 'life of the mind', 'fidelity', 'moral consciousness', and the 'formation of healthy psychic apparatus'. Crucially, healthy responses to 'experiences of loss' are centred as part of 'healthy care systems' (ibid.) and a necessary basis in terms of 'thinking for oneself', forming a 'true self', and thus 'constituting thought as creativity' by means of interactions with collective intelligence, strategies of memory transmission, and knowledge capable of instilling the '*feeling* that life is worth living' (ibid.: 1; original emphasis).

Conversely, Stiegler explores the 'bad relation' to the *pharmakon* as 'illnesses' and 'maladies of adaptation'. While *adoption* is the creation of 'long circuits' of 'transformation and learning', by way of contrast, *adaptation* is understood as the condition of 'harmful dependence', of 'disindividuation' and of 'short circuiting' that is destructive 'of autonomy and trust' and 'mutuality' that ultimately 'destroys pharmacological knowledge [and] spreads toxicity' (Stiegler, 2013: 130). As a result, cure collapses with poison. Writ larger, Stiegler regards the contemporary context as one of 'generalised addiction' in a wider 'addictogenic society' (ibid.: 27). He reiterates Winnicott's words in regarding adaptation as a 'poisonous' form of 'illness' that results when "a relationship to external reality" is established "which is one of compliance", that is, when "the world and its details" are "recognised but only as something to be fitted in with or demanding adaptation" (ibid.: 19–21). Thus 'compliance' is adaptation to 'dominant ideas that have not been produced and conceived by those who merely submit to them'. Moreover, "compliance carries with it a sense of futility for the individual and is associated with the idea that nothing matters" (ibid.: 21), thus short-circuiting the 'feeling that life is worth living' (ibid.) and rendering one 'incapable of taking care of itself or others' (ibid.: 32).

Within his project of pharmacology, Stiegler centres the urgent need to act back against such forms of collapse, loss, and ill-being in calls for an investment in 'niche construction' in which 'world-building' is the effective 'work of desire'. Contra '(re-)norming' one's own life world to 'bare adaptation', he sees 'work' as a collection of activities that are '*not reducible to employment*', and as a means by which '*savoir-faire* is creatively cultivated', leading in turn to the creation of vital milieux within the world (Stiegler, 2013: 39). Crucially, this system of care is 'grounded in anamneses'. Stiegler, by challenging Plato's opposition between anamnesis as 'good' or 'living memory' and hypomnesis as 'bad' or 'dead memory' (thus following Derrida in 'Plato's Pharmacy' famously 'unfixing' the binary 'decision-making' synonymous with the danger of writing corrupting the truth of reminiscence), supports instead that it is hypomnesis, by providing the technical milieu that allows for anamnesis as a purer form of thought (see also 'Anamnèse/hypomnèse', n.d.). Instead of eliminating the pharmacological effects of writing or technics in a more general sense, *pharmaka* can act, by accident almost and/or unexpectedly/spontaneously, as either poison or cure.

The response and responsibility to this context is that it requires the care of community and care of self in which 'we' all actively participate. The implications for heritage – and, more specifically, the recasting of heritage work on Stieglerian lines – as the means to turn poison into cure are significant. Indeed, Stiegler is careful to iterate that 'The human situation is *essentially* relational [and] ... transitional' and thus based on '*facilitations,* which presuppose mediators, *curators*, priests [*curés*] and therapists of all kinds' (Stiegler, 2013: 71; original emphasis). Here, what Derrida (2004) would call the self-appointed 'masters of the pharmakon' come into view in as a top-down heritage pharmacology dominated by the sovereign position occupied by the United Nations Educational, Scientific and Cultural Organization (https://www.unesco.org/en) and states-parties instigating adaptive compliance to nation state / 'world heritage', 'doxas', and care practices. A similar 'doxa' comes into play in terms of regimes of health care with the adaptive practices of the World Health Organization (https://www.who.int/) and the pathologizing force of psy-science, and, as features later in the article, with the United Nations Relief

and Works Agency (UNRWA, https://www.unrwa.org/), whose bio-power interventionism is experienced as a toxic imposition. Clearly, Stiegler regards such regimes of care as exerting toxic 'psychopower' ('Psychopouvoir', n.d.). Far from leading to the 'progression of universal knowledge', such psychopower leads to unhealthy dependency and the 'regression of local *savoir-vivre* and *savoir-faire*' and the 'destruction of local knowledge engendered by the standardisation of ways of life' (ibid.: 31).

The call to care and caring work then requires engagements with the local and the recasting of heritage that embrace both 'imaginative work' and 'art' and 'creativity' capable of going beyond the lines of neo-liberalism and praxis, thus providing the cure to its own poison and, crucially, moving beyond this. Moreover, 'art' and 'creativity' (and we might add heritage as adoption) are part of the 'experience of awakening' that regulate intensity and link to the curative and toxic. By these means, Stiegler advocates new potentialities and possibilities for imaginative dreaming and the life of the mind and spirit beyond adaptation/re-norming, thus capable of grasping new futures. This, Stiegler contends, ultimately requires 'bifurcation' as a means of 'reconstituting a political economy that reconnects local knowledge and practices with macroeconomic circulation and rethinks territoriality at its different scales of locality' (Stiegler with the International Collective, 2021), and enables the adoption and amplification of its associated curative efficacies of care.

Finally, before we encounter JS debates themselves, Stiegler's work is pivotal in grasping the different modalities of 'pathology' at play. Stiegler draws on Canguilhem to challenge the opposition between the 'pathological and [the] normal' to argue that at root 'pathos' can be understood as 'affection in general' and pharmakonically as '*bond* and as *illness*' (Stiegler, 2013: 27) Within this brief, the 'pathological' synonymous with adaptation is understood as 'a lesion, a wound and a weakness' (ibid.: 35). However, Stiegler further argues, there is 'another sense' of the 'pathological' that 'forms itself against those models of adaptation' and 'thus invents a new *pathos* – another kind of *philia* that is also a 'form of life' – by creating new long circuits out of the initial pharmacological shock' (ibid.).[2] These are articulated as 'the form of technical life proper to noetic souls, *pathos* – or what is referred to as *philia*, *eros*, *agape* or fraternity' (ibid.: 27), and thus as the vital foundation that creates the feeling and realities of a 'life worth living'.

Beyond a 'joke': Promised land or pathogen?

> There's a joke in psychiatry: If you talk to God, it's called praying; if God talks to you, you're nuts. In Jerusalem, God seems to be particularly chatty around Easter, Passover, and Christmas – the peak seasons for the [Jerusalem] syndrome. (Nashawaty, 2012)

My case study of JS and related debates crystallize the above dynamics while also offering grounded encounters, as a movement towards the 'local' and alternative critical insights gained into heritage pharmacologies and accompanying pathologies of care. Writ large, JS is the term used to describe typically temporary (although for a small minority permanent) 'episodes' experienced by some visitors to Jerusalem, who on first encountering the city feel compelled to perform certain 'uncharacteristic' and 'spontaneous'

ritual behaviours. The *Wired* media piece, quoted above, somewhat irreverently rehearses how JS symptoms begin with visitors 'becoming momentarily overwhelmed' or 'discombobulated' as they experience certain intense, often unexpected, emotions and 'obsessive thoughts' (Nashawaty, 2012). Such behaviours are understood to be triggered by being in a location whose heritage as 'loci genius' (spirit of place / cosmology of the centre) is experienced as alive with contagious, efficacious, symbolic-archetypal significance. This recalls heritage critic David Lowenthal's point that 'heritage is more about place than time' (1975).[3]

As a result, the phenomenon has been regarded by some as a sudden and extreme form of emotional-spiritual response, synonymous with successful and intense experiences of communion with such efficacies of place, and thus a phenomenon typically – though, as we shall see, not exclusively – identified with the quest for religious fulfilment (Van der Haven, 2008). Given that we can position religion, health (notably as biomedicine/psy-science), and heritage as 'arche-pharmacologies' (Stiegler, 2018) of care, the interactions and efficacies of these three domains are crucial.

However, JS featured in the pages of the *British Journal of Psychiatry* as a serious psychiatric concern, and symptomatologized/medicalized as a 'pathological illness' synonymous with harmful experiences of 'psychotic decompensation', 'delusion', and 'depersonalisation' (Bar-El *et al.*, 2000). Different severities of JS have been defined, with typologies running from I to III, with the most pronounced cases often leading to such visitors identifying with, and adopting the persona of, an iconic religious figure and thus regarding themselves as a specially ordained prophetic and messianic messenger. Moses, Jesus, John the Baptist, and the Virgin Mary are favourites, as is occasionally, and somewhat pharmakonically, 'the devil' (Peled, 2007). Further JS symptoms can thus lead 'otherwise normal housewives from Dallas or healthy tool-and-die manufacturers from Toledo to hear the voices of angels or fashion the bedsheets of their hotel rooms into makeshift togas and disappear into the Old City babbling prophecy' (Nashawaty, 2012). The media is particularly interested in reporting those 'severe cases' in which the core symptomatologies associated with JS are exhibited in those who have previously expressed no religious conviction. These, in turn, preoccupy the psy-sciences.

Thus, on one level, JS elicits a lightly mocking and/or comedic response. On another level, however, elevation of the phenomenon to its 'syndrome' status, through intense medicalization and, more specifically, psychopathologization, is a serious concern that can be traced back to its earlier categorization in the 1930s as a form of hysteria – a 'Jerusalem Fever' – in *Harefu'ah* (the Hebrew Medical Association Journal; Elon, 1989: 147). The coining of the term *Jerusalem Syndrome* in the 1980s acquired a millenarian aspect when presented by psychiatrists (Bar-El *et al.*, 2000) as a 'new pathology' that it was feared could reach epidemic proportions with the huge numbers of visitors expected to come to Jerusalem to welcome the new millennium.

As either 'Promised Land' or 'Pathogen', or better still, as I argue, 'at once', both dimensions coexist to encompass, and constitute, Jerusalem's pharmakonic interactions and efficacies. What interests me is that the diagnostic force of the psy-sciences has isolated into symptomologies those behaviours that are judged to have breached the threshold or 'crisis point' where functionality becomes dysfunction and sanity tips over into the pathology of 'madness'. The somewhat uncomfortable 'joke in psychiatry' reproduced in

Wired exposes not only the thin line between sanity and madness that, in turn, marks the tipping point of JS pathology, but also the ambivalence and thin line between care as cure and/or as harm. Here we confront the uneasiness too that underpins sovereign power over such 'decision-making' and subsequent crisis interventionisms. Within JS scientisms, the psy-sciences flex their muscles as modernity's appointed 'masters of the pharmakon'.

Pathways and pathologies

While we should avoid universalizing statements, there is some usefulness in Freud's point that symptoms as 'illnesses' are amplifications of 'normal' behaviours that are experienced by 'us' all (Freud, 1963[1917]: 358). In their extremes, they may be 'isolated' as 'pathological', and/or expressed as breakdown/breakthrough, and manifested in either magical/medical or catastrophic/categorical thinking and exhibited in their subsequent acting out. As a consequence, they hold insights into feelings, experiences that emerge in emotional enactments and fulfilment of desires that are otherwise more difficult to apprehend.

In what follows, I employ my combined critical Stieglerian lens and insights from JS debates to chart out three different pathways that, in turn, offer a radical rethinking of 'heritage pathologies' as multivariant pharmakonic tropes of care. This journey quest takes us from historical to contemporary contexts to apprehend various 'mediators, *curators*, priests [*curés*] and therapists of all kinds' (Stiegler, 2013: 71) – as both sovereign and non-sovereign 'figures' – that mark these trajectories. We encounter the emergence of powerful, prescriptive 'masters of the pharmakon' instituting care as top-down forms and forces of adaptation, 'compliance', and 'doxa'. Acting against this, however, often implicitly/unexpectedly/spontaneously, are alternative pharmakonic forms and forces that crystalize as alternative object relations, ritual behaviours, pathos and memory work. Here too, the 'hidden' pharmacological figure of the 'scapegoat' can be discerned that demands bifurcation, thus leading us to the 'local' realpolitik of Palestine and to the 'adoption' of grounded visions and alternative pathologies/pathos bound up in the wider quest/ion of 'what makes life worth living'.

Route one. Instituted regimes of care: Archaeologies, pathologies, and Jerusalem as 'poison'

> We [psychoanalysts] simply transform the 'love potion' of legend into science. Things of such magnitude can only be rediscovered. (Freud, quoted in Bjelić, 2016: 1)

Our first pathway emerges from the perspectives of 'modernity's' 'masters of the pharmakon' and associated 'instituted regimes of care' synonymous with heritage and health and their mutual entanglements. A united position and joint sovereignty over care, strengthened and secured as 'science as care', emerges as a shared heritage health agenda that, in turn, increasingly comes to dominate as forms of compliance and adaptation to 'rationalising-secularising' 'doxa'. To explore these possessional-pharmakonic acts, I follow in the footsteps of a somewhat 'unholy trinity' of the respective 'founding fathers' of psychoanalysis

(Sigmund Freud), Palestinian psychiatry and JS (Heinz Hermann), and archaeology (Flinders Petrie). These institutional and disciplinary patriarchs engage in their own ritual behaviours that see them adopt and adapt positionalities that project them as secular priests and messianic 'Moses' figures of their respective domains, as they deploy shared models, metaphors, and methods that formed a core part of the new efficacies they represented.

The commonality here is the project of instituting science as care, as a form of secular redemption. This necessitates taking on, or curing, the irrational 'other' – notably the 'madness' diagnosed as synonymous with Jerusalem as 'hierophany' and thus as a place afforded a 'magnitude' of significance as marked by and home to 'manifestations of the sacred' and the 'eruption of the divine' (Eliade, 1992).[4] Our 'unholy trinity' therefore emerge as central points in a dominant cartography, in which the emergence of various institutions and disciplinary spaces synonymous with scientism, secularism, and rationality as cure can be mapped. From new enshrinements and sacralizations of the couch, the clinic, and the academy, to the archaeological sites, museums, and collections that form part of a public-private network of exhibitionary and archival complexes. Infrastructures that Stiegler would see as 'adaptive' commodifications inextricably linked with the depletion of the 'local' adoptive pharmacologies-efficacies of care.

In Freud's words, the 'love potion of legend' is transformed into 'science' as these interventions are legitimated by these 'actor-institutions' projecting their respective contemporary 'Jerusalem' as 'poison'. Accompanying power-led object relations, as secular-rational self-fulfilling prophecy, thus fix the *pharmakon* in its 'toxic dimensions' as a diagnostic judgement on Jerusalem as loci affected by contaminations and toxins that require various practices of care. Interestingly, in dramas reminiscent of JS, these interventionisms bring into play and legitimate their own sovereign transformational pharmakonic forms and forces of care as cleansing, healing, and of preservation and protection. Writ larger too, these inspire promises of fulfilment that hold 'magnitude' in terms of secular modernity's own 'redemptive quests'. As we shall see, the latter of these, again to iterate Freud's words, is bound up in 'rediscovery' – more particularly, the scientific sacralization and redemption of 'ancient Jerusalem' as a cure-all for contemporary ills. This is also a pathway that is embroiled in acts of colonial possession – as pathological violence – and intense political strategization within which what is administered as 'care' is often experienced by 'others' – namely the 'local' – as 'harm'.

Archaeologies of mind, the mind of heritage pharmacology

The totalizing will to scientific redemption is best seen in dramatic interventions in Palestine in which heritage and health combine forces in the late 19th century. In the context of Jerusalem itself, these intimacies between heritage and health were regarded as interventions bound up in the 'birth' of archaeology and the study of the mind, as parts of wider projects that enabled agendas of 'public health' and 'mental hygiene' to legitimate further, and consolidate, these disciplinary domains and their sovereignty over diverse tropes of 'care'. This project of 'redeeming the land' assured that the language and metaphors of redemptive cure from disease, decay, and ruin would be deployed effectively as part of interventions to drain and cleanse mosquito-infested

swamplands, and to create clean water supplies by looking to newly excavated ancient water systems, which were considered as redeemable hidden worlds (Sufian, 2007).

However, the analogy between archaeological and psychological redemption is more than metaphorical. Freud, for instance, famously dubbed himself an 'archaeologist of the mind', and thus crystallized the connections between the work of psychoanalysis and the mental processes of the mind, and the material processes of archaeological excavation, investigation, and interpretation (Forrester, 1994). To invert and extend this logic, this context offers insights into the 'mind of archaeology' and the wider psyche of heritage pharmacology. This further embeds us within the 'psychodynamics' and 'psychopower' of care, and in questions of how these relate to professional-academic methodologies and interventions. It offers insights too into relationships and interactions between mental states, pathologies, the underpinning of object relations and 'cultural things', and intensities and states of being that interpolate and transform persons and places.

Moreover, mental health institutions and heritage professionals, as 'colonial instruments', become increasingly embedded (implicitly and explicitly) within flows of immigration and enforced displacements (Rolnik, 2012; Zalashik, 2005). The meaning of such displacements is an issue I return to below. The 'unholy trinity' were, however, responsible for creating this disciplined and modernized Palestine while 'fulfilling' their 'civilizing mission' (Sufian, 2007).

Redemption and/or as movement: Hermann and Jerusalem fevers

Links between heritage, health, and movement are thus forged in the modern age, as the experience of mass movement saw the paradigm of pilgrimage superseded, reworked, and variously repossessed in terms of new commodifications of travel, tourism, and adventure. They are also marked by immigration and the displacement of unprecedented numbers of people. All of our 'unholy trinity' are themselves bound up in these forces, whether in the position of refugee (Freud), immigrant (Hermann), or expat (Petrie, who subsequently took up residency in Jerusalem, where he spent his last years). It is important to highlight that the efficacies of the professional 'carers' – medical doctors, academic/field archaeologists – have not only derived from their roles as 'mediators' – custodians of disciplines, sites, objects, persons, ideas, and associated truth values; they also become powerful figures in terms of the flows, circulation, and movements (as well as the boundedness and fixity) of these variables. These include pharmakonic 'substances' that relate to the respective professional domains – 'medicine' here encompasses 'treatments' that range from conservation of objects and ritual cleaning of finds to psychotropic drug regimes. In personal terms, Freud's use of cocaine and Petrie's administration of drugs such as quinine to his fieldworkers blur professional/personal boundaries.

Dr Heinz Hermann, director of the first Jewish psychiatric asylum/hospital, Ezrat Nashim, in Jerusalem, is also cited as the first person to diagnose JS clinically as 'fever' (Elon, 1989: 147). Not only was Hermann himself a Jewish German immigrant to Palestine in 1924, and part of the importation of 'psychiatric knowledge and therapies to Palestine'; he also worked with Jewish immigrants (especially in the 1930s) experiencing or fleeing persecution (see Rolnik, 2012: 413). Hermann claimed that

"the special feeling of freedom of the Jews living in Palestine"' brought about a 'quickened cure' for such displacement (Hermann quoted in Van der Haven, 2008: 114).

Such psychiatry was prophetic and part of a complex 'frontier' vis-à-vis the 'selection mechanism of newcomers' that was framed by an ideology of the Zionist 'New Man' as synonymous with the shaping of a 'healthy nation' (Rolnik, 2012: 151). This framing meant that the 'beneficial effect' (Van der Haven, 2008: 114) of Palestine/Zion-as-cure needed to be set against competing claims and demands that many immigrants found 'hard to reconcile'. What troubled many was that the 'dream' of Palestine did not map easily onto the reality they encountered, most notably, among hardened Zionists. As Zweig put it impressively (and ambivalently), "Zionism is a disease one can recover from only in Palestine" (in Rolnik, 2012: 107).

While it is significant that Freud never visited Palestine himself, the influx of 'immigrant analysts' in the 1930s led to the founding of the Institute of Psychoanalysis in Jerusalem. This was an institution that combined the 'ideas of "father of psychoanalysis" and [of] Herzl as "prophet of the Jewish state"' (Rolnik, 2012: 412) to create what was known as 'Little Berlin' and what was essentially, as Rolnik puts it, 'Freud in Zion' (ibid.).

While Hermann and Freud participated in articulating the divide between religion and mental health studies, Petrie, the father of archaeology, is credited with undertaking the first scientific excavation in Palestine in 1890 at Tell el-Hesi (thought to be biblical Lachish). In so doing, Petrie ushered in a new scientific regime based on novel methodologies such as 'seriation' and 'stratigraphy' (Sparks, 2007) that supplanted previous explorations of Palestine as a 'rediscovery' of the 'Holy Land' using the Bible as map, guide, and primary source (Abu El-Haj, 2001).[5] Interestingly, critics regard this transition as symptomatic of the 'hazardous role of the Jerusalem Syndrome in biblical archaeology' (Goren, 2004). Petrie had created an altogether new vision of archaeology and heritage in which 'Palestine' was to be recast, fixed, and possessed as a 'scientific artefact' (ibid.).

Stratigraphy and seriation emerge as crucial methodologies that identify within archaeological-geological levels, layers, and structures that in turn act as 'archaeological-heritage pathologies' of sorts. By these means, archaeologists elevate themselves to 'symptomatologists' engaging in quests for the origins, nature, and development of civilization chiefly through sifting through the material cultural remains of prehistory. Such investigations crucially focus on points of 'crisis', causality, dysfunction, and disaster with the intention of bringing novel explanatory systems to bear. As a result, archaeologists are instituted as 'diagnosticians-pathologists' of civilizational *dis*-ease, the harmful 'toxic dimensions' of which are the iteration of racist-colonial civilizational scales – something in which medicine and the psy-sciences are also complicit.

While our 'unholy trinity' engaged with what they saw as a rational, civilized science, the thin line between care interventions (or indeed decisions regarding non-interventionism) producing cure and harm (whether intentionally or unintentionally) emerges as a marker of both heritage and health. Underpinning this in turn was the 'concept of insanity as a disease of civilisation', which 'by the end of the nineteenth century … was transferred from Europe to the "Orient"' (Zalashik, 2005: 415). It is here that 'two contradicting explanations' would again merge under the auspices

of colonial care and protection, which also led to the 'scientific "codification of racial ideology"' (ibid.). Indeed, new studies of psychiatry and psychoanalysis in Mandate Palestine and the early years of the Israeli state have uncovered these ethnic and racial prejudices in the treatment of, and assumptions made about, 'Oriental Jews and Arabs', and the positive embrace of European Jews as their 'superiors' (ibid.).

Similar motivations saw the use of sterilizations and lobotomies in the 1940s and 1950s that have since been exposed (Zalashik and Davidovitch, 2005). On the other hand, Petrie's pro-eugenics stance saw him embrace 'racial differentiation as a, or even the major cause of cultural difference' (Ucko, 2007). This was manifest in his archaeological theorizations of an ancient 'Dynastic Race' and Caucasoid civilization that he saw as superior to indigenous peoples (Silberman, 1999) and correlated with his political affiliations to right-wing groups and anti-democratic ideology in the modern sense (Drower, 1985). The development of a Zionist political agenda of a Jewish-only state in Palestine – that is, the reworking of the state as a 'biopolitical' entity – is part of these controversial future-orientated 'redemptive' models and increasingly underpinned by heritage and health as 'psychopower' (cf. Stiegler, 2013: 81–2).

Decontextualization of JS and 'unworldliness'

Jerusalem Syndrome, assessed from the above pathways, perspectives, and pathologies, itself exposes anxiety about how scientific and secular discourse can possess 'Jerusalem', located as it is for many beneath the sign of religion and the irrational, and therefore 'outside' the scientific and the modern. As previously stated, Freud (in contrast to Hermann and Petrie) never visited Palestine, a decision that interestingly was an acknowledgement of its efficacy – in other words, an encounter with Jerusalem was to be avoided.[6] Freud acknowledges too, while placing it in his own psychoanalytic diagnostics, that, like Athens and Rome, Jerusalem has a spirit of place (synonymous with a fusion of mind/body with location) that is preserved despite and/or because episodes of destruction, material change, and collapses of the past into the present. Indeed, his own therapeutic travel/pilgrimage was predominantly to Athens and Rome, where, despite disturbances, detours, and delays, he was – crucially, by ritualizing his 'therapeutic travel' or 'travel-woes/Reisemalheurs' on his own terms – able to possess, and be possessed by, the iconic heritages of Greece and Italy, in the latter case by adopting the personas of Moses and Hannibal (Butler, 2019; Rolnik, 2012).

Indeed, Freud's 'A Disturbance of Memory on the Acropolis' (1984[1936]), like JS itself, has become foundational to the broad genres of 'well-known' and 'non-place syndromes' that I have previously and purposefully recast as 'heritage syndromes' (Butler, 2016, 2019). It recounts an experience of 'splitting', so-called de-realization that, like depersonalization, is an acknowledged part of the syndrome's repertoire. Freud, however, ultimately regards Palestine, and more specifically Jerusalem, as an overdetermined, 'tragically mad' land, synonymous with 'sacred frenzies' and 'presumptuous attempts to overcome the outer world of appearances by means of the inner world of wishful thinking' – and, as such, a place of origin he recognizes within his Jewish heritage that he did not wish to visit/return to (Freud writing to Zweig, quoted in Elon, 1989; see also Freud, 1970[1932]).

What Freud identifies in his own, and what we can extend to wider, 'heritage quests' is that these can entail a pleasurable, although often violent, redemptive version of re-encountering an alternately novel and familiar place. Perhaps it is here that a critical understanding of JS exposes a crisis of ill-being and well-being – more particularly its 'pathology' – that can, with some paradox, be recast as attempts at repair of rupture and attempts to re-establish self/worlds. That is, in the efforts of those experiencing psychological duress to cure by using fantasy (see also Rose, 1998) as a shelter, refuge, and coping strategy. Freud, for example, invokes Goethe's phrase about the 'beautiful world' that can be rebuilt after it has been destroyed, and likens this to the behaviour of those experiencing mental ill health, as when

> a paranoiac builds it again, not more splendid, it is true, but at least so that he can once more live in it. He builds it up by the work of his delusions. The delusional formation, which we take to be the pathological product, is in reality an attempt at recovery, a process of reconstruction. (Freud, 1958[1911]: 71)

This attempt to deploy some coping strategy – whether failed or successful, healthy or harmful – is part of the JS paradigm, which implicates modernity's carers in a certain form of decontextualization (perhaps a depersonalization or de-realization fantasy of sorts). Here we see a strong parallel between a dysfunctional coping strategy and the sacralization of an actual site as a strategic and (over-?)protective form of 'unworldliness'. Crucially, the dysfunctional 'pathologies' of the 'pathologists' themselves are simultaneously exposed in the fixities/fixation and repetitions synonymous with the 'pathology of the oppressor' notably within Orientalist/(neo)colonial care tropes. Indeed, despite and/or because scientism, colonialism, and power indulge in their own protective 'unworldliness' and amnesias, there are episodes, countermovements, and counter-memory at play, which possess our three 'Moses' figures of scientism in alternative unexpected ritual responses reminiscent of JS. From adaptation to adoption, such 'episodes' breaks with the carapace of pathologies of compliance and open into alternative tropes of 'pathos' which in personal terms emerge as resistance and care of self within which alternative attachments are revealed. To focus on just one example, Petrie's forward-facing scientism is contradicted by his dislike of the modern age, which both archaeological excavations and Jerusalem protect him from. Indeed, rather than a rational return home to London to head 'his' newly founded scientific Institute of Archaeology, Petrie chose to let Jerusalem possess him by staying on (Butler, 2022). The first director of the institute, Mortimer Wheeler, in visiting Petrie on his deathbed in Jerusalem, describes Petrie's ultimate transformation into a 'Biblical patriarch' (ibid.).

Route two. The call and care of the world: Public dramas, communitas, and Jerusalem as cure

From poison to cure: in a pharmacological reversal or inversion, in route two, we explore tropes of care synonymous with 'curative dimensions' rather than 'toxic dimensions', thus shifting direction to rethink Jerusalem's efficacies as potent 'arche-pharmacology'

and 'pharmacopeia' of care. This pathway challenges and thereby 'unfixes' secular-scientism's diagnostic judgement upon, and sovereignty over, Jerusalem as a malign 'pathogenic factor'. In order to navigate this pathway, I further open up our encompassing framework of heritage pharmacology to the critical perspectives of a key figure within Stiegler's vision/manifesto of pharmacology: the political theorist Hannah Arendt (see Collins *et al.*, n.d.). I also look to the work of religious historian and JS critic Alexander van der Haven. As guiding forces, their critical perspectives enable us to further rethink pharmacologies of care and accompanying 'pathologies/pathos' in the mode of 'adoption' and for the articulation/cultivation of 'what makes life worth living'. More particularly, they offer a means to take on both the 'magnitude' of Jerusalem as heritage of 'place' and the earlier rehearsed 'joke in psychiatry' and thus further problematize the thin line between care/harm, normality/pathology, sanity/madness, and suffering/interventionism.

In subverting JS as an 'artefact/object' of 'pure scientism', we also confront contexts and cases within which the pharmakonic motif of pleasure/pain is secondary to the promise of the meaningful fulfilment of the quest. Recognition is thus given not only to Jerusalem but also to its fevers, syndromes, symptomatologies, and multivariant pathologies as more complex, ambivalent, and alternatively and/or simultaneously malign/benign, and in acknowledging that these are at play in wider diverse manifestations of 'heritage care'.

Arendt and Van der Haven as alternative 'mediators'/'figures of care' wield a joint critical force that breaks with the earlier rehearsed 'top-down' heritage pharmacology of care. They also offer insights into how non-sovereign 'others' might adopt and adapt their positionality as alternative 'philosopher-physicians', as 'symptomatologist-diagnosticians' and 'pathologists' engaged in alternative object relations. Such critical positionality projects its own efficacies in terms of further exposing state and institutional harm and accompanying pathologies and psychopower of violence while moving 'beyond' clinical concepts of 'health', notably 'madness-sanity', to embrace our alternative etymologies of 'pathology/pathos' within wider moral-ethical effects of public tropes of care. By rethinking extreme experiences, intensities, and states of being, from alternative perspectives and explanatory systems, neuro- and wider cultural-human/extra-human diversities-ecologies, these offer novel insights into the 'attractor qualities' that underpin wider 'heritage crusades', 'cultural quests', and accompanying 'popular heritage rites', 'ritual behaviours', and their pharmakonic interactions and efficacies.

The life of the mind: Surface and appearance

We first engage with Arendt, and Arendtian reflections upon the 'call and care of the world' (see Birulés, 2009). Using these, we can radically recast Jerusalem as a public site for the dramatic acting out of redemptive cures (as alternative 'therapeutic zone'), and as a potentially 'thoughtful' ethical domain in which self-fulfilment is mediated by caring for a place. The will to embrace JS and its transformative, pharmakonic potencies thus becomes a call for Jerusalem to possess, contaminate, and intoxicate you. This takes forward Van der Haven's point that the significant differences of opinion regarding what

is at stake in JS reside in the disjuncture between the 'expectations of the visitors' and 'those of the people who analyse them' (2008: 114).

Like Stiegler, both critics share an interest in alternative models of 'mind', 'spirit', and 'world' – notably as 'free-flowing' creative movements – and of care that challenge the static JS 'theories of cognitive dissonance'. In Van der Haven's view, the efficacy of Jerusalem itself can offer visitors a 'geographical solution' to spiritual, existential, and other needs (2008: 115). This alternative reading of communion with Jerusalem has as its core preoccupation an engagement with outside, surface, appearances, and public dramas. In these contexts, alternative narrative acts and explanatory systems more generally can help reclaim Jerusalem as a focus allowing the expression of the 'enormous variety and richness of overt human conduct' – most notably our sensory, experiential, and existential needs (Arendt, 1978: 35). As a result, it reconnects us with the core pharmacological quest/ion 'What makes life worth living?'

Arendt famously made her own pilgrimage quest to Jerusalem in 1961 to cover the Eichmann trial as a guest reporter for the *New Yorker*. This journey also made possible her controversial conceptualization of the 'banality of evil' (Arendt, 1994[1963]), which poses a fundamental challenge to psychological and psychoanalytical models of mental processes. For what Arendt discovered in Eichmann's behaviours and psychology was less the pathology of 'pure evil' and more the banality of experiences and of moral-ethical responsibility for the psychic internalization others might well fear. Arendt's concern with public expressions of those things that the psy-sciences and medical explanatory systems and categorizations see as inner worlds she projects outwards: in this way, she famously recasts totalitarianism not as a political entity per se, but as an experience of 'mass pathology' as apprehended in communal ritualized behaviours.

As Arendt later explains, she saw the banality of evil in the general need to belong to a collective will. By going along with something horrendous, Eichmann satisfied his need to belong to something. Thus, the meaning and structures of 'pathology' are both projected back on sovereign carers as state-sponsored political institutional players and projected forward as a moral-ethical responsibility of 'the people'. Arendtian perspectives thus 'make room for' radical recastings of cultural pathologies within my wider critical framings of heritage pharmacology. Crucially, Habermas iterates that Arendt identifies such mass pathologies as a crisis in terms of a 'breakdown' of 'things that matter' (see Habermas, 1977).

Arendt's own 'discovery' is thus an alternative conceptualization of the 'life of the mind' that has profound implications for heritage pharmacology, health, and directionality of movement. She argues that 'psychology, depth psychology or psycho analysis, discovers no more than the ever-changing moods, the ups and downs of our psychic life, and its results and discoveries are neither particularly appealing nor very meaningful in themselves'. She thus characterizes 'the findings of modern psychology' as 'monotonous sameness and pervasive ugliness … contrasting so obviously with the enormous variety and richness of overt human conduct, witness to the radical difference between the inside and outside of the human body' (Arendt, 1978: 35). As the critic Brunner reiterates, 'Arendt's approach leaves no room for a mental archaeology of the Freudian type',

which she sees as 'irrelevant to an understanding of the beautiful and plentiful multiplicity of human existence (1996: 63).

Jerusalem as communitas and cure

Offering similar insights, but from a different positionality, religious historian Van der Haven argues that 'the ambiguity of the experiences and behaviours of the Jerusalem Syndrome results in varying interpretations that reflect the world view' of Jerusalem as a public sphere, and which are similar to the public displays that characterize religious traditions of pilgrimage, spiritual care, and cure (2008: 112). He therefore rejects the psy-sciences fixing JS as a growing 'new pathology' by insisting on a diverse spiritual-social-counter-subcultural lens as an alternative explanatory system of meaning-making and creating truth values. Like Arendt, he also challenges the 'theory of cognitive dissonance' by dismissing psychologists' views that when 'personal redemption is unsuccessfully sought in a geographical solution', the resultant 'disappointment' is the trigger by which 'the subject disintegrates at the destination' (ibid.: 115). Van der Haven not only argues that there is no medical basis for JS to be considered a unique illness, but also contests the frequent claim that JS is a predominantly Protestant Christian issue. Reviewing surviving clinical data, he argues this view to be the 'product of biased analyses' (ibid.: 104).

This de-medicalization and recontextualization allow a means to invert the dominant pathological interpretation: 'JS should be recognised as a site in which psychiatric hospitalization of mentally ill persons is actually less likely to occur than in other situations' (Van der Haven, 2008: 104). Based upon his own fieldwork, he argues that 'abnormal sensatory experiences and cultural practices of communion with God intersect in the Jerusalem Syndrome, but also deviant behaviour as an outcome of both eschatological beliefs and compulsive pathological behaviour', adding that 'both outsiders and insiders often regard actions typical of the Jerusalem Syndrome as religious rather than as psychopathological behaviour' (ibid.: 103). Here we see care take on a role as an extended and extensive form and force operating 'beyond' the clinic.

'Dramatic experiences' (including 'private illnesses') regarded as 'normative', but being displayed socially, may create forms of communitas from JS behaviours. As a consequence, Van der Haven sees JS as occupying an established 'social position' that he situates within the historical genre 'Holy fool speaks', in which 'stigmatization by the social body is a badge of honour' and synonymous with the behaviour patterns and fulfilment of the role of 'religious deviant', who speaks 'truth'/'sanity' in a 'mad' world (2008: 112). Jerusalem's efficacies as 'medicine' are thus taken on as a coping strategy, a will to transform, and a vehicle for speaking 'truth' and achieving a 'just' future. In contrast to those JS sufferers who are left feeling humiliated and confused about their ordeal, informants emerge who gain pleasure from the experience and the opportunity to 'try out a "different lifestyle"' (ibid.: 116), to gain 'privileged insight into the invisible side of reality' (ibid.: 110), and to explore their "mystical-religious nature" in a tolerant, hospitable context (ibid.: 116).

Van der Haven concludes that acts by 'foreigners' (as visitors to Jerusalem) of displacing themselves and subsequently re-placing themselves in Jerusalem are testaments

to the existence of 'sites in Western culture where expressions of mental illness can become meaningful' (Van der Haven, 2008: 119). This alternative reframing of well-being implicates museum/heritage spaces in new formations that blur any sacred-secular distinctions. Ultimately, too, the nature of suffering is problematized for those that see themselves as 'prophetic critics or messianic savers' (ibid.: 111), for it is here that the pharmakonic motif of pleasure/pain is secondary to the promise of the meaningful fulfilment of the quest. Indeed, suffering and the pharmakonic are taken on as parts of larger visions of redemptive cure and redistributed psychopower. As another critic argues, 'Even in the act of salvation, the return of Jesus to Jerusalem is catastrophic' (Carroll, 2011: 3).

A sense of religious mission, catastrophic-magical thinking, visions of transforming the world, hallucinations, and divine calls are all, paradoxically, part of this efficacious repertoire. So too, at the very extreme, are calls to 'abolish all religion' or to destroy or 'cleanse' shrines that are believed to be 'false' and thus frustrate 'true/authentic' communion. As Van der Haven reiterates, the security services and authorities in Jerusalem regard such redemptive violence as symptomatic of religious behaviour, not as a mental health issue (ibid.: 111).

Heritage as appearance, tradition, and thinking

The above scenarios make it clear that within the diverse constellations and cosmologies of JS debates – and in encounters with Jerusalem more widely – there are a variety of attitudes to heritage and health that deviate from and subvert the 'doxa' synonymous with instituted compliance-adaptation to secular-sacralized couches-clinics and museum-heritage-archaeological spaces. For insights here, I return to Arendt.

The critic Steven Aschheim has argued in *Hannah Arendt in Jerusalem* (2001) that 'Jerusalem' in a more mobile-figurative sense serves as the metaphor for a 'free, open, and productive encounter with [Arendt's] life, work and thought'. What interests me is how Arendt sees heritage too as part of a moral-political agenda. She argues, 'We can no longer afford to take that which was good in the past and simply call it our heritage, to discard the bad and simply think of it as a dead load which by itself time will bury in oblivion' (Arendt, 2004[1951]: xvii). Arendt thus approaches heritage, tradition, and historiography in an anti-therapeutic and anti-salvational mode, while proposing that alternative notions of care need to reframe discussions. 'My first problem', she reflects, 'was how to write historically about something – totalitarianism – which I did not want to conserve but, on the contrary, felt engaged to destroy'. Her response to concentration camps was similarly to 'condemn them' (quoted in Birulés, 2009). This new critical, destructive, anti-conservationist, anti-preservationist, and anti-objectivist impulse towards heritage was, for her, driven by a moral attitude that responded to the 'call to and care of the world', and was ultimately bound up in the obligation to think (Arendt, 1978).

Are alternative dramas of depersonalization realized through totalitarian political ideologies? Arendt thinks so. In fact, she locates Eichmann's banality and his capacity for evil in the very thoughtlessness that such experiences and behaviours can induce. In comments reminiscent of Stiegler's work, she reflects on the aphorism '"Our heritage has been handed over to us without a testament"' (Char, quoted in Arendt, 2006: 33) to

argue the presence of broken threads of tradition located in discontinuous fragments. Yet this very fragmentation makes possible heritage-making / heritage work; for here, 'breaks or gaps are always possible and natality, thinkable' (see Birulés, 2009). Arendt's model of heritage is thus a composite of both new beginnings and the discontinuity of tradition reconstructed as critical moral thought. In this sense public dramas – that is, 'appearances' – interest her more than do promises of a 'homeland' (Arendt, 1978: 158).

At stake in heritage, history, politics, care, and the obligation to think is, ultimately, a reworked restoration of health. As the critic Brunner comments,

> Arendt is concerned with the moral and political effects of mental activities rather than with the mental health of political actors and their private relationships. In her discourse the ability to think on one's own is considered healthy not because it promotes the well-being of the thinking individual as a 'curative-therapeutic' basis to establish stable and satisfying friendships and love-relations, but because it induces those who are capable of a healthy narcissism to oppose or at least refuse cooperation with totalitarian evil – and thus seek to restore the health of a sick polity. (Brunner, 1996: 76)

Arendt's question, therefore, is how to construct health in a sick society.

Finally, in contrast to the pathologization of JS (in which the ultimate 'cure' for JS is to leave), Arendt fuses the motifs of thinking and/as 'healthy' movement. For one who once worked for the immigration of Jewish refugee children to Palestine, and was yet paradoxically condemned as a critic of Zionism, 'Arendt places great weight upon this notion of a faculty of judgement that "thinks from the standpoint of everyone else"... As Arendt beautifully puts it, "To think with an enlarged mentality means that one trains one's imagination to go visiting." "Going visiting", in this way, enables us to make individual, particular acts of judgement that can nevertheless claim public validity. In this faculty, Arendt finds a basis upon which a disinterested and public-minded form of political engagement can help us address the unprecedented circumstances and choices that the modern era confronts us with' (see Yar, 2005).

In the end, it is thoughtfulness and critical thinking that Arendt holds out as the coping strategy and protective moral framing for a resonant and responsible ethics of heritage and health – a movement in 'the moment' that makes possible a 'just' future.

Route three. 'Worldly' constellations of care: 'The shame of the world' and 'refugee syndromes'

My final pathway for understanding heritage pharmacology and accompanying dynamics of pathologization moves beyond the lens and framework of JS critiques to take us further into the realpolitik of extremis and thereby connects us more directly to with the 'hidden thread' within the pharmacological lexicon: that of the 'non-sovereign' figure *pharmakos*, or 'scapegoat' (Stiegler, 2013: 19–20). Following Van der Haven's assertion that 'The ambiguity of the experiences and behaviours of Jerusalem Syndrome results in varying interpretations that reflect the worldview and the interests of the observers' (2008: 112–13), it is to new contextualizations and other world views and experiences

of 'worldliness' that I now turn. It is also a movement of Stieglerian bifurcation further into the 'local' realpolitik.

Here, more thoughtful pharmacologies, archaeologies, and heritages of care implicate us in responding to the Arendtian 'call and care of the world', while also confronting us with what Primo Levi has called the 'shame of the world' (2013[1986]). I turn to the figures of Greg Tepper, a JS 'sufferer' (2019a, 2019b) and Israeli writer-blogger, who has spoken candidly about his experiences; Udi Aloni, a US-Israeli philosopher-activist and 'secular theologian' (2010, 2011); and Beshara Doumani, a Palestinian-US academic who isolated a vibrant strain of 'Palestinian archive fever' (2009). The efficacies of these 'actors' as alternative 'symptomatologists-diagnosticians' offer a means to apprehend in greater depth the 'pathologies of the oppressor', and more specifically of the 'oppressed' and the latter's desires and praxis in 'acting-back'.

This critical movement solicits the quest/ion of how heritage pharmacology might break with certain pasts/pathologies linked to ongoing oppressions and open these up to 'new' 'cosmologies-constellations-medicines'. Ultimately, it takes us from reflections on JS to a wider concern with the extremis synonymous with pharmakonic efficacies of contexts of both radical fixity and fluidity: those of confinement, encampment, and enforced displacement. Here, different 'people of pain' (Aloni, 2010) are brought into view, including reflections on the harm wrought by 'biopolitical rites of passage' and the pathologies of 'psychopower', synonymous with what I recast as 'refugee syndromes'.

'Prophet Prison': Locking Up Moses

In a critical turn to the Kfar Shaul psychiatric institution – the 'arche-pharmacology' of clinical psy-scientism and point of origin of JS pathologization – we turn first to Tepper and his experiences as 'inmate' within what he dubs the 'Prophet Prison' (Tepper, 2019b). As someone diagnosed with 'schizoaffective' disorder, Tepper has powerfully described his numerous 'incarcerations' in the Kfar Shaul clinic in blogs and other media. From personal experience, he thus further problematizes the 'psychiatrist's joke' by describing his own perspectives on the heightened states and behaviours he exhibits, including 'talking to God' and 'God talking to him' (ibid.). Tepper's testimonies offer full-scale inversions of JS care logics in which psychiatric interventionism as cure is experienced as harm and violence. He repeatedly draws out what might be the ultimate irony: 'If Moses were alive today', he would be 'locked up'. What might be understood as the clinical-secular prohibition on the 'figure of Moses', in Jerusalem of all places, exerts paradoxes and contradictions (ibid.).

The position of Kfar Shaul on the 'outskirts' of Jerusalem reiterates Foucault's point that the clinic is the space within which to put that which the wider society is 'unable to assimilate' (1977), and, as a result, the clinical viewpoint projects Jerusalem itself as non-assimilable. This positions the city with all its efficacies as the counterpoint to or 'scapegoat-pharmakos' of rationalizing-medicalized-clinical pathways. By way of contrast, Tepper gives depth of detail to Van der Haven's point that many 'sufferers' he interviewed, rather than experiencing JS as illness and breakdown, understood it as 'privileged insight' into "different lifestyle[s]" and 'invisible' worlds. Tepper writes,

'Without medication, my mind shows me a city of wonder'; Jerusalem is thus experienced as 'a revelation of the hidden that others never will see or hear'. The city is one of vivid visions and sensoria of which, he calculates, 'not even one hundredth of a percent' can be articulated, only experienced (Tepper, 2019a). In such a state, he witnesses a collapse of temporality that allows him to take in a kaleidoscope of different times, places, personas, and events all centred in Jerusalem as efficacious loci:

> I see buildings appear and disappear, from ancient times, in the landscape of Jerusalem and pyramids and buildings from Babylon are there and then gone,… she is a living city of historical times and places coming together and I try to understand why they come and go and what it all means and I talk to God with my thoughts and sometimes he answers and sometimes not and we talk about the world. (Tepper, 2019a)

Tepper similarly experiences 'ancient scripts flowing across the walls of the Old City', along with the presence of the supernatural, including 'angels' and 'demons', while hearing 'incredible music' and seeing 'stone walls' that change colours. Jerusalem is home to pharmakonic 'energy', with Tepper differentiating between shared positive 'energy' that can 'cure' by proximity and that which is 'dangerous'. Ultimately, however, he argues that when he experiences Jerusalem '[fr]ee of the meds' and 'with a free mind … there is beauty in the world' – an experience a 'buddy' suggests may be the 'general subconscious stream of humanity called the "ether"' (Tepper, 2019b). Once he is in Kfar Shaul, however, Tepper's 'Jerusalem of wonder' vanishes. He describes the clinic as 'the most inhumane, dehumanizing and abominable institution'. The clinic's 'inhumane' deathly drug regime, he argues, does not bring cure or care but merely a deadness of being and a banalization of his experiences (ibid.). He argues that, given that he does no harm to himself or others, such 'chemical medication' and sedation are manifestations of harm that from this standpoint severely compromise the quest/ion of 'what makes life worth living'.

People of pain, heritage care 'afterlives'

Aloni's work engages in alternative excavations and wider 'calls to care' in the context of Kfar Shaul. Digging deeper, he reveals pharmakonic heritage of place and its historical proximity to, and complicity in, violence synonymous with what he describes as different 'people of pain' (Aloni, 2010). Here, the perverse irony of the placement of the hospital and its function hides other looming pathologies. The stratigraphies of place reveal a doubling: '[The Kfar Shaul clinic was] established in the houses of the Palestinian village of Deir Yassin, and the inmates now reside in the homes of the murdered and deported locals' (ibid.). 'Kfar Shaul as clinic' and this doubling of 'Kfar Shaul as Deir Yassin' connects to the latter as *the* iconic symbol and traumatic symptom of the horror of the 1948 'Nakba' (Catastrophe). The 'uncanny' conflation of the heritage and experience of 'people of pain' continues as Aloni describes how 'a short time later [1951], the hospital was opened' and became 'home' to a therapeutic community of 300 Holocaust survivors. By calling up and communing with the heritage efficacies in the form and force of the popular folklore of place, he continues, 'Legend has it that

even nowadays, the Holocaust survivors hospitalized in Kfar Shaul communicate with the ghosts of the murdered inhabitants of the village' (ibid.). This complex alternative convergence of 'people of pain' as spectres communicating in a haunted landscape exists for Aloni as a potential community of care whose 'afterlives' collectively act back on the amnesia of the clinic.

To return to our ongoing concern with etymology, Aloni adopts a prophetic figure and message: 'The hospital's name, "Kfar Shaul", literally means "a borrowed village", and indeed one day we shall return it to its rightful owners.' Another challenge to 'theories of cognitive dissonance' emerges too as Aloni argues that with Kfar Shaul, 'the State of Israel manages time and again to create a reality which exceeds the most surreal symbolism of Latin American literature' (ibid.). This in turn prompts Aloni's intellectual-activist quest, expressed as a sense of ill-being: 'My life was overwhelmed with this psychotic feeling that every minute that I failed to do something, anything on behalf of Palestine, was as if I had destroyed a world and all its wonders' (2011: 43).

Palestinian fevers, refugee syndromes

As we follow this pathway, alternative pathologies/pathos and alternative syndromes and symptomatologies come into view, as the historical and ongoing violent dispossession has left Palestinians themselves possessed and fevered by the impulse to repossess lost homelands and identities. Here, Doumani makes his diagnosis of a particular strain of 'Palestinian archive fever that is spreading among Palestinians everywhere. Whether in Ramallah or London, Haifa or San Francisco, Beirut or Riyad [*sic*]' adding, that the 'full dimensions can hardly be imagined' (Doumani, 2009: 3). What ignites this 'fever' is the return to Arendtian 'fragments', as well as an overt and powerful urge to engage in heritage care practices in attempts to repossess heritage and health by creating spaces and opportunities for remembrance and commemoration and an 'archiving [of] the present, not just the past'. This is all enacted in the face of a 'continued and accelerating erasure of the two greatest archives of all: the physical landscape, and the bonds of daily life that constitute an organic social formation' (ibid.: 4).

What the example of this one site shows, in other words, is how complex such new and alternative archival 'constellations' (Doumani, 2009: 7) are and how, especially after 1948 and 1967, landscapes have been brutally transformed by 'green lines', checkpoints, the 'Security Wall', aggressive repopulations, land grabs, and settler colonization, all of which continuously creates new constituencies of displaced persons within and outside historical Palestine. These, as we shall see, are structures that have been recast as alternative physical pathologies of place. While, for some Palestinians, such enforced mobility (displacement) has taken them to San Francisco or Riyadh, others must of necessity inhabit satellite 'little Jerusalems' or 'little Palestines' in refugee camps (again within and outside Palestine), in which displaced Palestinians are forced into situations of fixity and non-movement.

Here, a 'refugee syndrome' can be diagnosed that is the antithesis of JS: an anti-pilgrimage away from, and as such detachment from, 'home/land' as efficacious 'axis-mundi'. New sovereign regimes of care in the form of the United Nations High Commissioner for Refugees (and, in the Palestinian case, the UNRWA) come into

focus and orchestrate powerful 'biopolitical rites of passage' (Peteet, 2005: 28). As forces of compliance and adaptive 'doxas', these reiterate Stiegler's concerns with the toxicities of psychopower. This grim drama entails ritual acts of depersonalisation/de-realization, synonymous with the unmaking and remaking of 'displaced persons' into 'refugees', which has its fullest expression in the 'cornerstone of humanitarian and host state responses to an influx of the displaced': 'the refugee camp' (ibid.). The camps themselves, and more particularly Palestinian refugee camps, can be characterized pharmakonically as, on the one hand, 'non-spaces', 'spaces of exemption', and 'laboratories' of 'control and surveillance' and, on the other, 'spaces of resistance' and 'refusal' (Hanafi, 2009; Peteet, 2005) and vibrant loci of heritage and memory-work (Butler and Al-Nammari, 2016, 2023). We must add a further grim and exclusively 'Palestinian paradox': the 'unresolved' nature of the Palestinian refugees' humanitarian 'rite de passage' that creates a situation of 'permanent impermanence' in which lives 'interrupted' take on further extremis.

Perhaps, then, JS emerges as a coping strategy and model for new possessional acts that embody the vision of a 'just' future, for being 'erased' also means being denied the very possibility of remembering and reconstructing. It provides what Edward Said called a 'triumphant ideology' within which the battle to rebuild identity is at its core an act of remembering, indeed, '[p]erhaps the greatest battle Palestinians have waged as a people has been over the right to a remembered presence and, with that presence, the right to possess and reclaim a collective historical reality' (Said, 1999: 12). Palestinians, variously characterized as 'besieged identities' (Said, 2003) and 'homo sacer' (Gregory, 2004), have seized upon this impulse to repossess self and world and 'just' futures in the face of loss, harm, and fragmentation. This is achieved by remembering, by literally/imaginatively reconnecting the members that constitute a collective identity. Grasping this collectively is a crucial lifeline of heritage pharmacology, as Palestinians have and continue to suffer internal and external displacement and conflict in acts of cleansing that recast them as variously exiles, diaspora, and refugees.

'The realm of the murderously absurd'

My final movement towards conclusion is enacted as a further Stieglerian 'bifurcation' that centres upon a particularly powerful vignette from the work of Palestinian Jerusalemite psychiatrist and psychotherapist Samah Jabr, as a critical point of praxis that brings the efficacies of both the 'local' and the clinical back into view. Jabr, dubbed the 'Franz Fanon of Palestine' and 'heir' to Fanon's legacy of 'anticolonial psychiatry', has used the 'clinical real' to engage in alternative critical recastings of 'place'.[7] It is the occupied ground of Palestine, Jabr (2017b) sees it – 'the realm of the murderously absurd' (ibid.) – that she diagnoses as 'pathogenic context'. Crucially, this context, in turn, exposes the mutually harmful interaction of pathologies of the 'oppressor/oppressed'. While a far cry from, though not unconnected with, the specific JS diagnosis of Jerusalem as 'pathogenic factor', this context in turn demands new pharmacologies of care.

The vignette itself is a clinical case study in which Jabr powerfully describes a 'young West Bank Palestinian woman' who in a 'psychotic state' witnesses the sky turning red.

Perceived as 'a calling', this 'call of the sky' is 'grasped' as a sign that 'Jerusalem had been liberated and that she was being called to walk in its direction' (Jabr, 2017a). Describing her behaviour as reminiscent of JS, yet as exposing stark contrasts and critical exclusions too, Jabr argues,

> Her wish for freedom, her deep desire to merge with a liberated Jerusalem surfaced to falsify the political reality. This beautiful psychotic vision resulted in border police attacking and capturing her. Although dozens of other Palestinian youngsters have been killed at checkpoints, she survived to tell her story. (Jabr, 2017a)

It is therefore, Jabr argues, within the very social fabric that such structural violences and harmful experiences of depersonalization and de-realization are embedded as part of 'everyday social facts on the ground'. The pain of this, she adds, is 'recorded in the soul as memories and fantasies' and is imbibed within the 'formation of social structures'. From the perspective of those she treats, Jabr argues that 'they see the occupation as the illness, not their reaction to it' and that the 'healthy' stance is to 'resist'. To grasp the particular needs and/as 'facts on the ground', Jabr's response has been to resist routinized therapeutic schema, an example of which is the rejection of the almost 'globalised-universalised' projection of the 'western' concept of PTSD as trauma model (see Goldhill, 2019). Jabr instead argues that in the Palestinian context, trauma is better understood in invidious ceremonies of 'humiliation' at play, within which both 'place' and 'mind' are 'occupied' in increasingly and intensely harmful ways (Jabr, 2007). Moreover, Jabr insists that 'cure' is less a focus on 'psychotropic medication' than a commitment to 'defend human rights and promote justice' (Lavergnolle, 2017).

In a crucial link that this time brings heritage back into view, Jabr's clinical-cultural therapeutic vision evokes the efficacies of heritage care synonymous with the particular Palestinian tradition of *sumud*, which translates as forms and forces of 'steadfastness', 'well-being', and 'perseverance'. *Sumud* is centred as a resource capable of bringing renewal and vitality to minds, bodies, and spirit deadened by oppressive banalizing forces. Critically, Jabr argues, while *resilience* is 'oriented towards a state of mind', *sumud* is also 'an orientation to action' synonymous with the collective 'maintaining [of] moral and social solidarity' (Dols, 2017). As such, it forms loci for the reclamation of dignity and for radically repossessing and rethinking the pharmacological quest/ion of 'what makes life worth living'.

Conclusions. Promises of fulfilment: What makes life worth living?

> [T]he question of the *pharmakon* is not merely an academic issue for learned philosophers: it obsesses each and every one of us.… This pharmacological question haunts planetary consciousness and the planetary unconscious, just as it haunts the immense loss of trust that inevitably results from the loss of care. (Stiegler, 2013: 4–5)

> We have on this land all that makes life worth living. (Darwish, *On This Earth*)[8]

In this article, by drawing on Stieglerian critical perspectives and JS debates, we have given intellectual and grounded substance to developing the concept of heritage pharmacology. From our starting point of JS, through to our final third pathway, it is clear that it is not only our aforementioned 'otherwise normal housewives from Dallas' and 'healthy tool-and-die manufacturers from Toledo' who have been dramatically affected by pharmakonic forces, or who, in transformed heightened states of being, have engaged in oft-unexpected ritual engagements in which the collapse and fusion of immanent and transcendent worlds provoke the adoption of archetypal/messianic personas. For example, Tepper, 'outside' the 'Prophet prison', and the young woman in Jabr's vignette, at the checkpoint, confront us with 'visions' of 'beauty' and 'wonder' that manifest as vibrant pharmakonic milieux that, like our journey, move across surface and depth and look up to the heavens, yet are always ultimately confronted by, and relational to, the 'local' realpolitik.

As demonstrated too in Freud's psychic-literal 'heritage quests', Hermann's initial belief in 'Zion' as psychiatric 'quickened cure', and Petrie's transformation into 'Biblical patriarch', even our secular scientists are not immune to such 'disturbances', or to the adoption of alternative personas. Within these experiences, we witness the crisis/collapse of imagined/real worlds open up to provide privileged loci, portals/conduits as resources around which our various 'actors' project and commune with efficacious pharmakonic life forces. As sometimes spontaneous/unexpected – even accidental – yet decisive acts, these are looked to as forms and forces of care and protection.

By recasting 'pathos/pathology' as mutuality, relationality, and vital creative-constitutive conduits to and interactions of anamnesis-hypomnesis, Stiegler's pharmacology offers a means to understand encounters like JS as experiences within which 'new possibility' can emerge. As a result, from what Stiegler would call an 'enframed stereotypicality' and associated 'traumatypes', there is housed the potentiality of an 'awakening' of things (see Stiegler, 2019). Thus, when the difference is too much between imagination and reality, rituals need to be in place. The intoxicating effect of Jerusalem can confront us with how realizable 'dreams' as an encounter with the unmitigating 'real' could be, once recast within the promise of change and as the unexpected performative acting out of a sublime that cannot otherwise be created. Here too, the 'noetic' comes into view; as Stiegler argues, the 'noetic' quality of a mystical experience refers to the sense of revelation (ibid.). Belief in miracles and JS experiences could be understood as a challenge to forced adaptation – and recast as 'bifurcation' – within which the adoption of the 'unexpected', 'miraculous', and 'accidental', and thus of 'difference', makes transformation possible (see Stiegler, 2018: 154–71; Stiegler, 2019: 286–312; Stiegler with the International Collective, 2021) . Here, the construction of worlds encompasses the extremes of performance that have profound implications not only for those experiencing JS but, crucially, for those sensing their 'non-existence' who thus act in order to exist.

Drawing the diverse threads of our journey together, heritage pharmacology can best be grasped as a highly potent field of 'object relations' – of adjustment/disadjustments and (de/re)attachments to culture and/as *pharmaka* – that confronts us with the new possibility and praxis of drawing out what is curative. Such interactions are

present in all our three routes – which, in turn, crystallize as dominant forms and forces to constitute various conditionalities of 'heritage pathos/pathologies' within our respective pathways – as they operate across and collapse into the diverse registers and worldings our quest has taken us to. Taking on the pharmakonic interpolates us all not only in the praxis of 'bifurcation', which relies on the recognition of the existence and 'adoption' of the 'local' as 'grounded in anamnesis', but also in the urgent need to act on the new 'curative' potential and efficacies that these fissures, fragments, and encounters expose, and thereby to cultivate 'trust' via the 'adoption' of shared mutualities of 'heritage care' and to harness new 'pathos' within a 'healthy' politics of *sumud*.

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Notes

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1. Stiegler's understanding of '*savoir-faire*' is as underpinning knowledge/know-how 'not reducible to employment' but 'creatively cultivated' through 'desire' and/as 'care' (2013: 39).
2. For Stiegler, 'circuits of transindividuation' within which the *pharmakon* operates are synonymous with 'long-circuits' as healthy 'movement' and 'circulations of intensities that traverse and form by opening up networks', thus creating 'care' as 'relations of attachment, *philia,* projections, identifications, acknowledgements, obligations, and so on' (2013: 72). 'Short-circuits', however, 'bypass' this process of sublimation 'by requiring the soul to *adapt* itself to a *doxa,* that is, to dominant ideas that have not been produced and conceived by those who merely submit to them, rather than share in them' (ibid.: 19; original emphasis).
3. Lowenthal's point being that lived experiences as deeply felt encounters with 'heritage sites/milieux' visitable as 'place' collapse perceptions of time/temporality.
4. Hierophany is thus the physical manifestation of holy or sacred reality (Eliade, 1992).
5. Flinders Petrie (1853–1942) is an iconic and increasingly controversial figure. Dubbed the 'father of archaeology' and of Egyptology, he is regarded as *the* key figure pioneering scientific excavation techniques, notably within the Middle East, and was crucial in the creation of the UCL Institute of Archaeology in London, as well as a number of museums and collections, such as the Petrie Museum (https://www.ucl.ac.uk/culture/petrie-museum); and in the training of future archaeologists. His colonial-racist-eugenicist views/legacies are currently under critical scrutiny (see Butler, 2022).
6. See Rolnik (2012) and Elon (1989) for Freud's responses to Jerusalem/Palestine.

7. https://www.imdb.com/title/tt7606778
8. See '"We Have on This Earth"' (n.d.).

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