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# Political Therapeutics: Dialogues and Frictions Around Care and Cure

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## ABSTRACT

In 1978, Italy passed a law establishing the abolition of the mental hospital. Up to that time, the traditional asylums were still governed by the 1904 law that positioned psychiatry within the criminal justice system by assigning it the function of *custodia* (control, custody) rather than of *cura* (care). In the 1960s and 1970s, Italian psychiatrist Franco Basaglia initiated a movement of de-institutionalization of the mentally ill that revolutionized psychiatric care in Italy. It also had a deep impact on restructuring the psychiatric system in other European and Latin American countries. In this article, I discuss the different psychiatric practices and imaginaries that resulted from the movement of democratic psychiatry and Basaglia's visions for a community-based and diagnosis-free care of the mentally ill. I ethnographically trace what I call the "Basaglia effect" in today's psychiatric practices, and focus on ethnopsychiatry as a counter clinic that emerged from Basaglia's legacy. I reflect on the frictions between care and cure that ethnopsychiatry re-articulates and works with in the context of contemporary migrations to Europe.

## KEYWORDS

Basaglia; care; cure; ethnopsychiatry; Italy; migration; psychiatry

Continuing to accept psychiatry and the definition of mental illness means accepting the dehumanized world in which we live as the only human world, natural, unmodifiable, which people face unarmed. If it is like this, we will continue to relieve symptoms, make diagnoses, administer treatments and cures, and invent new therapeutic techniques. But all the while we will remain aware that the problem is elsewhere.

Franco Basaglia (1987)

After hundreds of Eritreans died tragically off the coast of the Italian island of Lampedusa on October 3, 2013 while escaping a war in their country, the Italian government started the Mare Nostrum Operation.<sup>1</sup> This one-year-long rescue program was essentially a humanitarian response to the increased flow of people passing through the Sicilian Strait. In 2014, Frontex, the European Union agency, conceived to combat illegal migration from the Maghreb to Europe since 2004, joined forces with Mare Nostrum and started a new operation named Triton. Unlike Mare Nostrum, Triton is an EU-funded intervention with the main purpose of patrolling borders and fighting criminality, not rescuing people. This shift in strategies points to a move from a humanitarian logic to a warlike approach to control national and supra-national borders. The general message of this new approach is that Europe should lock the doors to newcomers and asylum seekers, yet still keep humanitarian and liberal values alive.

This paradox speaks to a fundamental contradiction at the heart of power itself (Foucault 2007). Gestures of solidarity expressed at moments of critical emergency are quickly captured and tamed by the logic of control, which aims to document, fingerprint, control, police, and thus produce knowledge about the other (Foucault 1980). Here power operates according to its split nature: on the one hand, it functions as a form of custody and control, while on the other, it operates through techniques of care and rescue of those who fit its categories of recognition (asylum seekers, victims of human trafficking, refugees seeking humanitarian protection). The relationship between custody and care in the management of people who figure as

“migrants” and “asylum seekers” to Europe echoes the history of Italian psychiatry and the management of other marginal people, the mentally ill. In this article, I draw from my ethnography of an ethnopsychiatric clinic, the Centro Frantz Fanon, in Turin, Italy, that provides psychosocial support exclusively to foreigners. Its clinical practice is one of the legacies of Franco Basaglia’s democratic psychiatry and the reform of psychiatric care, which in 1978 led to the closure of the mental health hospital and created a community-based mental health system. Basaglia recognized that the causes of madness were as much social as they were intrapsychic, and that the mental hospital produced pathology rather than care. Both Basaglia’s psychiatry and contemporary ethnopsychiatry challenge the ways in which custody and care are practiced inside and outside clinical spaces, and provide a political commentary on institutional logics of care and control.

Between June 2002 and July 2004, I conducted research with the Centro Frantz Fanon clinic, an alternative to public mental health services that offers psychological support to documented and undocumented foreigners. The Centro was opened in the mid-1990s by a group of politically engaged psychiatrists, psychologists, educators, and cultural mediators in response to the forms of discrimination non-citizens experience in the Italian health care system. They also advise Italian social workers, state bureaucrats, and mental health practitioners working with diverse populations.<sup>2</sup>

Ethnopsychiatry arose originally with colonial psychiatry and the study of indigenous pathologies, and today is located at the nexus of different legacies and discourses on mental health. On the one hand, the Centro’s practice is inscribed within the revival of clinical ethnopsychiatry in other European countries. In particular, it draws from Tobie Nathan’s experience in France and his therapeutic technique of reorienting patients within their traditional healing strategies (Fassin 2000; Fassin and Rechman 2005; Nathan 1994, 1996, 2001). On the other hand, the Centro is inscribed within both Basaglia’s tradition of a politically engaged psychiatry and Fanon’s reflection on colonial domination and the political and psychic dimensions of suffering (Fanon 1963, 1967[1952]).<sup>3</sup> These legacies enable this group of practitioners to see symptoms as reducible neither to a strictly biomedical account nor to a culturalist one.<sup>4</sup>

In this article, I argue that Basaglia’s “psychiatry without *manicomio*” (mental hospital) and the contemporary practice of ethnopsychiatry have produced counterstrategies to practices of custody and control, within and outside of psychiatric care, and offer a political space to rethink the phenomenological dimension of care (Binswanger 1958). The experiences of Italian democratic psychiatry and Basaglia’s work provide an example of the ways in which custody of the other (whether in psychiatric or humanitarian contexts) can be turned into forms of care, and how the distinctions between cure and care are blurred and often ambivalent. I reflect upon the story of Afèrdita, one of the Centro’s patients. Her story articulates the paradoxes of care and cure, and it embodies the frictions between different approaches to suffering that the state and alternative spaces of care provide. This story also illustrates how forms of custody keep haunting practices of care, showing the persistence of certain modality of power and the ways in which it frictions with alternative expression of itself.

### The “Basaglia effect”

In the early 1970s, Franco Basaglia (1924–1981) and the movement of democratic psychiatry initiated a revolutionary process of de-institutionalization of the mentally ill and critique of public institutions (Pandolfi and Bibeau 2005). No other alternative psychiatry groups had achieved the same success as this movement in Italy in the 1970s. The reasons for success were twofold: (1) Basaglia and his collaborators were able to bring the issues of mental health, marginality, and exclusion to national attention, and (2) as a consequence, a law passed that redefined the juridical definition of mental health and dangerousness (Lovell 1987:267). The roots of this reflection on society and mental health go back to a long-standing Italian intellectual practice partly inspired by Antonio Gramsci’s analysis of the relationships between hegemony and subaltern cultures, and the role of the organic intellectual in defining what counts as politics. Basaglia embodied a critical tradition of politically engaged mental health reform originating in the 1960s and 1970s, and was one of the main advocates of the 1978 Law 180. This law, also known as the Basaglia Law, marked the closure of the asylum and promoted the organization of a community-based psychiatry through the establishment of mental health centers.<sup>5</sup>

For Basaglia, in order to turn psychiatry inside out, practitioners had to work from within the system to address its contradictions and start a process of self-reflection. In line with Foucault's (1988) and Goffman's (1961) analyses of total institutions, he understood mental illness as a sociopolitical problem and imagined a public psychiatry able to comprehend the intersections of suffering and social misery outside of the asylum. The institutionalized patient is subjected to a pact with the institution that forecloses any empathy with his/her lifeworld. In *L'istituzione negata* (The Institution Denied)—a 1968 collection of essays by Basaglia and his most militant colleagues—Basaglia explained that to truly listen to illness, practitioners had to face it outside of any “institution whose function is to label, codify and fix those who belong to them into roles” (1968:374; my translation). His understanding of madness not as a mere social product, but rather as a complex nexus of contradictions (institutional, ideological, ethical, medical, political, and social) that manifest in patients' bodies, and his questioning the structure of psychiatric knowledge itself, highlighted psychiatry's problematic relationship to the law.

In Italy at that time, psychiatric hospitals were still governed by the 1904 law that positioned psychiatry within the criminal justice system and assigned it the function of *custodia* (control, custody) rather than of *cura* (care). As Anne Lovell points out, “Law, not medicine, had come to define the domain and boundaries of psychiatry, emphasizing the social aspect of medicine and attributing primary importance to the asylum (which was, after all, not so structurally different from the prison)” (1987:268). What Basaglia identified in the *manicomio* was a closed place within which the mentally ill person is reduced to an object, to an image of the asylum itself. In this way, the subject becomes productive not of wealth, but of social order (Basaglia 1987:274).

By involving the community in changing cultural attitudes toward deviancy, Law 180 disrupted former relationships between psychiatry and justice and ended the practice of doctors as the exclusive managers of mental illness. It unsettled the old distinction between custody and care, and re-imagined the clinic as a space of care:

The originality of this law lies in the disappearance of the judicial concept of “dangerousness,” from which was deduced the need for custody of the mentally ill, and hence for violating and repressing them. [...] [F]or the first time psychiatry must be prepared to confront those who suffer from psychic disturbances without protecting itself behind the screen of dangerousness and custody (Basaglia 1987:300).

Basaglia freed psychiatric practice from the idea that patients were dangerous to society, and thus needed to be separated from it. His work created a crisis not only within the psychiatric hospital, but also within society at large. As he clarified, “(t)o create a crisis [...] means breaking the certainty of the clear separation between health and illness, normal and abnormal, on which the social order itself is founded” (1987:300).

The crisis of psychiatry's custodial structure produced a series of “counter clinics,” therapeutic and political spaces that disagreed with pre-existing categories of health and pathology, dangerousness and safety, and allowed for new therapeutic relations. I use the term “political” in the sense developed by Jacques Rancière (1999), who makes a distinction between “policing” and “politics.” For him, political action is about creating a form of disagreement that changes the meaning of political engagement and redefines social order and the terms of discourse within a given community. Policing practices, on the other hand, are about the management of given social roles and places that are left unchanged though rearranged. In light of this distinction, one of Basaglia's effects was to produce clinical spaces that exceeded the clinic and involved the community at large, and provided an instance of politics where the language of biomedicine was contested, and forms of counter discourse and practice emerged. The strengths and limits of these clinical spaces simultaneously speak to the political potential of care, and to the paradoxical ways in which logics of care and custody remain in friction.

The Centro Fanon was one of these counter clinics. The debates that informed the clinical practice of this therapeutic group—and continues to inform it in 2017—issued from the political psychiatry Basaglia initiated. Their critique of state institutions, coupled with the commitment to rethink therapeutic interventions in the domain of public health for foreigners, indexed a specific kinship between Italian ethnopsychiatry and the legacy of “democratic psychiatry.” While initially Basaglia's focus was on the economically and politically marginalized, since the early 1980s, ethnopsychiatry has increasingly faced the

issue of marginalization and mental health by providing care to foreign populations. By stating that the health care of foreigners is a political issue rather than strictly a medical one (Beneduce and Martelli 2005), ethnopsychiatrists at the Centro echoed Basaglia's concern with the broad political dimensions of mental health and care. Similar to the epistemological and methodological break that Basaglia created from within psychiatry, ethnopsychiatry attended to the epistemological uncertainty that the treatment of foreigners poses to mainstream psychiatry. Moreover, the clinical practice and political engagement of the Centro's practitioners provided a critique of Italian politics of recognition and co-habitation. Their approach to therapeutic work within and outside the clinic challenged mainstream therapeutic and state apparatuses, showing the arbitrariness of psychiatric categories and of "multicultural" strategies to deal with difference. By adopting a phenomenological approach to foreign patients' experiences, and by suspending psychiatric diagnoses and pathologization, they turned psychiatry inside out and propose a counter practice that questions psychiatry's pretense of universality (Beneduce and Taliani 2006; Beneduce 2007).

Recent scholarly and clinical debates have called attention to the ways in which technologies of health and life have expanded the domain of medical and therapeutic intervention (Rose 2006; Foucault 1994; Nguyen 2010; Ticktin 2011; Fassin and D'Halluin 2005; Garcia 2010; Pandolfo 2008; Ramberg 2014). In particular, "the clinic" might be understood as a dispersed network of knowledge and intervention across multiple social fields. The many contemporary incarnations of clinical spaces are powerful sites for the (re)making of contemporary forms of life. Clinics and the relations they enable are thresholds through which humans and non-humans are positioned as particular kinds of subjects and enter into multiple power-laden relationships with authorities, spirits, therapeutic technologies, institutions, and nation-states. Clinical sites are thus located at the discursive nexus of medicine, psychiatry (Davis 2012; Kitanaka 2013; Young 1995), public health, and citizenship; the therapeutic practices and knowledges produced therein shape how humans come to understand, experience, and conduct themselves as well as become normalized, regulated, and governed as specific kinds of subjects in the world today. Particularly for foreigners, transcultural and ethnopsychiatry have shown the ways in which "difference" (experiential, political, or cultural) is mobilized in therapeutic practices and informs clinical experiences and outcomes (Giordano 2014; Kirmayer 2012; Beneduce 2007; Corin 1997; Pandolfo 2000).

In this article, I build on this body of literature and show the political force of ethnopsychiatry as practiced at the Centro Fanon, where clinicians combined the treatment of foreigners with a radical critique of psychiatric diagnostic categories, and thus provided an instance of politics where the hegemonic language of medicine was disagreed with, and different forms of care were enabled. This counter clinic was more a space of listening than a physical place of cure; or rather, it was a clinical interstice that troubled the distinction between care and cure, and it enabled forms of existence that the hospital and its language deny. When we are caught in institutional time and the demands of biomedical treatment, the time for listening to the enigmas of history and the unconscious, to the blurring of life and death, is suffocated. This clinic opened up a time for caring without necessarily curing, or, as Donald W. Winnicott once framed it, for a "care-cure" (1986)—a relation not punctuated by diagnoses and the eradication of disease, but by a holding, and the acknowledgment that others have their own words that need to be spoken and heard, and their own timing to be cared for. This form of care is often incommensurable with the care of the state that, by not recognizing other temporalities, uses psychiatric categories to make experience intelligible. In so doing, psychiatric and institutional care disempower other counter practices, attempt at reducing them to the same, and falls back into forms of "caring custody"—the eternal paradox of power.

## The case

I now turn to a clinical story in which I participated while conducting research at the Centro.<sup>6</sup> When we first met, Afèrdita lived in a shelter run by Catholic nuns, who also visited the clinic once every other week to consult with Afèrdita's therapist on how best to help her in the program that social services designed for her. At the time, Afèrdita was 33 years old. She had a seven-year-old daughter, Mailinda; a one-year-old son, Marcello; and she had lost another son, Pietro, who died when he was two years old,

before she immigrated to Italy. She had arrived from Albania two years before, eight months pregnant, with her husband and her daughter. They stayed in Rome with a cousin who lived in a shantytown on the outskirts of the city. After a few days, the husband decided to return to Albania. She continued the journey alone and moved to Turin with Mailinda because she knew someone from her country there. The woman she stayed with was a sex-worker, and Afërdita did not feel safe living with her. Eventually, through the help of social services, she moved to a shelter for foreigners on the periphery of town.

After a few months, the shelter's social workers sent her to the Centro Fanon. According to them, she was often very sad, could not sleep at night, had strong headaches, and struggled with the children. She was unable to contain her anxiety, and would rely on her daughter for support. She was always very tired, and in a depressive state that prevented her from getting up in the morning. She cried a lot. The Centro's psychiatrist decided to prescribe an anti-depressant and a sleeping pill, and social services supported her to become independent. They found her a job as a house cleaner, which she managed to do for a while. But Dr. Z—the psychologist in charge of her case at the Centro—thought that she had become more scared and anxious than when she had just moved into the shelter because she needed more support with the children.

One night, Afërdita walked into the garden where there was a well and tried to open it. The following morning, when the social workers asked her why she did it, she replied, "Because I wanted to throw myself in it." They thus decided to hospitalize her without consulting with the Centro's therapist. She was diagnosed as having had an "acute psychotic episode." She was in the hospital for three months, not because she needed treatment for the entire time, as Dr. Z explained to me, but because social services did not know where to house her since she did not have a residency permit.

Afërdita did not fit any clear-cut state categories for foreigners that would grant her a legal status: she qualified neither as a "victim of human trafficking" nor an "asylum seeker," and in order to be granted the "economic migrant" status she needed a regular full time job. According to Dr. Z, social services did not handle her case well at the time of her arrival. Since her second child was born in Italy, they could have requested a permit for her on that basis. None of the people in charge of her at the shelter where she lived did anything about it, and Afërdita did not know how things worked. She could now receive a residency permit because she was a mother of two minors who resided in Italy, or for medical reasons. These kinds of permits, though, prevented her from working and possibly from renewing them in the future. She could only have short training contracts, but not a regular job. After two years, she would have to renew it or leave the country. She was trapped in the interstices of these various categories of recognition and statuses, without fitting any.

While she was at the hospital, the shelter's staff could not look after her children and had to report her case to the Immigration Office, which in turn reported it to the Tribunal for Minors.<sup>7</sup> The children were then transferred to two separate shelters for different age groups, at opposite ends of the city. Social services asked Afërdita to sign a document to give consent; she had no choice but to sign it. Given her hospital diagnosis, her ability to be a mother was in question. The request to transfer the children to other housing facilities could easily be translated into a request to consider them for adoption. Meanwhile, Afërdita was moved to a shelter run by Catholic nuns.

The Tribunal scheduled her visits with the children, which occurred twice a week and were monitored by social workers and psychologists. Afërdita also met with the judge who told her that they would put the children in foster care while she got better. She had regular appointments with the judge who was appointed to assess her progress and overall competence at parenting. But when Afërdita was called before the judge and was asked about her life back in Albania, she would often start crying and talking about the dead people in her family. As I had learned from the therapy sessions at the Centro, there was a history of depression in Afërdita's family that ran through the women. Afërdita dropped out of school and stayed at home to take care of her mother, while her sisters and brother went to school. She thought that her mother had died of cancer, although they never did an autopsy. At other times, she would say that she had committed suicide, possibly by throwing herself into a well. Apparently, her grandmother had been diagnosed with brain cancer and suffered from depression, too. Afërdita took care of other old people with cancer who all died while she assisted them: her mother- and father-in-law and her

grandfather. Life had turned her into an attendant of death, as the Centro's ethnopsychiatrists explained. Stories about the dead were her life story, but this did not matter to the judge. Or, rather, these stories were translated by various institutional figures—the judge, social workers, and educators—into a register of the pathological, and were used to prove her unfitness as a parent. In this register, they begged for state control over her parental rights, and her tears were heard as a sign of depression.

In the clinical space of the Centro, these same stories resonated differently. Ethnopsychiatrists understood that Afërdita spoke from a space of loss and death. Loss was the experience she associated with Albania, but moving to Italy marked a different kind of loss: her husband, her children, and of what it meant to be a mother. Her tragic, tearful attempt to defend herself to the judge in the custody hearing was a measure of her difficulties in reoccupying the world in a new context and in making sense of the norms and rules that regulated social order. She searched for ways to exercise her existence (Mbembe 2001) in the various institutional languages whose codes she could neither interpret nor follow. The past would seep into her attempts to represent herself as a “healthy and good mother” before the law, a domain that demanded certain evidence in order to grant her the right to be a parent. Social workers and the nuns at the shelter advised her not to cry or talk about the deaths in her family in front of the judge. Her death stories were disturbing for those in charge of her case, because they forced questions of whether it is possible to live with death and to understand this experience outside the register of pathology.

When I joined her therapy sessions, the issue at stake was urgent. The Tribunal for Minors had requested that Dr. Z write a report on the course of Afërdita's treatment, and Dr. Z was struggling with how to communicate her progress in therapy to the other institutions that were evaluating whether she was a fit mother. The doctor underlined the fact that she had made some progress after being discharged from hospital, although now she was doing poorly again. But she never missed a single visit with the children, and social workers said that she really cared about them. She never missed a single therapy session either, which showed her commitment to doing better. Many different people monitored Afërdita and reported their observations to the Tribunal: the nuns at the shelter, the social worker, the people who observed her interactions with the children during her visits, and the children's psychologists. They all wrote reports on her for the Tribunal. These multiple institutional gazes produced different, cumulative narratives about Afërdita; they produced written accounts and spoken assessments that had the power to fix her in the temporalities of diagnoses, and in the anonymity of institutional bureaucracy and its forms of care (Stevenson 2014). The Centro's report was just one among many evaluations.

### **The Tribunal and the counter clinic**

One of these reports, the “Consulenza Tecnica d'Ufficio” (Technical Office Consultation), is the Tribunal's procedure to assess parents' psychological competence in taking care of their children. It is often referred to as CTU and it is supposed to be an unbiased report conducted by an external expert appointed by the Tribunal itself.

The CTU took approximately three months to draft. During this time, the Tribunal's mental health practitioners had to accomplish the following: (1) identify whether Afërdita was affected by psychiatric disorders, and if so of what nature and entity; (2) describe the symptoms and their consequences for her parental role; (3) describe the possible development of the disorder; and (4) describe the quality of her relationship with her children. These mental health experts referred to the DSM IV-TR for diagnostic purposes. After a series of consultations, they produced the following diagnosis: “Depressive nucleus of a persecutory nature; [...] the psychotic state has chronic and stable connotations, but it is not completely disabling in her social and environmental functions.” They confirmed the diagnosis made during her previous hospitalization in Italy: “Major Recurrent Depressive Disorder according to the DSM IV-TR.” In phenomenological psychiatry, the document continues, this kind of depression is also defined as “unipolar” as opposed to “bipolar.”

During her consultations with the Tribunal's mental health practitioners, Afërdita recounted her story again, starting from her mother's death. I learned new things about her from this report. For example, she recalled being hospitalized in Albania six months after getting married. She was

seventeen and her husband used to drink and have sex with other women. Afërdita stayed at home to take care of her in-laws, both of whom were dying from cancer. She and her mother-in-law had come upon a well filled with water. As soon as she approached it, Afërdita felt paralyzed and began to scream uncontrollably. They took her to the hospital, where she stayed for a month and a half. The diagnosis was “depression with delirious episodes.”

After six years of marriage, Afërdita learned she was pregnant. Her first pregnancy was easy. Her daughter Mailinda was born with a hip problem that was later resolved with a surgical procedure. After two and half years, her second child, Pietro, was born. The second pregnancy was more difficult. He was born with “a problem in his ears,” which turned out to be a form of meningitis. He died when he was two, after several failed attempts to restore his health. When this happened, Afërdita was hospitalized a second time with a similar diagnosis of depression.

The CTU document was strictly formulated around the same depression diagnosis. In one section, it refers to the ethnopsychiatric work Afërdita underwent. It states that the diagnosis of depression was “completely ignored in the current project for Mrs. Afërdita at the Centro Fanon, where they don’t follow the guidelines of treatment outlined by the APA (American Psychiatric Association).” Social services had not noticed any progress since she had been in psychotherapy there. Furthermore, the Centro’s therapist “has a protective and supportive attitude with a tendency to underestimate Afërdita’s depressive tendency.” Afërdita’s therapist did not formulate “a psycho-pathological diagnostic hypothesis,” and instead explained her distress as “the consequence of the lack of maternal care and little emotional containment” that she experienced as a child. According to the CTU document, the Centro’s therapist interpreted Afërdita’s case as a form of “reactive depression to the environment, with a neurotic frame.” The document concluded that the children needed to find “a stable and solid situation within an adoptive family as soon as possible.” The Tribunal deemed Afërdita a psychologically incompetent parent.

In contrast to the CTU’s claims, Dr. Z wrote two reports to the judge in which she acknowledged previous diagnoses, but also noted Afërdita’s steady progress in therapy. Dr. Z explained that Afërdita was facing her big life conflict: being abandoned by her mother who had possibly committed suicide. She was re-living the separation and abandonment from her own mother in the context that her children were in foster care and being considered for adoption. Afërdita felt powerless and frustrated because she did not know how to reassure her children when she visited them. She often asked for advice on how to be a “good mother” because she felt constantly questioned by various institutional figures whose languages and expectations were foreign to her. Overall, Dr. Z’s report documented Afërdita’s ability to reflect upon herself, her greater awareness of her limits and resources, “which can lead to strengthening her motherly function.” She was also more active in searching for a job, and was making new friends outside the shelter. But these reports do not mention curing Afërdita in the way the law requires, nor do they refer to any diagnoses that could point to a specific treatment, pharmaceutical or behavioral.

While ethnopsychiatry challenges the dichotomy cure/care by making space for care and its temporalities in the face of the state’s urgency to cure, it does not forget the importance of curing. They work from within the tension between caring and curing, which echoes Basaglia’s struggle against the mental hospital and its focus on control and custody. Cure understood as a return to “normality” —or as a form of control—does not fit with the ethnopsychiatric notion of care, which does not depend on translating suffering into diagnoses, but rather allowing the patient’s speech and memory to be heard on their own terms. Suspending diagnosis gives the patient time to listen to the wounds of her being and to co-exist with them without removing their incommensurability by explaining them away through a diagnostic category. As Roger Gintis put it, what is needed is not so much to bring people back to norms, “but to cure them from those very norms” (1978:6, my translation), and thus care for and cure life itself.

In the space of the clinic, the world of dreams came to life for Afërdita. She dreamed a lot and took to writing down her dreams in a journal. Together with Dr. Z, she attended and listened to her dreams as important moments of her life. The dream space was a different world from Albania and Italy. It allowed her to live in multiple worlds simultaneously; she did not have to cross from one to another, but could rest in between. She did not have to leave death behind in her dreams, as she was



asked to do before the judge. In this sense, the therapeutic space allowed Afërdita to be in the midst of death and loss while being alive and creating a new life for herself.

During one session, a year into her therapy at the Centro, she recounted a dream:

I am in Albania in my in-law's house. The house is empty; everyone has either gone away or died. My husband's parents have just died. I am getting ready to leave. The darkness of the time of illness is gone, the windows are open, the curtains flutter in the wind, and there is air and light coming into the rooms. My father-in-law comes back because he wants to see me. He gives me a bag full of black clothes because someone has just died, and 400 euros. I am happy about the gift, but hesitate to take the money. He tells me to eat good food and then to leave, but not to take the path that cuts through the bushes. I would ruin my new clothes. I saved myself by taking the path he showed me.

When she awoke from the dream, she was happy. As she told us about the dream, she smiled, "It is good luck to dream about a dead person who gives you a present." She did not dream about life very often. As we talked about this dream, she explained it as her father-in-law's blessing to migrate, to go toward the light. "Maybe he has helped you to take the right path," I suggested. "Yes, and maybe it means that I can have the children back," replied Afërdita. "Were you happy to take the path he showed you in the dream?" I asked. "Yes, definitely," she replied enthusiastically. But then her eyes became sad and she said, "Maybe, had I stayed in Albania, I could have kept my children. They would have never been taken them away from me." She had reentered the world where rules and categories turned her experience into pathology in need of a cure. "My deepest wish is to heal, to feel better," she added with an imploring expression. "But I am afraid of dying, of having brain cancer, something bad in my brain." Dr. Z reminded her that the last medical check did not show any problem in her brain, and that lately she had even reduced the dosage of the anti-depressant because she was feeling better. "Sometimes we are afraid of healing, of getting better," Dr. Z suggested.

The time of dreaming and of listening to their oblique messages are in friction with the accounts produced by the nuns, the Tribunal, and social services. In these reports, what emerges is a genre that represents Afërdita as a known object who is either possible or impossible to cure. A comparison between the reports produced by the Tribunal's mental health practitioners and the interpretations of the ethnopsychiatrists shows that while the institutions insisted on a cure, the clinic opened up a space of care whose structure and time were incommensurable with those of the institutions and of custody. This counter clinic did not focus on curing at all costs, but produced something similar to Winnicott's idea of care-cure, a clinical relation not framed within diagnoses and their respective course of treatment. This wasn't enough for the Tribunal.

The verdict was not lifted even when, months later, Afërdita started a relationship with Carlo, an Italian man in his late forties who was divorced and had a good job. He was devoted to her and provided her with great stability. They moved in together, and Carlo was open to adopting the children. Even Afërdita's sister and brother, who had migrated to Italy, were available to help with the adoption by providing a family network that the state should have recognized as suitable for the children. Afërdita found a lawyer who followed the case closely and tried hard to convince the Tribunal not only of Afërdita's improvement, but also of the family stability she had achieved. Nothing worked to her advantage. On the basis of her psychological assessment, the children were still given up for adoption. To me, it felt like a Kafkaesque trial: the more rules she tried to comply with, the more trapped in the system she became, and the more her situation turned into what one of the ethnopsychiatrists once described as "a case of epistemic violence that screams for justice because it was never heard."

Institutions such as the Tribunal can dismiss the Centro's approach to Afërdita's case precisely because ethnopsychiatry brackets diagnostic criteria and acknowledges other etiologies and healing techniques. Here lies its strengths and weaknesses vis-à-vis other institutions. In their report on Afërdita's psychological competence, the Tribunal's mental health practitioners implied that the Centro could possibly produce a "misdiagnosis." Thus, suspending a psychiatric interpretation automatically equaled, in the Tribunal's grammar, a misdiagnosis. But from the ethnopsychiatrists' perspective, suspending a diagnosis implied suspending the temporality of biomedical reasoning and the linear logic that assigns symptoms to a diagnosis, a diagnosis to a course of treatment, and a treatment to a cure.

At the Centro, practitioners usually do not use psychiatric diagnoses unless they work with patients who have previously been diagnosed by clinicians at the public hospitals before being referred to them. They create a dialectic with psychiatric diagnoses to either question them, or to continue the pharmaceutical treatments associated with them. Or, they may make a political use of psychiatric categories when they write psychological assessments for asylum seekers or victims of torture or trafficking. In these instances, the language of psychiatry may speed up the bureaucratic processes of obtaining documents. In Afêrdita's case, though, the CTU's use of strictly psychiatric diagnoses foreclosed the possibility of regaining custody of the children, and therefore represented a way in which she was under a different form of custody, that of the state. Meanwhile, in the ethnopsychiatrists' clinical opinion these diagnostic categories did not capture the dilemmas of her struggle.

### The paradox of care

What I saw taking shape in Afêrdita's experience was also a distinction between the ways various institutions wanted to cure her to make her qualify as a competent parent and the care—without the imperative of a cure—that ethnopsychiatric listening provides. I thus began to understand the difference between cure and care through the lens of what Basaglia framed as the friction between custody and care, and recalled Winnicott's idea of a blurred care-cure. While in order to cure her, the state and the nuns translated her experiences into pathologies and behaviors that need to be rectified and controlled (“do not cry in front of the judge”), the space of care suspends institutional languages and listens to that cry as a form of speech that comes from somewhere else. This type of care affirms Afêrdita's expression of emotion as a speech that, in and of itself, could reveal a different relationship to life and death, normality and pathology. It also afforded her the strength to start a new relationship with a man, and to rekindle a long-lost bond with her siblings. She was able to create a support network around her that could have helped her raising her children. I joined the ethnopsychiatrists in believing that with the help of family, she could take care of her children.

In the context of other institutional logics, curing implies transmuting dis-ease into ease, pathology into normality. Or, it may refer to a kind of cure that aims at dealing with her suffering through a form of custody, which separates her from the children and prevents the possibility of a family reunion, and simultaneously takes care of the children's well-being. Caring for her, on the other hand, means surrendering these categories and paying attention to her transgression of the rules—not as something to be redressed but as her active response to the institution's failure to attend to her despair.

Afêrdita's story is another instance of the ambivalence at the heart of state power. The state—in the form of social services, the juridical system, and shelters for migrants—aims to cure the foreigner, so it hospitalizes her; but this curative approach deprives her of the time it takes to be cared for, and of any rights that she might have to her children and/or to a job. As mentioned earlier, her legal status was suspended in a juridical limbo.<sup>8</sup> Religious and secular associations may diverge from the state bureaucratic orientations, but for Afêrdita this was not the case. Also, the state operates through the imperative to cure her quickly and at all costs, to see proof of her progress.

I had several conversations with ethnopsychiatrists about the question of time. Each experienced frustration in dealing with the different timeline of their institutional counterparts. To them, suspending a diagnosis also meant giving patients the time to orient themselves within institutional logics that were often unintelligible. The time it takes to cure and heal is at odds with the expectations of social services, the hospital, the Tribunal, the school, and the Immigration Office. Moreover, in ethnopsychiatry, different temporalities come together in the therapeutic space. For example, as I explored elsewhere (Giordano 2014), when spirits and other worldly presences take part in therapy, what time do they follow? How can the temporalities of unconscious memory, spirits, and bureaucracy co-exist?

The ethnopsychiatric setting—much like a psychoanalytic one—makes room for the paradoxical temporality of the unconscious. Afêrdita's memories emerged as stuttered accounts about the past and repetitions of memories that stumbled upon each other. In other words, the time of the unannounced—those words that should not be spoken in other institutional times and spaces, but

are nonetheless uttered, like Afërdita's insistence on speaking of the dead—has a place in this clinical context. There is also the time of trans-generational trauma, with its silences and dangerous prophecies (Beneduce 2010; Taliani and Vacchiano 2006). Indeed, as Afërdita's mother used to tell her before dying, "You will become just like me, but don't think about it now." This prophecy shaped much of her experience, posing an existential dilemma that she constantly resisted.

By suspending diagnostic categories, the ethnopsychiatrists heard Afërdita's cry as coming from afar. The tone of her melancholia was acknowledged and the accounts about death were heard as symptoms of her life story. This listening provided a form of care that did not fix her experience in diagnostic categories. In a phenomenological sense, diagnoses are perceived as preventing the production of a narrative that, however tentatively, can link different etiologies and healing practices. Basaglia's phenomenological influence taught psychiatrists to create a more direct relation to patients' lifeworld, and to create "a terrain of encounter" through empathy (Basaglia 1981). As one of the Centro's therapists explained to me, ethnopsychiatry positions the patient as a political subject "not because s/he is a victim of human trafficking or an asylum seeker, but because they tell us about their suffering in their own terms," through symptoms and dreams. In this setting, the power dynamics between patients and doctors can be inverted because the patient herself crafts her own stories. This is a different therapeutic relationship than the one created by the institution, and it allows for a different unfolding of the patient's psychic life.

## Conclusion

Afërdita's story leads me to make a broader argument about the kind of counter clinic and politics of therapeutics that ethnopsychiatry proposes, and its kinship with Basaglia's revolution in the mental health care system. Ethnopsychiatry as practiced at the Centro opens up a political space in which therapists can attend to the multiple temporalities of trauma and of experience, thus creating an interruption (Rancière 1999) with the discourses proposed by other institutions. As Basaglia argued, illness can only be truly faced outside of those institutions that label and codify it. It is in this counter space that I see ethnopsychiatry attending to difference without necessarily wanting to know it or translate it into something known. Both in Basaglia's work and in the work of ethnopsychiatrists, I see the force of the political at work: their critique of psychiatry and of the diagnostic apparatus undoes the language of psychiatry and creates new therapeutic spaces where a different language and set of practices can emerge, and disagree with established discourses on difference. However, this counter space provides a form of care that is often incommensurable with other institutional languages. It does not perform the same power of psychiatric knowledge or of humanitarian and legal categories of recognition. It operates in the register of experience that exceeds such diagnostics, and which can be silenced by the logics of state.

Cure always allows the state to exercise its control on the body of the other, to take care of her while simultaneously depriving her of economic rights, or, in Afërdita's case, custody of her children. Cure can turn into a form of custody. The politics of care, on the other hand, challenges the ambivalent logics of care and cure and, by suspending categories, creates counter sites of experience. Afërdita's case, for example, illustrates how, through care, her death story was held as an account in and of itself, seen in the fullness of its absences, instead of being heard as a missed or deadly narrative. This holding empowered her to re-create relations and family bonds that nourished her, allowing her to fight for her children. The system failed her even in the face of her attempts at following rules and norms, and her desire to be well. When the untranslatability of experience within codes is acknowledged, the clinical relation becomes a political one that allows for transformation.

This story also allows me to return to the time of crisis when the split nature of power clearly reveals itself. As mentioned above, in a state of emergency the seemingly more benevolent face of power suspends border control while extending care to those who seek refuge within the sovereign nation state. In showing its caring face, however, power reaches into the very body of the foreigner by obsessively documenting and translating her into one of the categories of recognition made available by the state. This care constantly risks transmuting itself into variations of custody and control, where those cared for undergo the triage of the state that leaves many behind. The experience of Basaglia and of the counter

clinics that it generated indicate a different politics of acceptance of those who seek refuge, one that suspends translation and understanding for the sake of listening to the relations that others make possible in the midst of a social and political world that is radically changing. These politics do not necessarily provide quick solutions, but they propose an ethics of suspension where categories are challenged and experience acknowledged in its untranslatability.

## Notes

1. For more details see <https://news.vice.com/article/italy-is-about-to-shut-down-the-sea-rescue-operation-that-saved-more-than-90000-migrants-this-year>.
2. In Italy, this kind of alternative mental health service lacks any institutional or economic support. Therefore, at the time of my research, the Centro was funded mostly through projects sponsored by the region, the municipality, and occasionally the European Union. Even though the Italian health care system is set to provide universal coverage, not all receive the same access to care and services. This was one of the reasons that led the Centro's practitioners to open a clinic exclusively geared toward the care of documented and undocumented foreigners. For more details on the Italian system of health care, see <http://international.commonwealthfund.org/countries/italy/>.
3. On the influence of Basaglia's practice and Fanon's work on Italian ethnopsychiatry, also see Jarvis (1977), Beneduce (2007), and Menozzi (2015).
4. In Italy, the Centro Fanon is a unique clinical site. Other Italian scholars and practitioners interested in mental health, culture, and care often define themselves as transcultural psychiatrists. Unlike in ethnopsychiatry, the transcultural approach draws from DSM-5 defined diagnoses while assessing patients' symptoms within their larger political and cultural contexts through the Cultural Consultation guidelines included in the DMS itself.
5. Although Basaglia was one of the main leaders of the Italian anti-psychiatric movement and Trieste was the cultural and political center from which he operated, the anti-institutional movement was very active in other Italian cities (Varese, Parma, Arezzo, Perugia, Nocera, and Rome, among others).
6. A more developed analysis of this clinical case and my positionality appears in the reference Giordano, 2014.
7. Law 149 (2001) is the current legislation on foster care and adoption in Italy. Titled "Discipline of Adoption and Foster Care for Minors" (*Disciplina dell'adozione e dell'affidamento dei minori*), this law states that when parents are unable to provide for their offspring, social services must provide different forms of foster care (family or shelter). If problems with the biological parents continue, children are considered for adoption.
8. When I knew her, the options on the table for obtaining a legal status were two: she could either receive a residency permit for being the mother of two minors who resided in Italy, or she could apply for medical reasons. Neither of these permits would allow her to work, and yet she was asked to prove that she could sustain the psychological and financial responsibilities of a family.

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