INTERVIEW

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Education and Health: "I didn't want to be a professional who simply pathologized, who medicalized" – An interview with psychiatrist and educator Jairo Werner

Educação e Saúde: "Eu não queria ser simplesmente um profissional que patologizasse, que medicalizasse" – Uma entrevista com o psiquiatra e educador Jairo Werner

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How would you describe your professional and academic trajectory so far? What achievements stood out the most throughout your career?

Jairo Werner Júnior: My professional and academic trajectory has a common and somewhat permanent characteristic: the articulation between Health and Education. At the end of 1977, I graduated from the Faculty of Medicine at Fluminense Federal University. As an undergraduate, I had the opportunity to study pediatrics during internship, organize a study group in child psychiatry and carry out health and education work at the UFF advanced campus in Oriximiná-Pará, through the Rondon project. While still an undergraduate, I became interested in the areas of child development and child neuropsychiatry, which are closely related to Vigotski's Pedology and Defectology. During my medical degree I was also able to study Theology for a few years, which allowed me to work as a theological education teacher and have the classroom experience with students in the seventh and eighth years of elementary school.

The experience in the theology course was important for my training, complementing the medicine course, which is very technical. In theology, on the contrary, I had the opportunity to learn about subjects in the human sciences, such as philosophy, history and psychology.

Having graduated in medicine, I specialized in pediatrics, with a focus on child psychiatry, and at the same time, I pursued a specialization in educational administration in the education field, since I was working at school. I have always been concerned about educational insertion; *I didn't want to parachute into school.* In other words, I wanted to be a doctor who also had pedagogical knowledge.

Later, I took the specialization course in Child Development at the Federal University of Rio de

Janeiro (UFRJ), with Heloisa Marinho[1], a great Brazilian educator who has many aspects in common with Vigotski and was the one who introduced me to this author for the first time. Marinho dedicated herself to teacher training, organizing the first courses in early childhood education, literacy and special education in Rio de Janeiro.

The specialization courses had a methodological characteristic similar to those developed by Vigotski. They focused on child development and education in general, but put children with disabilities into perspective. These trainings had very interesting and innovative characteristics: students from various professional areas, in addition to pedology and pedagogy classes with Heloisa Marinho, brought and shared written observations of children from their professional practices and were also able to meet and participate in the approach of students with and without disabilities, integrated into a large art studio and a Natural literacy room – which operated close to the Mangueira-RJ slum[2].

In this work dynamic, my sources of observation were mainly carried out with children hospitalized at the university hospital. At that point I was already working as a doctor and professor at the UFF Faculty of Medicine and the experience helped me a lot to understand the mediation processes between adults and children and between children and each other. So, when I needed to give practical classes to internship students in child psychiatry, it was easier to organize medical-psychiatric care along the lines I learned from Heloisa Marinho.

As the great demand from patients (1979) for the child neuropsychiatry service was, at this time, already constituted by referrals from the school, requesting evaluation and reports for students complaining of school learning problems. There was a need to expand my knowledge about the issue of school failure and I then sought a master's degree in Education at the Faculty of Education at UFF. It was very important to understand that school failure reflects the exclusion that operates within the school, reproducing the process of social selectivity and finds in health a way to legitimize school failure as an individual medical problem. In this context, it was important to meet researcher Victor Vicente Valla, professor of Health and Education, who worked exactly with the issue of school failure and was my master's supervisor. The master's degree resulted in the dissertation entitled: "Desenvolvimento e aprendizagem das crianças das camadas populares: contribuição à desmedicalização do fracasso escolar" (Werner, 1993).

The demand for health education, to this day, worries me a lot, as the field of Medicine remains unprepared when it comes to taking a more critical view of the medicalization of students sent by school.

In the case of the Child Neuropsychiatry Service that had been organized with the advice of Heloisa Marinho, the way of caring for children who were victims of academic failure was completely different from the standard of our university hospital, as it was made up of a large art studio combined with a children's playground, which even gave rise to the extension project Child Psychiatry Without Walls. Thus, children sent by the school, with or without disabilities, with or without illnesses, did not feel treated as miniature or sick adults, but as children and students at a school. It was contradictory that education referred students to us, looking for a medical solution, while I looked to education, particularly Heloisa Marinho, for an educational way to better understand and serve these children. Vigotski shows that instruction can boost student development. Based on this premise, the objective was also to prove to those children that they were capable of learning.

1 With a degree and PhD from the progressive University of Chicago, she was a professor of educational psychology at the Rio de Janeiro Education Institute. Born in São Paulo in 1903, but having lived and worked in Rio de Janeiro until 1994, she is one of the most notable Brazilian educators. In addition to being an educator, psychologist and philosopher, Heloisa Marinho stood out as a child development scientist (pedology) and as a mentor to generations of teachers at the Rio de Janeiro Education Institute and Colégio Bennett. As a pioneer, she organized the first teacher training course in the area of early childhood education, as well as post-normal literacy and special pedagogy courses. An active participant in the group led by Anísio Teixeira and Lourenço Filho, Heloisa Marinho obtained significant results with the natural literacy method of reading and writing in Rio de Janeiro and Volta Redonda.

2 In the Sociedade Pestalozzi do Brasil building.

In the 1970s/1980s, when the school referred the student to a health service, the child, in general, underwent an electroencephalogram and ran the risk of being diagnosed with *cerebral dysrhythmia* (grade 1, 2 or 3) and being medicated, even that this change merely meant a standard deviation of the normal frequency distribution of the electroencephalogram (EEG) tracing and not a pathological change. Many children, however, when correlating the EEG results with school problems - a spurious cause and effect relation - were medicated for years with anticonvulsants (gadernal, carbamazepine). Medicated unnecessarily, they were left in a kind of chemical straitjacket for forced control of the EEG tracing, even without a neurological clinic consistent with seizures, for example. Some schools, mainly private, even required a normal EEG to enroll a student.

With my critical stance on the medicalization of education since that time and using a *more educational* approach with patients, I began to be seen by my peers, pejoratively, as more of an instructor or child entertainer than a psychiatrist. This, however, far from making me embarrassed, made me happy, because it was exactly what I was looking for. I didn't want to be a doctor who simply pathologized, medicalized school failure or other social issues, locked in a classic office, with a reductionist view of development.

In order to have a more critical place of speech, however, in relation to medicine itself and child psychiatry, it was necessary to obtain a doctorate in Medicine. I chose at the State University of Campinas (Unicamp) to pursue a doctorate in Mental Health from the Department of Psychiatry of the Faculty of Medicine, as Unicamp was the World Health Organization Collaborating Center for the adaptation and translation of the ICD-10 chapter about *Mental Disorders and of Behavior*. My interest was to analyze the diagnostic criteria for Hyperkinetic Disorder - the ICD-10 name for Attention Deficit Hyperactivity Disorder (ADHD). Precisely the topic of my thesis was "Transtorno hipercinético: contribuição de Vygotsky para ressignificar o diagnóstico" – which is in the UNICAMP digital library and generated an article (Werner, 1999) and a book (Werner, 2001).

While I was pursuing my doctorate in the health area, I maintained my relation with Education, as I took elective courses in the Postgraduate Program in Education at the Faculty of Education at Unicamp. This insertion was fundamental, both for my academic and professional trajectory, as it allowed me to participate in discussion seminars about Vigotski and his work in the Thought and Language Research Group, coordinated by professors Angel Pino, Maria Cecília Rafael de Góes and Ana Luiza Smolka. A decisive fact for me to better understand Vigotski, not only with these renowned professors, but also in interaction with other students and colleagues, such as professor Anna Maria Lunardi Padilha, who continues to be an excellent interlocutor for me, to this day.

What experiences do you consider to be a milestone in your professional career that brought you closer to scientific production at the interface between health development and education?

JWJ: We are nothing more than our relationships. We are historically marked by the encounters that constitute and enable us to have constitutive experiences.

Experience with Heloisa Marinho

In my case, the most significant first meeting was precisely with professor Heloísa Marinho, as she has a whole history related to research into the development and language of Brazilian children (Werner, 2015; Marinho, 1935, 1955; Marinho & Werner, 1982). Like Vigotski, she also understood that the normal can help to understand the pathological and the pathological (disability, schizophrenia) can help to understand development. I learned from her how to organize the space, environment and school routine for children with and without disabilities. I also learned how to teach children to read and write, using the Natural Method (Marinho, 1987). All these experiences were fundamental for

me to build my theoretical and methodological base on education, development and defectology.

Experience with Vigotski and the Assessment of Affective-Cognitive Processes (APAC)

Another impactful encounter in my training was with Vigotski's own work. This meeting helped me understand the issue of the cultural formation of personality, the social relations that constitute the human being. Vigotski was also the epistemological basis that supported not only the search for a critical analysis of my clinical area, but also the consolidation of arguments to propose new interventional approaches. In this sense, it was possible, for example, to propose the assessment of higher psychological functions, from a systemic perspective, using a type of analysis that is not centered on the subject, but on the interactive processes taking place, which I called Assessment of Affective-Cognitive Processes (APAC).

Africa: Children in Armed Conflict

The work of *Child Psychiatry Without Walls*, within the university hospital, continued to be innovative. Because of him, the United Nations Children's Fund (Unicef) invited me to work with children who were in a situation of armed conflict, in Mozambique, on the African continent. It was this mission that gave me the great opportunity to meet with the Minister of Education of Mozambique, Graça Machel. The challenge put by the minister was to prepare professionals to work with children who are victims of armed conflict, with their traumas, as well as health problems related to malaria, malnutrition, etc.

With my educational experience with Heloísa Marinho and the theoretical foundation in Lev Vigotski about the personality issue, my team and I, for five years, had the fantastic experience of living with students and teachers from Mozambique. The idea was to avoid stigmatizing children and students as deficient or incapable of learning, always emphasizing 'the essentially social character of the psychic'.

The experience was very important for us to show how the school was the main agent of mental health for those displaced children, violated by the war and that teachers needed to be prepared and empowered to respond to these demands, not being trapped by the idea that students who went through/were going through such severe trauma would not be able to learn and develop.

Experience with high-risk newborn babies in the incubator

From Africa to the Antônio Pedro University Hospital (HUAP), another significant experience was the work carried out with high-risk newborns who used mechanical ventilation in the incubator. High-risk newborns bring us the challenge of interrupting and preventing immediate access to socio-affective interaction, which can compromise their development. About this issue, I wrote a short article (Werner, 2000). In it, I was able to see that, in the case of a baby confined to an incubator, the importance of contact and interpersonal care is central. The interpersonal relation, according to biological markers, has a positive impact on the neurophysiological axis, the heartbeat and even the baby's immunity.

All these experiences were fundamental because they revealed to me who I should be on the side of: those who suffer, those who are being excluded – whether due to biological and/or social factors. In Brazil, we live this reality a lot in an unequal, oppressive society, which excludes huge portions of the population from access to health and education.

Experience with Early Childhood Education

In the case of Early Childhood Education, for example, my experience was also important (1986) with the *Primeiro a Criança* program, of the Brazilian Assistance Legion, with the UNICEF support. The program had the goal of reaching one million children, with the aim of increasing the number of daycare centers, making them educational institutions and not simply a place of social assistance for mothers to work outside the home.

At that time, the educational dimension was not guaranteed from the daycare perspective, as is the case today. Of course, the social and welfare function is important, but the proposal prioritized the education and development of the child. It was very important to participate in the educators' training in various parts of the country, introducing a focus on child development.

In this context, we transformed the Heloísa Marinho Development Scale into a *development card*. The card maintains the characteristics of the proposed scale, emphasizing the understanding of the child's pedological age, as Vigotski points out. It was important to check, for example, whether children's pedological development somehow indicated the quality of daycare centers. Here, we have a relevant aspect: the child's development is an important element to verify whether the child is receiving his basic and educational needs.

The training we were developing had an interdisciplinary element to understand child development and a way of linking the organization of the daycare environment (environment) and diverse, expressive and creative activities; a curriculum rich in content and experiences focused on children's interests and needs. Participating in this program, coordinating the child development part, allowed me to better understand the reality of the country and the precariousness of early childhood education.

Experiences in the Child Psychiatry Sector

I worked in early childhood education, but without ceasing to care for children and adolescents in the Child, Youth and Family Psychiatry outpatient clinic, continuing the Child Neuropsychiatry Service which, after 16 years at the University Hospital, was destroyed along with the studio and the playground, probably, for political and ideological reasons. However, after a few years, I managed to reorganize it in a University location, closer to the community and further away from my opponents. The objective of the service continued to be to understand the real issues that underlie child and adolescent psychiatric demands.

The care model has never focused on diagnoses, medicalization, labels, the primary core of deficiencies or mental disorders, but on the interactive process aimed at the full development of the patients' personality with autism spectrum disorder, disabilities, spectrum disorder schizophrenia etc. To this end, the sector has, to this day, a spacious kitchen for activities such as the pizzeria; all inserted in a public child psychiatry service. It was a huge effort to create these differentiated spaces, but with a lot of struggle and resistance it has been possible to maintain them. The results are very effective. Students, especially future doctors, have had the opportunity to experiment and prove that it is possible to have a type of child psychiatry service that deviates from the traditional model of a set of outpatient clinics focused solely on mental disorders.

Experience with children and adolescents and psychoactive substances

In the same way, when I receive children from the streets and drug users, teenagers who use crack, who also comply with socio-educational measures, the most important thing is the perspective that is given to them. This makes a huge difference!

This experience enabled me to develop an approach related to drugs, from Vigotski's historical-cultural perspective, reported in my text: "*Abordagem afetivo-cognitiva na prevenção e tratamento dos problemas relacionados com o uso de drogas*" (Werner, 2010).

The pizzeria's work, for example, began precisely because these children and teenagers couldn't stand being in closed offices or therapies. They needed/need something more practical, dynamic and meaningful; learn to make and eat pizza collectively, mixed in diverse groups, without forming ghettos. The pizzeria was the guiding activity and the path found for self-regulation and personality development. Our chef-pizzaiolo is a former drug user and achieves good communication and interaction with participants (teenagers, staff and students). The conversation and cooperation that

takes place in the kitchen generates the opportunity to form bonds and incorporate new knowledge and skills. It is these very simple, very cheap experiences that allow us to concretely address the patients' needs and demands, through the reframing of their life trajectories.

With these experiences with teenagers using drugs, I started working with the Public Prosecutor's Office aimed at children and teenagers who live on the streets and are drug users. It was when crack use became widespread in Rio de Janeiro and it was essential to propose joint health-education activities, through programs linked to restorative--compensatory aspects, including this public in activities together with other children and adolescents, thus avoiding the ghettos formation.

Many other significant experiences of applying Vigotski's social vision of human development have been very rewarding in my career, but I would like to highlight the need to integrate, in medical practice, diagnosis, guidance, therapy and prognosis based on the child's assessment. The evaluation must be more pedological, that is, along the lines of the Vigostkian perspective, not only focused on the past, on the psychic functions already formed, but prospectively, it must aim to identify the child's functions and abilities that are in training processe. Unlike the traditional way, assessment cannot be divorced from diagnosis, therapeutic guidance and prognosis, as they are part of the same set. In medical manuals, to make the *Attention Deficit Hyperactivity Disorder* diagnosis, criteria are established that do not make it possible to know the singularities of each child, placing them in an undifferentiated mass, whose treatment and prognosis would already be pre-established.

Traditional assessment, therefore, only serves to place the child in a diagnostic category. In my practice, however, the assessment points to the concrete path to follow, whether therapeutic or educational. Thus, the assessment should indicate, for example, in the case of a child complaining of inattention and hyperactivity, how in the interactive process with the examiner or another child, he managed to stay concentrated on the activities, through social mediation.

The evaluation also allows for the most unique and prospective prognosis for that child, when in line with the concept of Zone of Imminent Development developed by Vigotski. For this reason, I insist that my medical students share the solution of a task with the person being evaluated, *lending their own psychic structure to the patient*. I recommend that they do not try to carry out a supposedly neutral assessment, as the objective is precisely to find out how the *inattentive child*, for example, managed to stay focused on the activity and participate in it. Identifying: what resources were used and what type of mediation was necessary? It should not, therefore, be a conventional assessment, which only highlights flaws and faults. In other words, negative evaluation based on what the subject was unable to do.

Medical assessment and diagnoses have contributed to the medicalization of school failure. Medical reports, increasingly requested, end up legitimizing the process of social exclusion of the lower classes, as they place the "blame" on an individual student's disorder who does not learn. For this reason, we have an ethical and political duty to be on the side of students from the lower classes, as they have been victims of a process of social selectivity that has one of its most perverse aspects in school failure.

I am aware that it is necessary to have a knowledge repertoire about Vigotski and his Historical--Cultural Psychology aimed at facing the real demands that arise. In this case, Medicine normally expects the patient to leave the consultation with a medication prescription. This type of solution and resoluteness, however, has many limits, because, first of all, the doctor's response needs to be effective, that is, be medically and socially important for that child, their family and the community in general, offering support and a concrete path forward.

How did you get involved with Vigotski's studies, especially defectology? In your opinion, what was Vigotski's greatest contribution to the scope of his work, considering research, teaching and extension?

JWJ: The historical-cultural perspective supports all the integrated teaching, extension and research projects that I coordinate, articulating theory and practical challenges. The great contribution of Vigotski's metatheory and theory vision was to enable a broader understanding of my own experience in the child psychiatry sector that I coordinate. In Vigotski's texts about Defectology and in his studies about mental disorders, I found foundations for the practice (Vygotsky, 2018). The author's notes about the experience with clinical cases are very rich material.

I had to face a challenge as soon as I started as a professor at the Faculty of Medicine, aged 25, when I needed to organize, at the University Hospital, the Child Neuropsychiatry sector - associated with the extension project *Child Psychiatry without Walls*. So, I prepared myself to deal with serious cases: rare syndromes, congenital and genetic problems, etc., but I soon realized that, in addition to receiving few cases with these problems, the majority of the demand was made up of children who presented complaints related to school issues: learning and behavior. Another demand of the service was to care for children with severe malnutrition, who were hospitalized and did not develop during that period. So, I started a clinical stimulation program aimed at children hospitalized with nutritional and developmental deficiencies. Clinical stimulation is the term used by Heloisa Marinho, which largely corresponds to Vigotski's Defectology. Today our extension program "*Rede UFF De Saúde Mental da Infância e Juventude*"[3] encompasses several extension projects, in which undergraduate students actively participate.

In the area of undergraduate teaching, therefore, it was a great achievement to include the area of Child Psychiatry in the discipline of Integral Medicine for Children and Adolescents in the UFF medicine curriculum, with a syllabus based on Vigotski's historical-cultural references. In the mandatory curriculum of the Medicine course, we also have: the doctor-patient relation module in pediatrics, supervised fieldwork and the elective internship in child psychiatry.

In the Scientific Initiation discipline, research is also based on the principles of Historical-Cultural Theory; being yet another opportunity for students to get closer to Lev Vigotski's theory.

In addition to these mandatory subjects in the Medicine course, I coordinate two optional/elective subjects for more than 10 undergraduate courses. It is the subjects of Child Development and Child Neuropsychiatry that have the greatest competition (around 100 students per semester). Students from Medicine, Education, Physical Education, Pedagogy, Social Assistance, Nutrition, History, Social Sciences, Communication, Psychology, among others, participate. The subject of Child Development can be considered as Pedology, as the proposal is to provide common basic training to students who are in various degrees, about: child development and the notions of normal and pathological. I offer these two subjects in partnership with professor Anna Maria Lunardi Padilha, who teaches classes linking health and education in a very concrete way. In them, we therefore based ourselves on Vigotski's seven classes about the Fundamentals of Pedology (Vigotski, 2018).

In research, Lev Vigotski's conceptual basis is the most concrete thing we have. This allows me to be both in Africa, assisting and researching children in armed conflicts, and in Antarctica, in the project I coordinate entitled: "*Dimensões de saúde mental no isolamento antártico*" (SaúdeAntar Project- 2018-2027). One of the axes of research in Mental Health is Vigotski's concept of experience and, therefore, the search is for a more qualitative approach: interviews, observations, narratives and

3 The extension program "Rede GEAL-UFF de Saúde Mental da Infância e Juventude" integrates the following projects and extension actions: Escola Fantártica – Núcleo Comunitário, Psiquiatria Infantil Sem Paredes, Justiça Restaurativa e Telessaúde & Teleducação.

memorials as data construction instruments. Mental Health from a dialectical perspective represents the subject's process of struggle and resistance in the face of their need for social belonging.

From a conceptual point of view, which Vigotski's theoretical elaboration had the most impact on your way of understanding human development?

JWJ: Certainly, there are several concepts. But I would like to highlight just 3.

Imminent Development Zone

The concept that had the greatest impact, initially, was the concept of the Imminent Development Zone. This concept helped me, mainly, in the evaluation and treatment processes focusing on the centrality of the other's participation in the development process.

Semiotic Mediation

The semiotic mediation concept of was also very important. After all, when we talk about the human constitution, we talk about the human being as a symbolic and, therefore, historical being: a being of language, in language. Here, the semiotic mediation concept will support this psyche idea, helping us to understand that the natural is transformed into cultural by human action.

Social Compensation and Overcompensation

The compensation and overcompensation concept that point to the secondary core of the disability, the social constitution of the personality. It is the secondary dimension that explains how Derek[4], who became blind in the incubator, became a professional big wave surfer in Nazaré, for example. Vigotski recognizes disability as the primary nucleus and the secondary nucleus as the social and educational possibilities that mark the subject's life trajectory, revealing the power of development of a given personality.

Considering the 100 years of Vigotski's first texts that involve the theme of disability, how current and relevant is the work?

JWJ: Vigotski seems to speak to the current reality. Mainly in my area, for example, in the case of evaluation. Almost a century ago, Vigotski already considered clinical diagnoses as a mere description of symptoms or complaints preceded by a medical term. For him, we must move from a merely diagnostic and clinical, negative assessment to a pedological assessment with a prospective perspective. About this, Vigotski (2012) explains:

We can summarize [...] three decisive moments that underlie this analysis: analysis of the process and not the object, which reveals the effective dynamic-causal link and its relation in the game of external indications that disintegrate the process; therefore, an explanatory and not a descriptive analysis; and finally, genetic analysis that returns to its starting point and restores all developmental processes in a form that in its current state is a psychological fossil (Vigotski, 2012, p. 70).

Thinking about issues involving people with disabilities, how do you observe the advances of Vigotskian ideas in education and health?

JWJ: In education, Vigotski's ideas are a little better known than in health, but they are still far from being applied consistently, whether due to the limitations imposed by hegemonic - mechanistic and organicist conceptions of disability - or due to lack of access to the production of assessment and education instruments within the scope of historical-cultural theory.

4 Brazilian Derek Rabelo achieved several records, being recognized as the blind surfer who faced the biggest wave recorded to date in Nazaré (Portugal). Additionally, he is the only visually impaired person to surf challenging locations such as Pipeline, Hawaii, and Teahupoo, Tahiti.

In the area of medicine and child psychiatry, to incorporate Vigotski's vision, there is still a long unexplored path to cover, especially in working with people with disabilities and people with mental disorders. To this end, in Brazil, not only is it necessary to have more knowledge about Vigotski's work, with the dissemination of good translations (by Zoia Prestes and Elizabeth Tunes, for example), but we also need to transform the current cultural moment, aiming for a more conscious and fair. The celebration of 100 years of Vigotski's defectology is extremely important to mark the fight for those excluded and oppressed because of their disabilities.

Considering your studies of Historical-Cultural Theory and contemporary challenges in health and education, what would you say to the new professionals' generation?

JWJ: Looking back on my four decades of professional experience, I identify that it is very important not to give up the fight for ideas and concepts that can combat the harsh reality of health and education in the Brazilian context. When we study Vygotsky's work and work on this dimension of the subject as a symbolic being, as a social being, we are engaged in a struggle over the conception of man and the world. So, having this awareness means being committed to a paradigm shift to see students and children with disabilities in another way, different from how hegemonic society sees them. In the productive capitalist world, people suffer when a child with a disability is born because they think that they will not be able to be happy because they are not productive for the system. We therefore have this obligation: to resist and fight to occupy spaces, changing mentalities and practices.

I hope because I see many of my medical students with new attitudes, interacting in a more interactive and collaborative way with patients. They are no longer as concerned about prescribing medications or labeling children. I like to demonstrate that a different medical practice is possible in different situations and contexts: the baby in incubator, child victims of war, patients in hospital outpatient clinics or psychosocial care centers, or even assistance in Antarctica.

Unfortunately, many of the accumulated experiences such as those reported are not applied by public policies, not due to lack of effectiveness, but due to social forces that work against the necessary social transformations.

The new generations need to be persevering and consolidate Vygotskian conceptual basis to better face this fight in favor of the good cause, that is, guaranteeing access to quality health and education for all! The struggle is difficult, but it is rewarding. It gives meaning to life! Fighting is necessary! Many advances are the result of social pressures. The new generations must resist and not allow themselves to be co-opted by dominant mechanistic, organicist and non-historical conceptions. Having a purpose and fighting with and for your people is an experience that expands the affective--cognitive processes of our personality. Fighting is good for everyone's mental health!

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