AM
Rivista della Società italiana di antropologia medica / 11-12, ottobre 2001, pp. 353-379

Rhetorics of madness and practices of healing.
An ethnography in the field of mental health

Massimiliano Minelli

Sezione Antropologica, Dipartimento Uomo & Territorio, Università degli Studi di Perugia (Italy)

In this paper, based on fieldwork carried out in an urban community in Central Italy (Gubbio, Umbria), I will outline the network of discourses and practices involved and articulated in debates about community mental health problems [(1)].

For this purpose, once I have identified the local political issues about the planning of social-health services, I will then describe the psychiatric process of dealing with mental health problems (particularly in the case of psychotic disorders), with an intricate plot of social relations and symbolic constructions. In this perspective, I will use projects of re-inserting patients into the world of work as case studies.

I will discuss basically two processes: the first is the birth and development of the psychiatric field; the second is the social contextualisation of narratives about working-life, illness, and care experiences produced by patients, relatives and professionals. As we shall see, the intensive study of daily practices can highlight aspects that could otherwise go unperceived when looking at the public form of representation. In particular, I want to show how the symbolic construction of social boundaries and healing practices can be peculiarly combined by the agents in relation to the discursive status of the "subjects" involved. Political strategy and forms of action/resistance are in this way dialectically articulated between polarities (public/private, self/other, and visible/invisible) and situated in opposing perspectives concerning how to manage the elapsing of time. Social practices about madness can activate dimensions of embodied social experience, for the most part "inarticulable", representing a situated critique of the local cultural assumptions about society and psychiatry.

1. The psychiatric field

Recent contributions in medical anthropology (Gaines 1992, Bibeau 1997, Littlewood 1998, Nichter 1998) have stressed how health policies, medical practice, and contesting "rhetorics of self-making" (Foucault 1988, Battaglia 1995) – used by different social actors – can be appropriately located in the field of local professional and popular ethno-psychiatry. From such a perspective, the network of psychiatric services and popular resources[1] can be considered as the generative *locus* of social practices that affect the confrontation between "madness" and "psychiatry". Moreover, in public debates about mental health problems, the privileged objects of observation can be represented by the semantic cores around which therapeutic practices interact with hybrid objects continually renegotiated and open to different forms of definition. I think that such hybrid objects are particularly interesting in the case of the Italian community psychiatry that has developed in the years following the psychiatric reformation act (1978, *Law of psychiatric reform 180*), best known as *Legge Basaglia* (2).

Italian public psychiatry – more than other branches of contemporary medicine – is as a field of knowledge and power (3) where conflicting strategies concerning institutions of social production (the world of labour) and social reproduction (the family, the school) are acted out. In daily routines of psychiatric services, social workers are engaged in mediating social micro-conflicts and establishing different alliances.

The confrontations about local policies and the rhetorical strategies concerning mental health problems could be interpreted with particular attention devoted to the development of public psychiatry. The Italian psychiatric field has been characterised by meaningful and substantial changes in its policies – implemented by the de-institutionalisation processes of the '70s and '80s – concerning mental illness and, in a more general sense, public health. In recent years, new elements have been at stake. With fluctuating and heterogeneous levels of institutional intervention and of popular participation, debates concerning the real activation of the "fundamental rights" of patients have been promoted. "Fundamental rights" concerning the ways of co-operation and organisation of initiatives in the local communities, and aggregation involving patients, families and psychiatric workers.

In the 1970s in Umbria, lively political debates took place within the local communities, often in rural areas, to re-insert patients discharged from mental hospitals into community life. A process of social negotiation was promoted to develop public Mental Health Centres (*Centri di igiene menta-*

le, CIM) in the whole region. During the eighties, pressures connected to new economic policies of budget reduction and to the processes of economic management (*aziendalizzazione*) in the Local Health Units (*Unità sanitarie locali*) have substantially led to a polarisation of the positions regarding the request for application of the *Legge Basaglia,* particularly, the implementation of residential or partially-residential structures for ill people.

In particular, the public Psychiatric service [4], where I did my fieldwork, exhibits some of the contradictions that have been progressively revealed throughout the last three decades, in the differentiated renewal process of Italian psychiatry [5]. Furthermore, the double nature of the interventions of public psychiatry – medical and social – is a source of paradoxes incorporated into the very structures of the local psychiatric network. I shall briefly outline some of their salient features.

The Mental Health Centre in Gubbio today appears to some inhabitants of the town as a container of secret encounters still burdened by the stigma of *madness*. The shame ("*la vergogna*") that people used to feel when passing the Mental Health Centre rooms seems today notably reduced. Nevertheless the patients and their relatives are still involved in persisting situations of discomfort derived from stigmatisation. Psychiatric nurses and doctors recognise that the problems encountered by patients and their relatives in addressing the CIM [6] (*Centro igiene mentale*) are, for the most part, a consequence of a peculiar history of the "Servizio" (the name used by psychiatric workers to refer to the psychiatric service). A psychologist outlines the historical transformations in the following way:

> *«Here we have, in a sense, a historical discourse. At first all the patients were old: either aged – that is to say, those who had been here for a long time and were rather elderly –, or old, in the sense that they had a lengthy psychiatric background. At one point, then, we had many retired people, many of whom received an old-age pension.* [...] *Therefore, roughly since 1985 – in 1985 our Centre was reduced to its lowest terms; at its historical minimum we had approximately, more or less, sixty people – we had a service with these features:* a service with a small staff, essentially with chronic patients, patients from the Psychiatric Hospital... who had been discharged into the community [territorio] when the Hospital closed [...] *There was a range of... we could say, a residue of improper patients, too. We had a lot of improper requests and even patients with acute crises – cases that must be followed by the Service –, and we had great difficulty in persuading the patients to accept treatment. Because* "the CIM is the place where madmen are treated", *because "people go there to..." This aspect must be considered, because if we have a Psychiatric Centre only with old, sick and easily recognisable psychiatric people, then...»* (Luisa C., psychologist / INT PS3) [7]

If the Psychiatric service, the "*CIM*", – up until the mid 1980s – was perceived by people as a consequence of a parthenogenesis of the Psychiatric Hospital of Perugia, the implementation of the Mental Health Centre could also be interpreted as a restitution to the local communities of that "madness" moved, for about a century, from the urban and rural centres into the Psychiatric Hospital. Therefore, for a long period, most of the local population identified the territorial psychiatry (viewed as pharmacological and substantially chronic) with serious, evident, and somehow "public" mental illness.

These lay interpretations of the psychiatric activity are now still partially maintained, even if the requests for psychiatric intervention – especially those concerning large areas of social suffering that previously didn't come to the Service's attention – have increased considerably. In medical transactions, for instance, a conspicuous number of patients' demands have an existential tone. Questions expressed in psychological terms, through language that intertwines an idiom of strong emotions and elaborate descriptions of the "inner self"; a peculiar investigation of individual vulnerability and social etiological factors – like *stress*, fatigue, and so on.

> *«Then we can see the entry of what we could call "minor psychiatry". It concerns discomfort, or more precisely, the area of uneasiness and discomfort which is not very important from a psychiatric point of view: panic-attacks, reactive depression, the trouble a teenager can have trying to untie family bonds. Everything happens. On one hand, that's a good thing, in the sense that the Service not only deals with many different issues but also becomes able to offer higher quality answers to various problems, because we haven't only a concentration of... On the other hand, now we are obliged to reduce just a bit the range of patients and services, and to devote ourselves more to specific matters* [lo specifico]*.»* (Luisa C., psychologist / INT PS3)

The members of the Psychiatric Service have adopted specific strategies to bypass problematic forms of interaction and to respond to the new questions expressed by their patients and families. In the following interview excerpt, a psychiatrist compares an old patient's stigma to the new requests for optimising social performance in the Psychiatric Service.

> *«We have invested especially in the reception of all requests. We have also tried to make the Service known externally, working with the community, making the public aware of interventions of prevention, where possible. Years ago there was a huge... because in '86 and '87 there were really few serious patients, and everyone came from the Psychiatric Hospital. Because there was a lot of prejudice too. Now, the prejudice has changed a little bit and the attitude towards psychiatry is different. Therefore the person that comes to the Centre now wants either to improve himself, or a member of his family. Well, this all means a person goes to a psychiatrist because he wants to function at his best.»* (Laura M., psychiatrist / INT PSC1)

Despite the increasing diffusion of idioms of distress characterised by pronounced psychological tones, and the consequent recognition of a hegemonic social role ascribed to the psychiatrist, the "Service" occupies a marginal medical area, sometimes subordinated to other biomedical branches. In fact, community psychiatry still has a marginal role in the management of economic funds and in the process of defining parameters for the output-evaluation of different Health Care Services.

In this way, the interviews I had with the psychiatric staff emphasise a contrast between the excessive formalisation of the administrative procedures – that is quantitative evaluation of resources and outcomes mostly diffused with processes of new management (*processi di aziendalizzazione*) – and the daily routine in the Mental Health Centre. The growing number of interventions, the differentiation of the rehabilitative structures that require routine activity, and the reduction in the time spent on the staff assessment meetings make an evident structural distinction between various occupational figures and a hierarchical division of roles and competences. Whenever the psychiatric staff enters into this sort of spiral, the hybrid side of mental health practice – mainly referable to the social action of the rehabilitation projects – disconnects from psychiatric professional knowledge and joins the social workers' "lay practices". In this way the *social* side of psychiatric practices risks being separated from the *technical* side and practitioners must recognise that it becomes increasingly difficult to prevent wide areas of society from becoming medicalised. In fact, psychiatrists are continually solicited to clarify the boundaries of their activity just like technicians. They have to avoid generic attention to social suffering and social control; but as representatives of the more qualitative and hybrid part of medicine (Giacanelli 1978). They have to be inevitably engaged in activities that are "too social" to constitute the pivotal axis of medical care. In other words, the public psychiatric staff is forced to work between a broad social delegation concerning responsibility on "madness", or a substantial subalternity to the other biomedical disciplines in the local policies for promoting health and prevention.

Nowadays, the dialectical relationships between the structural articulation of psychiatric field and the processes of local management of mental health problems tend to be shaped by the opposition between the increasing bureaucratisation of Psychiatric services and the "non-regulated creativeness" attributed to social workers and lay social actors belonging to the local community. Furthermore, I should like to add that the process described here in very general terms is part of a historical structural reorganisation of the psychiatric field. From such a perspective, processes of institu-

tionalisation and emerging cultural forms tend to be embodied in the social praxis in proximity to the oscillating boundaries between *society* and *medicine;* boundaries that are continually redefined in relation to historical changes in psychiatric knowledge and practice.

In this regard, it could be hypothesised that a cultural phenomenology of the habitus (Bourdieu 1977, Csordas 1990) of patients and operators as well as the local delimitation of boundaries of community and of acting bodies/selves (Kaufman 1988) – especially in public debates – could provide good access either to social practices in conflicting situations, or to agencies of different social actors possessing different symbolic capital. For this purpose, public debates about mental health policies seem particularly meaningful.

2. The local debates

During my fieldwork, I paid particular attention to the questions that patients and their families asked local administrators, physicians, and social planners in debates on residential psychiatric communities and problems about employment [8].

The most interesting aspect of these debates was the peculiar interplay between public issues and the daily experiences of patients and their relatives. Moreover, a prevailing strategy adopted by social actors, as we shall see, consists of acknowledging the symbolic boundaries of 'Self' and 'Community', and interrogating some tenacious oppositions – such as normal/abnormal, health/illness, reason/madness –, to promote new "opportunities of citizenship".

In the "public arena" – where sometimes a thick plot of "private" and "public" meanings emerges [9] – social actors emphasise personal and domestic experiences by making a linguistic shift that notably changes the emotional tone of political confrontation. Patients' biographical paths are characterised by specific configurations of meanings and strong emotions, produced either during doctor-patient encounters within the therapeutic setting or, more generally, whenever the patients find themselves working out the meaning of the tests they have to face in the working world.

My fieldnotes describe different ways of constructing social meanings, which are exposed in public debates, specifically those concerning plans for rehabilitation. For instance, I recently participated in a meeting which discussed initiatives to find employment for the psychiatric patients, where a number of contradictory aspects clearly emerged.

About 40 people gathered in a Gubbio Hotel to discuss employment: psychiatrists, psychologists, members of social co-operatives, the staff in charge of the *Servizio inserimento lavoro* (SIL) [Employment service for people in need], some local entrepreneurs, patients, citizens, and members of the Association for the implementation of the psychiatric reform (*Associazione per l'attuazione della riforma psichiatrica*, Ass. Arp). In his introductory intervention, an operator of the SIL gave a summary of the situation. He stressed that employment is an important goal for patients, and that work is the object of many expectations in our society. He added that anxiety and strong emotions are linked to problems of occupation, autonomy and productivity. In his words: «*our society is divided on the basis of division of labour. I mean, usually it accepts the equation that normal is equal to work: if someone doesn't work, then he is abnormal*». He argued finally that, in order to understand the analysis of the labour market, and the mediation activity of the SIL, it is necessary to clarify that «work is not therapy». This is the aspect which social workers are usually forced to remind the entrepreneurs, when they repeat that «therapy is done within the psychiatric office». In fact, «*the SIL, together with the psychiatric service, plans itineraries of* normalisation*, projects of* normality» (FWN 1)

From this perspective, the Employment service (SIL) is engaged in planning "projects in order to give the patients a series of trials". In the projects, the policies that acknowledge the patients' fundamental rights have an explicit aim, which is to construct the patients' identity. In fact, according to social workers, work lets the patients overcome the identity acquired through psychiatric diagnosis. During the debate, the same operator outlined a sociological framework, perhaps rather rudimentary, in which he stated: «*society is divided into roles, around which we construct our identity*» (*ibidem*).

The "job" (like the rehabilitation activity in the Psychiatric centre) is thus presented as an intermediate locus where the patients' potentialities are tested. It is represented as a liminal place of apprenticeship, where patients state that they need more time to prove themselves, where the rhythms of work are suitable for learning and where they can also make errors. Therapists, especially, also define the "job" as a portion of reality outside the domain of therapy. When psychiatric operators – particularly psychiatrists – try to identify their possible interlocutors within the community, they generally prefer to second the relatively reassuring division between medicine and society, therapy and social work. This rhetorical strategy traces boundaries around the spaces of therapy and rehabilitation – the psychiatrist's office, and the Day Centre of Rehabilitation – which, because of their

own hybrid nature, often go beyond the narrow domain of medical approaches. In fact, every project concerning cases of psychosis needs to interact with the family, the neighbourhood, and the social groups to which the patient could be affiliated.

On the occasion of the public meeting mentioned above, the employers asked for more information about mental illness so that they could understand better what really happens in employment plans. They raised the issue that it might be necessary and opportune to know the life history of the people with whom they are committed during the working day. This request prompted another social worker to ask some questions. She said: «*What is normality? Who is normal? Many things are unknown to me too... What is the personal experience and the story of a person? Should we seek knowledge about the life-history of the people we meet and, if so, how long for?*» (FWN2).

These questions seem to claim that there is an area of emotional negotiation which derives *obtuse meanings* from social experiences, not directly visible (Taussig, 1987: 366-367, 393-395). The peculiar object of this negotiation is what Michael Taussig calls *implicit social knowledge*, a point at which history and social memory interact, and where we can see «what makes ethical distinctions politically powerful» (Taussig, 1987: 366). In this case, ethical distinctions seem to refer to a crucial choice, which the actors of the political debates have to face: either considering social exchanges under the psychological profile of the involved subjects (10), or paying close attention to the social demarcation of bodily boundaries that fluctuate in social interactions (11). Really, the embodied experience of social interaction – which has a conclusive role in discussions about psychiatric patients and their behaviour – cannot be separated from the power-relationships working in the local psychiatric field and the labour market (12). A psychiatric patient's words, pronounced in the course of the meeting on employment, help us to clarify this point.

Stefano, C., intervening with certain enthusiasm, described his present situation: his work in a small grocer's shop was going nicely, but – he sustained – it is important to have good relationship with the social environment. In Stefano's specific case, for instance, it was important to patronise a pub owned by one of the CIM nurses and to take part in the religious activity of a Catholic community. «*Although social prejudices toward mental illness are still widespread*», Stefano argued, «*the main problem is* to introduce social workers *to different places in the town*». And addressing the social workers directly, he asked: «*Please, tell us what kind of relationship you have with the town*» (FWN3).

The patient, questioning the quality of the social workers' daily life, does not properly express a "psychiatric need". Instead he proposes a problem to all the inhabitants of the town by evoking their shared "implicit social knowledge". That is, his main question is not only how psychiatric workers, as embodied social actors, usually build social relationships for the patients, but how they live and build common places for themselves and others in the town. Stefano claims that a split between "productive time" and "non-productive time" cannot be passively acquired. He points out that people must have a wide perspective so that they can locate the time of labour within a larger economy of time: an economy of time – involving a plurality of social life aspects – in which the problem of finding a job is not separated from creative activities or from the material and symbolic construction of the whole community (13).

3. A case study: "job stories" and practices of healing

As we have seen, a project concerning «psychiatric patient inclusion» often forces the protagonists of the public confrontation to re-define the social environment in which the patient has to be inserted. These transactions involve the social workers themselves who try directly to appraise the possibilities of social exchange in the local community, sometimes considered closed and fragmented in various narrow social groups.

Public debates on mental health issues amplify and combine local representations of madness and, in a sense, represent a stage on which social dramas generated by structural tensions are performed. If this is so, the "public stage" allows us to appraise how the narratives produced during the disputes about mental health policies can feed back to the social processes, providing them with "rhetorical structure", modalities of use, and meaning (Turner, 1986 [1982]: 134). In this way, we can observe better the metaphoric polarisation between semantic oppositions, and how such oppositions are articulated in the patient's narratives to express illness experiences and social conflicts.

So from the patients' narratives about their working-life we will find it useful to extrapolate descriptions about the social status of the employment insertion, trying to avoid limited interpretations of the psychic dynamics of the people involved. In a broader sense, we have to deconstruct the complex collective processes corresponding to psychiatric modes of production of biographical paths: what characteristics does a patient need to be inserted into the working world?; how are conditions of disadvantage appraised?; and how are material and symbolic "needs" considered.

3.1. The "Servizio Integrazione Lavoro" (SIL)

The *Servizio Integrazione Lavoro* (SIL) is a social service consisting of a social assistant, and employees of various social structures that deal with handicaps, substance abuse and mental health. Within the SIL, there is a group of specialists who draw up agreements with public administrations and private firms to promote employment for patients.

In its first phase of activity, the SIL analysed the labour market in the local area and made a survey of the firms available to employ patients. The procedure usually adopted by the SIL is the following: the name of a patient is put forward by one of the social services, the SIL-workers meet this person and, after interviews with the patient and her/his relatives, the case is evaluated. Finally, a plan with priorities and objectives is formulated. In the following excerpt from an interview, a psychiatrist describes the characteristics that are requested during the case-evaluation of the patient.

> *«Often, a project can simply try to verify if the person is able to tolerate the frustrations, even small ones, deriving from the specific type of work environment. Usually, the environments chosen are the least frustrating possible, with more tolerant dynamics than other working areas, and so on. Therefore, we try to point out which kind of* tolerance *the patient has, and his capability of* self-responsibility *as well. That is to say, the extent to which the person is able to carry out an assignment. Not only from the executive point of view, but chiefly from the point of view of* the burden of responsibility, *because this is what creates tension.»* (Giovanna E., psychiatrist / INT PSC2).

In the SIL projects, we can see a particular semantic integration of aspects of the local economy and of traits of subjectivity (responsibility, tolerance, etc.). So, in many circumstances, the possible psychiatric accesses to the biographical history of the patient need to be evaluated, and the procedures that produce the psychiatric history of the patient outlined. Within the psychiatric network, the negotiations between various social actors have to be appropriately situated in the modes of production of social relationships – not only with reference to the patients but, in general, to all the social subjects involved in mental health policies.

We must, therefore, consider the features of the wider context if we are to understand the idioms the patients use in order to speak about themselves and their own relationship with labour and society. We can outline at least four salient traits:

1) Firstly, the *inserimento lavorativo* in the investigated area is mainly promoted in small and middle-sized manufacturing firms, handicraft workshops and commercial activities. Such firms make it possible for patients to have a job with a variety of functions. These jobs frequently allow the patients to discuss the work with their employers and therefore to negotiate mutual expectations.

2) Secondly, patients' employment is promoted in an urban area where innovative ways of co-operation, involving either psychiatric patients or social workers, are still not adequately developed.

3) Thirdly, the objective possibility of finding a job must be put in a social context in which many people looking for a job are forced by the labour market to move to nearby areas. The patients can also be considered social subjects who are planning their own future in the milieu of an advanced industrial society, where ideologies of *flexibility* and *precariousness* connected to the working world are strongly rooted. This happens even if many working experiences are promoted in environments where the organisation of labour is less rigid and working rhythms less urgent (trade, tertiary sector, artistic craftsmanship).

4) Finally, many patients (between the age of 25 and 45), who are involved in employment projects, although they had never been inmates of the old mental hospital, have been treated for short periods of time in the Psychiatric service of diagnosis and care (*Servizio psichiatrico di diagnosi e cura*). The everyday life of these patients is nevertheless organised and strongly tied to the rhythms of their current psychiatric treatment.

3.2. Planning an uncertain future

A salient trait of the patients' narratives [(14)] about illness, rehabilitation, and working-life, is their attempt to produce – with peculiar narrative choices – complex plots through the combination of individual or collective events and personal experiences of uncertainty, crisis, and bewilderment. In these narratives, we can find a double social memory: one concerning the history of the community (the city and the villages in the surrounding territory), the other concerning the psychiatric service and its social roots. This is a history of deep structural transformations of the local economy linked to the emigration experience, the crisis of agriculture and the urbanisation process. They marked the family life-stories since the first half of the 20th century, the institutional landscapes, the regional welfare policies and the role of psychiatry in public health since the '60s .

The cultural configuration that best depicts this plurality of interpretative levels consists of interpretations about the elapsing of time, delays, and pressing working rhythms (often in factories). In fact, descriptions about the beginning of the illness trace an existential route within situations of hard conflict toward established stages marking sexual maturity, the access to a gender identity, and the crucial passages to acquiring "citizenship": school, military service, first working experiences, etc. The life histories are often marked by conflicts in the factory, particularly during the first phases of the psychiatric illness. Conflicts where sometimes the people risk losing themselves.

Edoardo M. (32 years old), a political science graduate, works now as a clerk on an employment plan in an industrial firm. After a period of hospitalisation, he has been under the care of the psychiatric service for the last two years. He remembers his experiences as a factory worker in the first part of his working life. His criticism of the factory and the assembly line is quite severe.

> Edoardo – *«I had working experiences immediately after I graduated from high school. I went to work in a factory – in a small factory. I had to thread iron rods. It was ridiculous, I didn't like it at all. I didn't like the environment.* You produced nothing. You didn't create objects that could…*»*
>
> MM – *«What did you do there every day?»*
>
> Edoardo – *«I was working at a machine, I had to put the rods inside, these were threaded, I pulled them out, and then I put some more inside. It was a workshop, not even an assembly line factory. Later, the owner wanted to make me work on Labour Day too. I said: "Yeah, bye bye!" Then I had another awful experience in a ceramic workshop. The fact is that the factory doesn't suit me. I don't know who...* [he laughs] *I don't know.* Because the factory – in my opinion – kills people. It kills people physically, but it also kills people mentally, because working on the assembly line means exploiting the body and armouring the mind.*»* (Edoardo M. / Int pt 4).

The fast rhythm of de-personalised work is frightening. The factory is frightening, too. The anxiousness to follow the rhythms of the other workers forces some patients to quit. Giuseppe E., for instance, after several failed attempts, now aspires to find more "human rhythms" and different labour relationships in a working environment.

> Giuseppe – *«I worked at the M.* [a furniture factory] *for ten months, but it was a bad experience. Because… even if I earned a million, a million and a half* [of Italian lire] *a month, you had to do... you were in charge of a part of production, it was an assembly-line-job and you were obliged to make so many pieces in an established time. So if you were in a place where you could work well, everything was OK, but if you were in a place where you were obliged to do an extra piece, and you could not make it on time, then you became anxious. Sometimes you fell behind with your job and it was difficult to catch up, and then your boss often told you off. Even because there was… At the end you were working for seven or even eight hours, with a lunch-break. It was a fairly fatiguing job.»*
>
> MM – *«And then you quit.»*
>
> Giuseppe – *«I left... after discussing it with my parents. They told me 'if you really can't make it, just quit.'»* (Giuseppe E. / Int pt 18).

In many of the patients' narratives, in contrast with the pressing elapse of time in the factory, we often find descriptions of peculiar "situated practices" in current employment projects. In an ordinary working day, the patients have to arrange things meticulously and on time. Their tasks consist

mainly of placing goods on shelves, putting various products in order, and labelling merchandise with prices. To "put in order", "to clean", "to organise", these are all aspects of production/consumption which are often not even considered in a rigid organisation of labour. They are activities inserted in the gaps of the work procedures.

> MM – *«You said that your job consists essentially of positioning the goods…»*
>
> Bruno – *«Yes, from the stock to the shop. A wide range of goods: from toiletries to various wines, dairy products and meat to various groceries.»*
>
> MM – *«And vegetables?»*
>
> Bruno – *«No vegetables, no milk, no fish. I was assigned to the aisle where there were dog and cat products, and I help the man in charge of the bottles of water.* [...] *I also help whoever calls me, whoever needs something. The boss sees whoever needs help and calls me. I help the man in charge of the pasta, and then the one in charge of the oil, the tomatoes, the desserts, even the one in charge of toiletries.»* (Bruno N. / Int pt 12).

Sometimes, as in the case of Giorgio L., an assistant-gardener, the activity of arranging objects is directly related to the construction of the landscape. Giorgio's work is mainly to protect the garden from weeds and harmful insects.

Mauro, a 35-year-old sales clerk in a shop, uses a specific foreign word to speak about his present strange work.

> *«I have been working in this shop for the last three years. Everything is going fairly well. Mmm, I am practically… My work consists of moving the products to the front of the shelves so that people can read the price easily.* This is called "merchandising" in English. *Sometimes, but not often, I put the stuff on the shelves. This is a job that is similar to a sales clerk.»* (Mauro F. / Int pt 7).

Actually, the organisation of space-time seems to balance the uncertainties in the emerging social interaction. Uncertainties which seem to be related to ways of questioning the inarticulable dimensions of "normal" daily life: silence, the inner world of the emotions, doubts concerning "reasons and causes" (15) of obscure behaviour, and the inaccessibility of the pain of other people. An uncertainty that social actors sometimes use to discuss the boundaries and the margins of the Self (16).

As in the case of Tommaso T., a 44-year-old car-park attendant, who belongs to a co-operative that manages a public parking lot. He works six hours a day, six days a week. He is frightened by the reactions of nervous motorists, who are "the victims of rush". In his story, exchanging glances with unknown people are a motive for reflecting on his closed and shy character.

> TOMMASO – *«Yes, I stamp the ticket, I lift up the bar and I let them go through. Then if they find a place they park, if they don't find one, they don't pay. There are others... Instead, with the ticket, I ask them to pay and I elevate the bar. They pay according to the hours they have parked. That is, they pay a thousand lire per hour: one hour a thousand, two hours two thousand.»*
>
> MM – *«You told me that there are good people and others...»*
>
> TOMMASO – *«Like everywhere, everywhere… But you know, overall, you don't known how to behave, because it's really hard. Aside from the fact that I am not a big talker, I am even closed, and shy, and so on… Anyway now everything is going well. This is a good period, I wish that everything would continue like this.»* (Tommaso T. / INT PT 20).

The risk of being entrapped in a scheme of a "non-chosen life" is what many patients try to avoid. There are moments when they withdraw or escape. When they feel that something is not going well, they are tempted to leave, and to separate themselves from the shreds of normality (often built around the fulcrum of their job). At this point different forms of therapist-patient relationships come into play.

3.3. Looking for a job: crisis, struggle, and imagination

The precariousness of conflicting relations with the outer world is a distinctive trait of the biographical stories. The daily actions linked to the working-life are part of a larger consideration concerning an uncertain future.

Patients discuss their expectations and desires. That's why a «phenomenological approach based on the construction of personal meaning/being» (Frankenberg, 1988: 330) becomes particularly deep, whenever they delineate the features of the working world [(17)].

In Stefano's narrative – the 35-year-old patient mentioned above – the stories of his parents' and grandparents' working experiences are linked to vicissitudes of his illness and of social rehabilitation. His narrative is important because it gives us a deep perspective of the transformations that have occurred in the psychiatric field within which he traced his life history. During one of our encounters, he told me with a smile on his face that he was «a historical patient», in that he has been a part of the history of the psychiatric service for many years. So, his narrative strategy (in describing his interests, reading, projects) is twofold: on the one hand, he tells a story about his movements, with his family, in the network of private and public psychiatry; on the other hand, he marks the semantic boundary between material and intellectual labour.

Stefano, born in Luxembourg to Italian migrant workers, during the first years of his life followed his parents who had to travel around to look for a

better job. In fact, a few years after Stefano's birth, his father, who had been working as a truck-driver for a wine merchant in Luxembourg, was hired as a mechanical worker in a big factory in Northern Italy. Stefano remembers the heavy work his father had to do, his father's descriptions of life in the factory, and his attempts to leave the assembly line, to return back home to his native Umbrian village where he could finally retire.

> «*When he* [Stefano's father] *was a welder he couldn't go on anymore... perhaps he could, I don't know. Then his only escape was to begin to study. For a certain period he attended a specialisation course, and so he avoided being fired during an initiative of dismissal promoted by the factory.* And he liked that job quite a lot, because it was a "brain job" [un lavoro di testa]." (Stefano C. / INT PT 10).

Stefano began feeling ill when he was a 19-year-old undergraduate student. At the beginning, he felt a sense of bewilderment, an increasing fear, until finally what he calls "the voices" arrived. Then, the period in which he heard voices was followed by what Stefano calls the "mystical moment" and the fear that people around him could be subjected to an inevitable genetic mutation. His family then decided to move back home to Umbria, in order to find possible answers to Stefano's affliction – which had manifested itself in a large industrial area, a context where it was more difficult to find adequate help and assistance.

> STEFANO – «*At a certain point, the most terrible thing that happened was when the voices arrived. I mean, with voices one begins... I began to believe that my parents were not my true parents, but the doubles* [sosia] *of my true parents, and so on. That's why I have suffered so much, because you suffer terribly for such a thing.* [...] *But I think that then I was already ill. In the sense that when it was spoken about... – what's the correct name? not nervous breakdown, but depression – I was probably already depressed. However, for instance, when I used to read about depression in the newspaper, I said, "Come on, I feel tired, but it must be because of all the studying I do".*»
>
> MM – «*And had you begun to feel like that before? When you were at University…*»
>
> STEFANO – «*No, it happened later, thinking about it again, when I saw… When I realised that I was ill. For example, I don't know, another thing was that I often got drunk and it was a sad drunkenness. It wasn't that I was drinking so much. But then, when it was summer, I really drank a lot. This later made me reflect about my situation. And now I do miss the University. The truth is that my friends often told me to stop drinking, and to begin studying again, but there was little to do.*»
>
> MM – «*So you weren't able to stop.*»
>
> STEFANO – «*The alcohol? Yes, it was basically because I had nightmares.*»
>
> MM – «*They were connected…*»
>
> STEFANO – «*It was like a huge narcotic. Well, because it becomes funny, for instance, when you fear you could be a part of a genetic mutation, or, you yourself, a genetic mutant. You are terribly frightened.*» (Stefano C. / INT PT 10).

About three years ago, the psychiatrist told Stefano that he was on the road to recovery. Therefore, it was time to reduce the intake of psychotropic drugs. Everything seemed as if it were going well, when suddenly Stefano stopped eating, he withdrew, and avoided all communication with others. He was admitted to the General Hospital of Gubbio and was fed intravenously. Then from there, he was taken to the Psychiatric service for diagnosis and care in Perugia.

The sickness was a process of continuous change that alternated between ups and downs. The initial *debacle*, which deeply marks a biographical history, can be contextualised in narratives where periods of well-being and suffering oscillate. In Stefano's case, the inevitable conflict with the psychiatric service was produced and reconstructed after long conversations with his therapist.

During my fieldwork, I frequently spent time walking and talking with Stefano in town – sometimes even along the road that led from his house to his job. At the time he was engaged in a downtown office, where he worked two hours a day three days a week. He often repeated that his wasn't a real job, but only a trial period. «*I would like a true job*» he often added, but then he too realised that he wouldn't have been able to carry out "an-eight-hour-day-job". Perhaps a part-time job could have been the solution. But he complained that when he was experiencing periods of despondency, and radical crisis, paradoxically he felt that he had a higher productive functionality. Now that things seem to have sensibly improved, and that he no longer feels the weight of his illness, Stefano says that he needs a «*real job*».

> Stefano – «I hope they find a real job for me. *Even though I like the work that I do now. My daily tasks are going to the post-office to deposit checks, sending insured or registered letters, and so on… I operate the personal computer to issue the firm's invoices. Above all it is a word-processing job… I fill out deposit forms… You know, nothing in particular. In fact, there are days that I have nothing to do. For instance, last Wednesday, I worked only twenty minutes.*» (Stefano C. / Int pt 10).

A "true job", a "real job", are recurrent expressions in psychiatric patients' narratives. During his long illness, Stefano has had various temporary jobs: such as a librarian or a clerk in a bureau, etc.; and there have also been proposals of manual work. Some of them were accepted, as in the case of the recent employment as assistant in a grocer's shop, others refused. Regarding the proposal of manual jobs, Stefano recalls:

> *«Then they made me a proposal to enter into a community where reaping-machines and bulldozer are used, but my father… I didn't feel up to working with a bulldozer. Then I changed my mind, but my father said, 'No, you shouldn't do that kind of work, because I can't imagine my son working with a bulldozer'»*(Stefano C. / Int pt 10).

Today Stefano is again planning to enrol at University, in the faculty of Political Science. He hopes to begin writing and to take an interest once again in politics. He does mention that now his health is better than it was a year ago, although he still feels insecure.

> Stefano – *«I still have the same dream, that is to have enough money to buy a tobacconist's shop and to make it my livelihood.»*
>
> MM – *«That's your dream.»*
>
> Stefano – *«No, my real dream would be to have a bookshop…* [a long silence] *My greatest dream would be to attend the University again… and to write something.»* (Stefano C. / Int pt 10).

Politics, one of Stefano's passions at the time he attended University, is described as collective spaces where personal and social imagination seems to convene. A locus where the uncertainty connected to the embodied experience of social need is projected in a collective future:

> *«Politics must be the realisation of a social project. I think that politics should be more related to social needs. For instance, I would like to see the trade unions not as the transmission belt of a political party, but instead the political party as the transmission belt of the trade unions* [then he smiles]. *However many things have changed in my life, so I am not able to express political opinions objectively.»* (Stefano C. / Int pt 10).

Stefano expressed the idea that politics should be strictly related to social needs with an enthusiasm that was immediately dampened by his ironic smile. He has to consider the difficulty that he lives in an ever-changing reality, and his fear that he could lose himself once again. His imagination of the future, his dreams that could become concrete possibilities of life, here show a peculiar combination of collective projects and personal desires: political ideals, social projects, a love of books (he is fond of detective and spy stories), a passion for smoking. In Stefano's narrative it is therefore possible to perceive the delicate texture of personal agency through a changing historical reality, and the possibility that imagined social shared experiences could be suddenly invested with uncertainty and affliction of the incarnate self.

3.4. Questioning processes of insertion

The plans of the Sil are continually monitored with the purpose of testing how patients cope with the difficulties they encounter. Operators try to appraise parameters, which define working environments, causes of social pressure and the personality of the patient. That is, they try to analyse either the organisation of labour or the psychological processes of the subjects.

Many patients ironically observe the implementation and follow-up evaluation of the projects by the SIL. In Stefano's narrative, for instance, questionnaires and psychometric tests administered at the SIL are considered as ineffective tools that cannot grasp experiences and concrete daily problems. Moreover, the double nature of such questionnaires doesn't escape Stefano's attention. On the one hand, the tests are described as tools chosen to delineate the personality and the attitudes of the applicant (for a job, a house, a rehabilitating activity, etc.). On the other hand, they are considered as techniques to classify and diagnose personality disorders, psychiatric illness, and problematic behaviours.[18]

Stefano recalls that before being admitted to the "residence group" – the house that he now shares with three other patients – he had taken the *Minnesota* test (Minnesota multiphasic personality inventory, MMPI). The psychologist administering the test suggested to him that he had to jot down some considerations about the questions included in the list. There were too many questions – Stefano remembers – and he didn't feel like writing.

> STEFANO – *«Yes, you know those test they give us… they mean nothing. What do they mean? They asked me "do you feel well or unwell?" "Well". And then?»*
>
> MM – *«They are the SIL tests.»*
>
> STEFANO – *«Yes, they are the SIL tests. There is also "the Minnesota". The Minnesota test. I can't see the point of that. I did it before entering the residence-group. I did it at the Psychiatric Service, with the doctor. She gave me the test and asked me to fill it out.»*
>
> MM – *«What do you think about the idea of the test?»*
>
> STEFANO – «[With a whisper] *I don't know what to say. Because, when I took the test, my fears were more rooted than now. I mean, there are times you feel like a monster, in the sense you are formally deferential to other people, but you are substantially scared to death. And you wonder what kind of formal deference to have. Anyway I took the test, but now I don't know if it is useful or not.»* (Stefano C. / INT PT 10).

In this passage, the attitudinal tests for employment do not seem to be dissimilar to those diagnostic tools that are used to define and manage a psychiatric patient's life-course. In a sense, idioms of tests and trials seem to recall the same paradoxes emerging during working trials and continuing apprenticeship.

In fact the patients, like therapists and psychiatric operators, perceive work as a trial, but they do not seem to accept the idea that this trial does not lead necessarily to a steady job. To force a therapeutic relationship some patients can use such ambiguity. This is precisely what happened to Pietro, a 30-year-old patient working in a handicraft workshop. After two years of

psychiatric treatment, he decided to interrupt his pharmacological treatment and to break off the therapeutic relationship but still try to keep up his job (which he had got from the SIL). But when Pietro realised that his job was threatened because of his dismissal from the Psychiatric service, he called the Labour Union to find out what exactly his situation was and what it really meant to be a psychiatric patient on an employment plan.

In these circumstances, the relationship between psychiatric care and work is radically questioned, and contradictions, emerging in the intermediary locus between society and medicine, can be activated in local forms of resistance. The following excerpt of a conversation I had with the SIL's psychiatrist concerns the ambiguous bond between psychiatric care and work:

> MM – *«It's a situation, I would say, which is not so ambiguous at the beginning, but which becomes so contradictory. It tends to be…»*
>
> Psychiatrist – *«Every time. Because it would not have been so ambiguous if the work was directly part of the therapeutic intervention. If SIL* [Employment service] *had been a part of the CIM* [Psychiatric service] *this ambiguity would probably not exist.»*
>
> MM – *«But perhaps there would be others.»*
>
> Psychiatrist – *«Of course.* [she smiles] *We are favourable to ambiguities.»*
>
> MM – *«Even if these contradictions emerge and then seem to be somehow resolved, they highlight objectively more complicated situations. In this manner, psychiatry can never resolve them because it is, itself, part of a range of conflicts and relationships…»*
>
> Psychiatrist – *«Exactly, but even…* even because the person, the citizen, the real one, lives within contradictions. Therefore, if the patient is "outside contradictions", it means that he is "outside citizenship". And it is true that these ambiguities come out more clearly if the person is progressively liberated from psychiatry. Because when he is under "Psychiatry's wing" things are fairly clear.» (Giovanna E., psychiatrist / INT PSC2).

The link between "acquiring citizenship" and "living within contradictions" proposed by the psychiatrist is quite interesting. In her model, the patients' actions can contribute to unmasking some taken for granted assumptions of social life. The resulting impact of such actions could be very problematic for psychiatric devices too.

In this regard, it may be useful to consider ambivalent linguistic uses of the word *tirocinio* [apprenticeship], in the descriptions of the plans of the *Servizio inserimento lavorativo*. The semantic network where the *tirocinio*-apprenticeship is situated progressively loses its core meaning, from the moment that the acquisition of professional ability does not seem to maintain any strong link with the perspective of steady employment. So the "*Tirocinio*" does not necessarily seem to be a real "apprenticeship", but a training that

– because of the crisis of the labour market – does not result in direct access to a steady job. Edoardo's critical perspective about his expectation of an improbable steady job, after a training period, is very meaningful.

> *«OK, then, at that point, you* [the employer] *say "I accept or I don't accept the tirocinio". Because, at that point, you say "I have here a guy who can operate alone, after explaining some specific things to him." Then, at that point, what are you going to do? You ask: "Is my firm at his disposal for an apprenticeship?" Yes or no? If you say no, other possibilities are looked for. But not in a year! Because if I wait for a year, it's because, in the meantime, you evidently told me that you have had organisational problems, but you have also thought of giving me another possible job. And this is what they made me believe.»* (Edoardo M. / INT PT 4)

Those aspects of psychiatric rehabilitation, which Benedetto Saraceno ironically calls the peculiar psychiatric vocation of *entertainment* (Saraceno, 1995), are here subjected to strong tensions deriving from the patient's expectations of a stable job. It seems that around the crucial issue of the division and the management of Time not only are there healing practices, but also psychiatric disputes about job and rehabilitation activities.

The interaction between work, time and transformation of the Self in therapeutic settings is particularly interesting whenever we observe that the acquisition of ability in the Day Centre of Rehabilitation (*Centro di accoglienza diurno* CAD) is described with terms recalling those which are used to speak about the patients' working life. In the interviews with patients and psychiatric workers, the two contexts – work and rehabilitation – show points of contact and seem to interact around the crucial matter of "a situated economy of time".

According to the psychiatric staff's rehabilitation model, the Day Centre of Rehabilitation is the frame of social and cultural activities that runs parallel to effective therapeutic itineraries. In fact, psychiatric workers tend to consider the *Centro di accoglienza diurno* as a place where the practices activated are only supports to facilitate the therapy ("*facilitatori*"), and they do not directly affect it. In their model, psychiatrists have the role of sponsoring the activities and supplying means and opportunities, while maintaining a certain distance from the actual problems directly concerning illness and care giving.

In fact the activity of "meta-reflection on processes activated in therapeutic relationship", considered by psychiatrists as a peculiar trait of the therapeutic task, seems to be very difficult in the case of rehabilitation. This is particularly evident in the discussions that psychiatric operators have about the possible assessment of "concrete", "material", hands-on activities carried out in the Day Centre of Rehabilitation – that is, workshops about

painting, writing, video-making, cooking, and so on. The central question of assessment, then, is how such a hybrid space should be evaluated?

In the following excerpt of an assessment meeting, a psychiatrist outlines the volatile features of the moral world where patients' agency is tested.

> *«We have some parameters. They are parameters of subjectivity. The patient becomes responsible for his subjectivity before us and before the world. The more he becomes aware of his expressions and requests, the more this thing* [the activity of rehabilitation] *is good for him. For instance, this is a very general element, which is also a strong criterion for judging … His requests, the way in which he expresses himself as a person who is asking questions, or doing something… The fact that he is not passive, but more aware* […] *They are very long processes, and it is highly complicated to define the parameters that really… and sometimes they are subjective parameters. Perhaps videotapes could be used, even those videos that we made together with the patients three years ago… and we can see them today: posture, mimicry. That could be done. Because it becomes so complicated to define the efficacy… It is just as if we try to compare ourselves today to how we were three years ago. We are different.»* (a psychiatrist during an Assessment meeting / Ass 4).

The passage above makes it possible for us to grasp aspects, substantially opaque, of those transformations – occurring in a setting of rehabilitation – which seem to be closely related to processes of embodiment (Csordas, 1990, 1994; Connerton, 1989). Since it is not possible to constantly monitor rehabilitating activities, the quality of transformations occurring over long periods of time could be referred to the "embodied presence" of the patient within psychiatric devices.

Finally, considering the ways in which psychiatric devices are produced, we can see how, in the "domain of the mind" circumscribed by psychiatric practices, indices concerning patients' bodies are a crucial issue in understanding transformations that can occur over long periods of time. The moulded *habitus* (Bourdieu, 1977) symbolises, therefore, the patient's changed capability of negotiation, his "presence" (de Martino, 1977; Pandolfi, 1993) empowered through activities in workshops and other rehabilitation environments.

As we have seen, in assessment dialogues, psychiatric patients are depicted as embodying devices of rehabilitation. But the efficacy of healing practices and the opportunity of recovery are projected in a blurred and distant future. Ironically the practices of rehabilitation reveal that they have the same inner paradox – as Arthur Kleinman suggests – which is at the heart of health care and medicine: «Psychotherapy, the major form of symbolic healing in contemporary health care and biomedicine, illuminates a postmodern paradox. Healing has become increasingly marginal to the West's dominant healing system.» (Kleinman, 1988:139).

4. Conclusion

In this paper, I have analysed some of the problems of the knowledge and practices of community psychiatry, paying attention to the contradictory experiences that emerge from local confrontation and the daily activities of the psychiatric field.

From the chosen perspective, rhetorics of madness and practices of healing have been considered not as opposed to each other, but in a dynamic mutual relationship, within the policies of mental health. Rhetorics, far from having a merely instrumental value, represent attempts to force the existent order into a conflict of interpretations. For this reason, they have to be considered in their deep cultural roots, either as authoritarian and hegemonic exercising techniques, or as tactics working from the bottom at the corrosion of structured power relations (Comaroff; Comaroff, 1991; Herzfeld, 1997). On the other hand, practices can be considered as attempts, continuously renewed, to naturalise existent social reality, through innovations and experimental forms which have, in turn, a historical problematic nature.

As we have seen, an analysis of public psychiatric practices shows the "obtuse" and "inarticulable" meaning (Taussig, 1986) of oppositions (mind/body, public/private, visible/invisible, self/other) emerging either in local debates, or in situated descriptions of the paradoxes of illness, labour and embodiment. Moreover, a discontinuity between patients' narratives and psychiatric projects of rehabilitation suggests that when psychiatry withdraws into the "technical locus of therapy" – avoiding the fruitful exchange at the margins with society, labour and creative activities – it tends to be reabsorbed in forms of psychiatric management of risk (Basaglia, 2000; Castel, 1973).

Finally, in the mental health field, the confrontation between visible/public elements and rhetorics of self-making can illuminate features of local processes of producing what is natural and hegemonic. The fact that these processes are so important in understanding some of the naturalised dimensions of the social world evidently does not mean that practices of healing can be effectively and consciously performed by social actors in the "political arena". Such practices, however, appear in their ambivalence either as possible ways of confirming social boundaries, or as potential criticisms of cultural stereotypes. In any case, questions concerning bodily experiences and paradoxes emerging from local debates – rather than being neglected – can be used in the local community to produce experimental forms of coping with illness, care and madness.

Notes

(1) The research was carried out between November 1998 and June 2000, in a Mental Health Centre in a community in Umbria – the territory of Gubbio in the *Comprensorio Eugubino-Gualdese* (province of Perugia, Umbria). The area chosen seemed particularly interesting because of the coexistence of different community resources and (popular and professional) help-seeking behaviours concerning mental health problems.

(2) In the context I will refer to the plurality of the resources which denote the co-presence of different and conflicting *systems of reasoning* (Young 1995a, 1997) about social suffering, madness and death. The research was essentially based on a set of case studies through which is explored local networks sustaining a plurality of social practices and knowledge about health, sickness and the body. Most of the ethnography was centred on a small number of people who have used different forms of treatment and support. The cases have been considered as an index of social conflict areas between providers of care-competence and subjects with different levels of power.

(3) According to Franco Basaglia, the importance of the "Italian experience" resides in an attempt to recognise social contradictions and to declare the role ascribed to the psychiatrist as "intellectual", involved in processes that reproduce fundamental power divisions and current systems of social control. In most of his theoretical writings (Basaglia 1981, 1982, 1987, 2000), Basaglia considers the bodily experience of patients (subjected to "hospitalisation") as a primary argument in the analysis of psychiatric institutions. He argued the importance of promoting a social process of legitimisation of individual, social and political bodies (see Scheper-Hughes; Lock 1987), in order to increase the chances of social interaction and exchange. In this way, he sustained a necessary and enduring praxis in the permanent social confrontation and conflict. As Bendetto Saraceno (Saraceno 1995) has recently suggested, this approach implies peculiar sensibility for different sources of "otherness" in the social space.

(4) I use the term "field" in the meaning outlined by Pierre Bourdieu (Bourdieu 1977, 1989, 1994).

(5) The Mental Health Centre in Gubbio is committed to protecting and to promoting mental health prevention and care, and programmes and co-ordinates the existing network of intermediary structures in North-East Umbria.

(6) An interesting description of the recent transformation of Italian psychiatry is in Scheper-Hughes – Lovell 1987. In the English language, there are the works of Lovell (Lovell 1985), Ramon (Ramon 1983, 1985; Ramon; Giannichedda 1988), and the polemic reading of Jones (Jones 1988). A general history of the "Umbrian psychiatric experience" is not available at the moment. An accurate review of the writings produced in the last thirty years has been edited by Patrizia Guarnieri (Guarnieri 1998). A framework could be outlined looking at some interesting works: Micheli 1982, the interview of Carlo Manuali in Venturini 1979, Scotti - Brutti 1980, 1981, Guaitini 1974, Scotti 1995. An anthropological analysis of attitudes toward psychiatric transformation of the 70s is proposed in Guaitini; Seppilli 1979. The authors have outlined a tripartite model of fractured modernisation of Italian society to describe layered and contradictory cultural interpretations of madness and psychiatry.

(7) "The CIM" (Center of Mental Hygiene) is the name still used today by inhabitants to refer to the current Mental Health Centre (CSM). The whole history of the de-institutionalisation processes and the social construction of psychiatric territorial networks is focused on this outdated terminology. The Centres of Mental Hygiene were in fact, in the 70s, the first psychiatric structures, exclusively territorial, in Umbria. Within a political movement to promote health care and prevention, CIM was the main advocate of reinserting ex-hospitalised patients into their own native communities. Concerning this subject, one can see the transcriptions of the public meetings (*assemblee*) in Guaitini 1974.

(8) The following conventions are used in reporting my fieldwork material: Fdw: fieldwork diary notes; Int: audio recorded interview; Ass.: audio recorded assessment meeting. All names used in the text are fictitious. In the audio recorded tape transcript I have emphasised some meaningful passages.

(9) I have gathered together and studied the documentation on local public debates held in the last 30 years. Among the documents are the minutes of the *assemblee* that were held to discuss the organisation of the new territorial psychiatric services in the first half of the 70s (see Guatini 1974); public interventions and debates in local media about some cases of suicide in Gubbio (in the middle of the 80s) which involved psychiatrists and local administrators; video-recorded public meetings, called *conferenze permanenti* (in 1990, 1991, 1992); public interventions – in newspapers and on a local TV network – by politicians, psychiatric workers and members of the Association for implementing the psychiatric reform. More recently I attended some *assemblee* about the new Pact for community mental health, an initiative activated by public administrations and psychiatric services at the beginning of the year 2000.

(10) A thick plot of meanings, which the protagonists of debates try frequently to unravel by resorting to stereotypes. As Michael Herzfeld has shown (Herzfeld, 1997: 156-164), the study of stereotypes in social poetics and rhetorics, may represent a fruitful access not only to hegemonic cultural constructions, but even to forms of resistance to established powers.

(11) This is generally done in some public and private discussions about psychiatric cases, which consider the "structured structures" crossed by patient's biographical pilgrimages of individualisation (Bourdieu, 1994). For a particular case of psychiatric rehabilitation, see Estroff (1993).

(12) "Language games" seem to prevail in social interactions which are connected to the social production of the "private experience" (Wittgenstein, 1953, 1978; Das, 1996, 1998) – not only the patients' experience, but even the experiences of all the social actors involved as well. On demarcation of bodily boudaries see Devereux (1967).

(13) I consider the insightful suggestions of Veena Das (Das, 1998) about the relationships among "language games", "private experience" and "embodiment". The interest in the body, the role of scepticism in social relations and how "public secrets" (Taussig, 1993) are played in hegemonic processes, can also be discussed in a critical framework, which includes anthropological works that are rather different from each other: De Martino reading Heidegger and Gramsci (de Martino, 1977), Taussig reading Benjnamin (Taussig, 1987, 1993, 1999), Das reading Wittgenstein (Das, 1998).

(14) Time in medical and psychiatric settings is a crucial matter when we try to observe the intercourse of meanings within precise power relationships. For time and medicine, see Frankenberg 1992. As far as psychiatry is concerned, an original critical perspective – with a psychoanalytical approach – has been adopted by Fachinelli 1979, 1983. In the case examined here, local conceptions of time can not be separated from the experiences and power relations of labour (Thompson, E.P. 1967) and consumption (Appadurai, 1996).

(15) In this study, I only consider male patients, for the following reasons: *a*) firstly, because there are more male patients in rehabilitation projects: most of the patients attending initiatives held in the Day Centre of Rehabilitation are males, between the age of 25 and 45. *b*) Moreover, gender differences seem to recall a sort of division of psychiatric labour; in fact, the prevailing male presence in rehabilitating groups is the counterpart of the prevailing female composition of the psychiatric staff. *c*) Finally, in the acquisition of citizenship through employment insertion, some biographical paths of the patients are marked by established steps, which seem to be particularly well defined in the case of the social construction of the male gender.

(16) For the distinction between "reasons" and "causes", see Bouveresse (1991), Young (1995b), Wittgenstein (1978).

(17) In psychiatric settings, dynamics directly involving the dialectics between visible and invisible (Devereux 1967) are sometime consciously used by doctors and nurses. This happens in working groups, where the communication of patients' symptoms is discouraged, and some aspects of group interaction are collectively questioned.

(18) See Kaufman (1988) and Corin (1990). Interesting suggestions by Lock and Scheper-Hughes (Scheper-Hughes; Lock, 1987) regard the opportunity of interpreting idioms of emotions in correspondence of the overlapping three bodies: individual body, social body, and body politic.

We have anyway to remember the criticism that de Martino (de Martino, 1977) moved to those phenomenological approaches which seem to forget the fundamental role played by social history in embodiment processes.

(19) Kurt Danziger (Danziger 1990), in a penetrating study of how psychology produces his subjects of inquiry, has shown the pivotal role played by psychometrical tests in the paradigmatic configuration of the psychological science.

References

Appadurai, Arjun (1996) *Modernity at large. Cultural dimensions of globalization*. Minneapolis; London: University of Minnesota Press. Trad. it. *Modernità in polvere*. Roma: Meltemi, 2001.

Basaglia, Franco and Franca Ongaro-Basaglia (eds.) (1981) *Scritti. I. 1953-1968*. Torino: Einaudi.

Basaglia, Franco and Franca Ongaro-Basaglia (eds.) (1982) *Scritti. I. 1968-1980*. Torino Einaudi.

Basaglia, Franco; Scheper-Hughes, Nancy and Anne M. Lovell (eds.) (1987) *Psychiatry inside out. Selected writings of Franco Basaglia*. New York: Columbia University Press. (European Perspectives).

Basaglia, Franco (2000) *Conferenze brasiliane*. Milano: Raffaello Cortina Editore.

Battaglia, Debbora (ed.) (1995) *Rhetorics of self-making*. Berkeley: University of California Press.

Bibeau, Gilles (1997) "Cultural psychiatry in a creolizing World: questions for a new research agenda". *Transcultural Psychiatry*, vol. 34, num.1, p. 9-41.

Bourdieu, Pierre (1977) *Outline of a theory of practice*. Cambridge: Cambridge University Press. Orig. ed.: *Esquisse d'une théorie de la pratique, précédé de trois étude d'ethnologie kabile*. Geneve: Librairie Droz; Confédération Helvétique, 1972.

Bourdieu, Pierre (1989) «Social space and symbolic power». *Sociological Theory*, vol. 7, num. 1, p. 14-25.

Bourdieu, Pierre (1994) *Raisons pratiques. Sur la théorie de l'action*. Paris: Éditions du Seuil. Trad. it.: *Ragioni pratiche*. Bologna: Il Mulino, 1995.

Bouveresse, Jaques (1991) *Philosophie, mythologie et pseudo-science. Wittgenstein lecteur de Freud*. Combas: Edition de l'Eclat. Trad. it.: *Filosofia, mitologia e pseudo-scienza. Wittgenstein lettore di Freud*. Torino: Einaudi, 1997.

Castel, Robert (1973) *Le psychanalisme*. Paris: Librairie Francois Maspero. Trad. it.: *Lo psicanalismo. Psicanalisi e potere*. Torino: Einaudi, 1975.

Comaroff, John L. and Joan Comaroff (1991) *Ethnography and the historical imagination*. Boulder; San Francisco; Oxford: Westview Press.

Connerton, Paul (1989) *How societies remember*. Cambridge: Cambridge University Press. Trad. it.: *Come le società ricordano*. Roma: Armando Editore, 1999.

Corin, Ellen (1990) "Facts and meaning in psychiatry. An anthropological approach to the lifeworld of schizophrenics". *Culture, Medicine and Psychiatry*, vol. 14, num. 2, p. 153-188.

Csordas, Thomas J. (1990) "Embodiment as a Paradigm for Anthropology". *Ethos*, vol. 18, p. 5-47.

Csordas, Thomas J. (1994) *The sacred self. A cultural phenomenology of charismatic healing*. Berkeley: University of California Press.

Das, Veena (1998) "Wittgenstein and anthropology". *Annual Review of Anthropology*, vol. 27, p. 171-195.

Danziger, Kurt (1990) *Constructing the subject. Historical origins of psychological research*. Cambridge: Cambridge University Press. Trad. it. *La costruzione del soggetto. Le origini storiche della ricerca psicologica*. Roma; Bari: Laterza, 1995.

de Martino, Ernesto (1977) *La fine del mondo. Contributo all'analisi delle apocalissi culturali*. Torino: Einaudi.

Devereux, Georges (1967) *De l'angoisse à la méthode dans les sciences du comportement (1)*. Paris: Flammarion. Trad. it.: *Dall'angoscia al metodo nelle scienze del comportamento*. Roma: Istituto dell'Enciclopedia Italiana Treccani, 1984.

Estroff, Sue E. (1993) "Identity, disability and schizophrenia. The problem of chronicity". In Lindenbaum, S. and M. Lock (eds.) *Knowledge, power, and practice. The anthropology of medicine and everyday life*. Berkeley: University of California Press, p. 247-286.

Fachinelli, Elvio (1992 [1979]) *La freccia ferma. Tre tentativi di annullare il tempo*. Milano: Adelphi.

Fachinelli, Elvio (1998 [1983]) *Claustrofilia. Saggio sull'orologio telepatico in psicoanalisi*. Milano: Adelphi.

Foucault, Michel (1988) "Technologies of the Self ". In Martin, L. H.; Gutman, H. and P. H. Hutton (eds.) *Technologies of the Self: A Seminar with Michel Foucault*. Amherst: University of Massachusetts Press. Trad. it.: "Tecnologie del sé". In Martin, L. H.; Gutman, H. and P. H. Hutton (eds.) *Tecnologie del sé: un seminario con Michel Foucault*. Torino: Bollati Boringhieri, 1992, p. 11-47

Frankenberg, Ronald (1988) "Gramsci, culture and medical anthropology: Kundry and Parsifal? Or Rat's tail to sea serpent?". *Medical Anthropology Quarterly*, vol. 2, num. 4, p. 324-337.

Frankenberg, Ronald (ed.) (1992) *Time, Health and Medicine*. London: Sage Publications.

Gaines, Atwood D. (ed.) (1992) *Ethnopsychiatry. The cultural contruction of professional and folk psychiatries*. Alban: State University of New York Press.

Giacanelli, Ferruccio (1978) "Per una storia sociale della psichiatria italiana". In Centro Italiano Storia Ospedaliera (ed.) *Storia della sanità in Italia. Metodo e indicazioni di ricerca*. Roma: Il Pensiero Scientifico, p. 219- 233.

Guaitini, Grazietta (1974) "Le assemblee popolari sulla politica psichiatrica dell'Amministrazione provinciale di Perugia". *Annali di Neurologia e Psichiatria e Annali dell'Ospedale Psichiatrico di Perugia*, vol. 68, num. 1-2.

Guaitini, Grazietta and Tullio Seppilli (1979) "Malattie mentali e devianza: rappresentazioni culturali e processi di informazione e di egemonia nel quadro del cambiamento sociale". *Educazione Sanitaria e Medicina Preventiva*, vol. 2, num. 1.

Herzfeld, Michael (1997) *Cultural intimacy. Social poetics in the Nation-State*. New York; London: Routledge.

Kaufman, Sharon R. (1988) "Toward a phenomenology of boundaries in medicine: chronic illness experience in the case of stroke". *Medical Anthropology Quarterly*, vol. 2, num. 4, p. 338-354.

Kleinman, Arthur (1988) *Rethinking Psychiatry. From Cultural Category to Personal Experience*. New York; London: The Free Press; Collier Mac Millan Publisher.

Jones, Kathleen (1988) *Experience in mental health. Community care and social policy*. London: Sage.

Littlewood, Roland (1998) *The butterfly and the serpent. Essays in psychiatry, race and religion*. London; New York: Free Association Books.

Lovell, Anne M. (1985) "From confinement to community: the radical trasformation of an Italian Mental Hospital". In Brown, P. (ed.) *Mental health care and social policy*. Boston: Routledge and Kegan Paul.

Manuali, Carlo (1979) "Intervista con Ernesto Venturini". In Venturini, E. (ed.) *Il giardino dei gelsi. Dieci anni di antipsichiatria italiana*. Torino: Einaudi, p. 179-194.

Micheli, Giuseppe (1982) *I nuovi catari. Analisi di una esperienza psichiatrica avanzata*. Bologna: Il Mulino.

Nichter, Mark (1998) "The mission within the madness: self-initiated medicalization as expression of agency". In Lock, M. and P. A. Kaufert (eds.) *Pragmatic women and body politics*. Cambridge: Cambridge University Press, p. 327-353.

Pandolfi, Mariella (1993) «Le Self, le corps, la 'crise de la présence'». *Anthropologie et Sociétés*, vol. 17, num. 1-2, p. 57-98.

Ramon, Shulamit (1983) "Psichiatria Democratica: a study of an Italian community mental health service" *International Journal of Health Services*, vol. 13, p. 307-324.

RAMON, Shulamit (1985) "The Italian psychiatric reform". In MANGEN, Steen P. *Mental health care in the European Community*. London; Sydnay; Dover, New Hampshire: Croom Helm, p. 170-203.

RAMON, Shulamit and Maria Grazia GIANNICHEDDA (eds.) (1988) *Psychiatry in transition. The British and Italian experiences*. London; Concord, Mass.: Pluto Press.

SARACENO, Benedetto (1996) *La fine dell'intrattenimento. Manuale di riabilitazione psichiatrica*. Milano: Etaslibri; RCS.

SCHEPER-HUGHES, Nancy and Margaret LOCK (1987) "The Mindful Body: a Prolegomenon to Future Work in Medical Anthropology". *Medical Anthropology Quarterly*, vol. 1, p. 6-41.

SCHEPER-HUGHES, Nancy and Anne M. LOVELL (1987) "Introduction. The utopia of reality: Franco Basaglia and the practice of a democratic psychiatry". In SCHEPER-HUGHES, N. and A. M. LOVELL (eds.) (1987) *Psychiatry inside out. Selected writings of Franco Basaglia*. New York: Columbia University Press, p. 1-50.

SCOTTI, Francesco (1995) "Trenta anni di psichiatria in Umbria 1965-1995". In *I luoghi della follia. Dalla "Cittadella dei pazzi" al territorio. Percorsi della psichiatria in Umbria dal '700 ad oggi*. Firenze: Arnaud Editore, p. 63-94.

SCOTTI, Francesco and Carlo BRUTTI (1980) *Quale psichiatria? 1. Strategie per la trasformazione dei servizi psichiatrici. Storia e documenti.* Roma: Edizioni Borla.

SCOTTI, Francesco and Carlo BRUTTI (1981) *Quale psichiatria? Vol. 2*. Roma: Edizioni Borla.

TAUSSIG, Michael (1987) *Shamanism Colonialism and the Wild Man. A study in terror and healing*. Chicago; London: The University of Chicago Press.

TAUSSIG, Michael (1993) *Mimesis and Alterity. A Particular History of the Senses*. New York; London: Routledge.

TAUSSIG, Michael (1999) *Defacement. Public secrecy and the labor of the negative*. Stanford: Stanford University Press.

THOMPSON, Edward P. (1967) "Time, work-discipline and industrial capitalism". *Past and Present*, vol. 38, p. 56-97. Trad. it.: "Tempo, disciplina del lavoro e capitalismo industriale". In Società patrizia, cultura plebea. Otto saggi di antropologia storica sull'Inghilterra del Settecento. Torino: Einaudi, 1981, p. 3-55.

TURNER, Victor (1982) *From ritual to theatre. The human seriuosness of play*. New York: Performing Arts Journal Publications. Trad. it.: *Dal rito al teatro*. Bologna: Il Mulino, 1986.

WITTGENSTEIN, Ludwig (1953) *Philosophische Untersuchungen*. Oxford: Blackwell. Trad. it.: *Ricerche filosofiche*. Torino: Einaudi, 1967, 1974, 1983).

WITTGENSTEIN, Ludwig (1978) *Bemerkungen über die Philosophie der Psychologie = Remarks on the philosophy of psychology*. Oxford: Blackwell. Trad. it.: *Osservazioni sulla filosofia della psicologia*. Milano: Adelphi, 1990.

YOUNG, Allan (1995a) "Reasons and causes for Post-traumatic stress disorder". *Transcultural Research Review*, num. 32, p. 287-298.

YOUNG, Allan (1995b) *The harmony of illusions. Inventing Post-traumatic stress disorder*. Princeton, NJ: Princeton University Press.

YOUNG, Allan (1997) "Modi del ragionare e antropologia della medicina". *AM Rivista della Società italiana di antropologia medica*, num. 3-4, p. 11-27.