Doctoral Dissertation.

Interuniversity Doctoral Program in

Urban and Regional Development (37th cycle)

POST-ASYLUM GEOGRAPHIES OF MADNESS

FINDING SPACE FOR GETTING MAD

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January 2025

DECLARATION

I hereby declare that the contents and organization of this dissertation constitute my own original work and does not compromise in any way the rights of third parties, including those relating to the security of personal data.

Alessandra Mossa Turin, January 31st, 2025

* This dissertation is presented in partial fulfillment of the requirements for Ph.D. degree in the Graduate School of Politecnico di Torino (ScuDo).

ACKNOWLEDGMENTS

Completing this PhD has been a journey full of challenges, growth and moments of profound learning. As well as discouragement. I am deeply grateful to all those who have supported me along the way and helped shape this work into what it is today. Firstly, I would like to express my sincere gratitude to my supervisor, Michele Lancione. Your guidance, insight, and unwavering support have been invaluable throughout this process. Your encouragement and ability to challenge me intellectually have pushed me to think critically and beyond the limits of my comfort zone. I am therefore profoundly thankful to you. You always did more than you were supposed to; with uncommon sensitivity and care. To my incredible colleagues and friends at Polito - Saanchi, Sofia, Elia, Francesco, Igor, Maureen, Anthony - thank you for the stimulating discussions, and the shared moments that have made this experience richer. Your ideas, encouragement, and shared struggles have been a constant source of motivation and inspiration. I am also grateful to all the teachers and colleageus who followed and supported me on my academic path - Nancy Holman, Alan Mace, Francesca Leder, Giulio Verdini, Mara Ferreri and Natalia Slutskaya. Your teaching laid the foundation for my academic journey, and your passion for your fields inspired me to pursue this path. I thank you for believing in me, for helping me develop the skills and mindset necessary for this work - and for your insistence that I pursue my doctoral studies. To all my flatmates, who provided a home away from home during this journey, thank you for your patience, your humor, and your kindness. Living with you has been a source of stability and joy, even during the most stressful times – thanks to Stefano, Nikolai, Vicky, Salvador, Carlos, Patrick, Moa, Nick, Violet, Jon, Wards, Ezra, Francesca, Alessandra and Valentina. To all my friends who have supported me in countless ways, I am endlessly grateful. The list is long and so I save it. Your encouragement, understanding, and faith in me have been a source of strength throughout this process. Whether through a kind word, a shared laugh, or a distraction when I needed it most, you have been an essential part of this journey. This thesis is as much a reflection of your collective support as it is of my own effort. Thank you for being a part of it. Finally, I want to thank my family, who even though they did not always understand or share what I was doing, they always helped me to do it anyway.

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ABSTRACT

This PhD research sits within the literature that looks at the process of deinstitutionalization of the mental health system through the lived geographies placed outside the asylum. It addresses mental health geographers' call for a practiced and situated knowledge about mental health and aims to provide an examination of different geographies of mental care located in the city of Turin. By monitoring a series of mental care practices that go from drop-in centres to supported accommodation, my study intends to assess the current and future implications of these spatial and relational practices in terms of belonging, self-determination and resistance. Through an analysis of benefits and detriments that users recognise in each of these practices I will get a more specific understanding of how different spatial arrangements, and their associated narratives, contribute to dynamics of power and exclusion. This study aims to identify pros and cons that different settings imply for chronically ill patients and will offer a fine-grained analysis of how a variety of spatial arrangements act at the individual and collective level. Through an autoethnographic account and life-history narratives, I intend to understand how space is co-constructed, embodied and narrated from within. This, without neglecting the wider social and economic context within which these arrangements have been produced. The spatialisation of mental health management will be explored in light of the shifting social attitude towards mental health that has occurred since the radical psychiatric movements of the 70s and the consequent closure of the asylum. Being at the intersection between the spatial and economic restructuring of the management of mental health care, the lived experiences of its users and the spatiality of the everyday, I assess the political economy of the contemporary mental health care system and their impact on individuals. A particular focus is placed on how power materialises, and on the coping mechanisms put in place by people on a daily basis.

KEY WORDS: geography of mental health, deinstitutionalization, mental health care system, Basaglia, Law 180, life-history narratives, autoethnography

CHAPTER 1

INTRODUCTION

1|THE RATIONALE FOR A STUDY ON THE IRRATIONAL

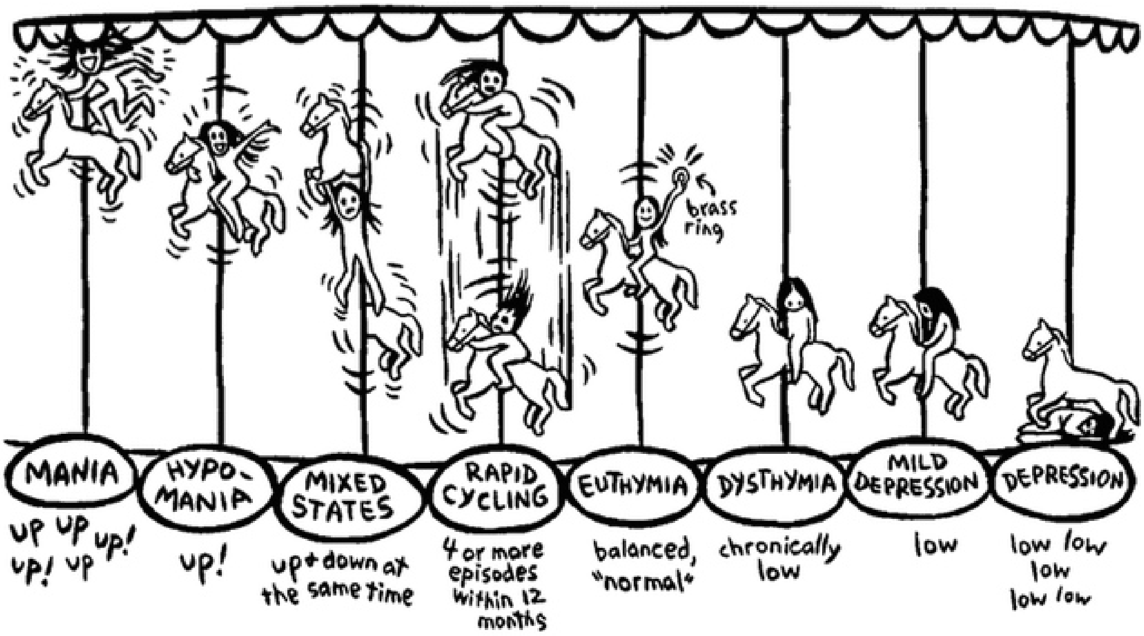

Figure 1.1: Mood states of bipolar disorder type 1. Graphic image from Ellen Forney (2012) 's memoir about her experiences having bipolar disorder.

I had my first manic episode in 2006. I have been lucky enough not to be hospitalised; this mainly thanks to my family, that could afford private care, and a network of friends that has slowly learnt how to deal with my extreme ups and downs. Given the cyclic nature of my mood swings, in 2011 I have been diagnosed with bipolar disorder typology 1, an illness that affects about 45 million people around the world (WHO, 2019), and from which you cannot fully recover. Since then, I have been under pharmacological and psychiatric treatment and I have conducted what, from outside, might look like a normal life. My diagnosis gave me a label that, as a fluid social construction, holds little meaning for me today. In the past, however, it has played a fundamental role in the long and painful process of self-acceptance that every individual with a mental health condition - or more generally, anyone who deviates from the norm - is called to undergo. I was assigned the box within which I was no longer an exception and, despite all the problems of having to recognise myself through someone else's eyes and categories, it made me belong to a group and gave me the strength to “come out”. It made me able to describe one part of me that, before that, was nameless and therefore incomprehensible. It drew the line between a “WE” and a “THEY” that is sitting within a process of othering that should definitively be challenged, but that, I reckon, was necessary to make me feel less ashamed (Cohen, 2018a). It took 10 years before I decided to join a support group[1]. There, we shared surreal stories, delusional and suicidal thoughts; all looked “normal” or at least familiar to us. The first thing I was asked when I joined the group was: “Are you a beneficiary?”. Ironically enough, they were framing our illness as a benefit. Whoever was there, as a friend, partner, relative, was indeed lacking something. They were lacking a degree of understanding that the group, deprived of judgment, was always keen to fill through personal insights. It was then that I started to wonder if being treated at home, visiting a psychiatric once in a while, despite representing a privilege, was necessarily ideal.

Since my first manic episode, I have visited a couple of former asylums and while walking through their corridors, parks, rooms I cannot avoid questioning if having your own parents as wardens, in other words, being under an “ableist gaze” that probably cared too much and felt too responsible, exacerbated dynamics of marginalization and control. Dynamics that, I believe, tend to be minimised, and therefore justified, by the horror that unvoluntary and life-long containment implied and that, I want to stress, are not going to be put under scrutiny here. Debates on LGBTQIA+ community have affirmed though *“the need to know that one is not alone in one’s circumstances”* (Butler & Parr, 1999, p. 202) and having a physical and/or virtual space where you can be open is instrumental in defeating loneliness, creating a sense of belonging, getting visibility and, ideally, political representation (Butler, 2015). As much as the Queer community, to which the mad could legitimately belong, we need to look for such spaces, as one and provisional way to tackle isolation and an eroded identity, being aware though that processes of othering should go hand in hand with inclusive practices.

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[1] https://www.bipolaruk.org/

Why are people with mental disabilities out of the picture of any political action? Where is the right to appear and to assemble, Judith Butler (2015) evokes for marginalised groups? How could we, as a society, “make room” or “give way” to a group that is profoundly ashamed and might even advocate for the right to disappear? To what extent family members, friends, medical professionals have the right to talk on our behalf? As if they were lawyers or mediators who only occasionally consult us. In geographical terms, what does it mean to make a space accessible to the mad? Along the lines of Vanolo’s (2024) call for the *”Autistic city”,* could the right to the city for the mad benefit all and create a more equal city? Despite the undeniable increase in interest and awareness around issues of mental health in recent years, thanks also to the outreach work carried out by celebrities and a greater media coverage, the way we talk about mental distress may still be discriminatory or perceived as such by many (Anderson, 2003; Gronholm & Thornicroft, 2022). By normalising anxiety and depression, or by finding individual solutions to systemic social problems, we tend, unless we have some sort of first-hand experience, to disregard more severe psychiatric issues, where and how they are treated, to what extent as a society we are responsible for those severely affected by them. Responsible as part of the problem and, therefore, in duty to take care of us according to health, economic and social needs.

With these questions in mind, I knocked on Michele Lancione’s door and asked him to supervise a thesis, rather unconventional for a department of Regional Planning, on post-asylum geographies of mental care, in other words, the network of mental health care spaces that emerged in the wake of the traditional “asylum” undergoing closure. In practical terms, a thesis on what, I lately discovered being an established field in the British academy, at least since the 90s (Philo, 1997, 2001, 2005). My aim was to explore the status of current spaces of madness, understood through the everyday lived experience of their users and through the eye of a person who has experienced psychosis at first hand. With Michele’s human and academic support, I then started my journey in the Turin mental health care system, explored in the dual guise of researcher and user.

In the following sections, I will briefly introduce the literature that has constituted my main reference, the overarching research questions, the relevance of the problem and my contribution. I will explain the epistemological and methodological lens I have adopted and how the fieldwork has been identified and designed. I will also provide with some information about the context, represented by the city of Turin, the local mental health system and the cooperative I have been working with.

2|FINDING PLACE FOR GETTING MAD

My research sits within the literature that looks at the process of deinstitutionalization of mental health systems through the lived geographies placed outside the walls of the asylum (Parr & Philo, 2003; Philo, 1997). It addresses mental health geographers' call for a practiced and situated knowledge about mental health and aims to provide an examination of different geographies of mental care at the local scale (Butler & Parr, 1999; Conradson, 2003a, 2003b; Parr, 2000; Parr & Philo, 2003). By monitoring a series of mental care practices that go from drop-in centres to group homes, my study has assessed the current and future implications of these spatial and relational practices in terms of belonging, self-determination and resistance. Through an analysis of benefits and detriments that users recognise in each of these practices, and their impact at the urban level, I got a more specific understanding of how different spatial arrangements, and their associated narratives may contribute to dynamics of power and exclusion. This study aims to identify pros and cons that different settings imply for chronically ill patients and will offer a fine-grained analysis of how different spatial arrangements act at the individual and collective level (Söderström et al., 2017; Söderström, 2019). Through a life-history and first-person narratives, I wanted to understand how space is co-constructed, embodied and narrated from within (Cortazzi, 1994, 2001; Plummer, 2001; Miller, 2011). This, without neglecting the wider social and economic context within which these arrangements have been produced. I therefore located the analysis within the historical, economic and cultural environment that anticipated and shaped the implementation of the Italian psychiatric reform of the 70s, highlighting the rhetorical, spatial and normative elements that resist or are instead openly denied (Basaglia et al., 1987; Lasagno, 2012; Foot, 2015; Rovatti, 2013; Cohen, 2018). The present spatialisation of mental health management has also been explored in light of the shifting social attitude towards mental health that has occurred since the radical psychiatric movements of the 70s and the consequent closure of the asylum in Italy. Being at the intersection between the spatial and economic restructuring of the management of mental health care, the lived experiences of its users and the spatiality of the everyday (Chouinard, 2012), I have then looked at the implementation of the Italian mental health care reform and its impact on individuals.

3| RESEARCH AIMS AND QUESTIONS

The premise of this study is that space, self-narratives and relations, being co-constructed, cannot be detached from any discussion on power over the self and identity production. Despite that, the relevance of looking at mental health issues spatially and relationally, has not been fully acknowledged in the scholarship of mental health (Crooks et al., 2018). My research, beyond putting the relational nature of space at the centre of the analysis, will also fill the gap represented by a substantial lack of first-person narratives around experiences of madness[2]. Through autoethnographic accounts and life-histories, I aim to understand how space is perceived, embodied and narrated from within. Being aware that every storytelling does not simply describe reality but actively contributes to make it, I will therefore focus on first person and un-sanitised narratives built up around each embodied and relational practice (Atkinson, 2009; Atkinson & Delamont, 2006; Miller, 2011). In researching lived geographies of madness, an understanding of the extent to which material and immaterial boundaries contribute to mental distress and to changing forms of identity, discipline and sense of belonging can be obtained.

All this considered, my research addresses mental health geographers' call for a practiced and situated knowledge about mental health and contribute to *"an understanding of space as simultaneously real, metaphorical, material, symbolic and embodied"* (Bondi & Fewell, 2003, p. 544). Through my study I am

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[2] I fully acknowledge the important work already out there, including figures like Alda Merini, as well as more recent contributions such as those by Giangiulio and Luvera, all of which have significantly advanced first-person narratives and representations of madness. Many of the most well-known accounts, however, continue to emerge from within the institutional context of the asylum. While these narratives are vital, my research seeks to decentre the asylum or psychiatric wards as the primary spatial frame through which madness is understood and represented. Even recent projects - valuable as they are - often remain shaped, explicitly or implicitly, by institutional contexts. In contrast, I am particularly interested in how madness is experienced, narrated, and negotiated outside such settings: in everyday geographies that are often overlooked in both academic and policy discourses. The aim is to expand the spatial imagination around madness, making space for experiences and voices that unfold beyond institutional boundaries and that challenge conventional modes of visibility, care, and control.

looking at how people, speeches, affections intertwine in a particular setting (Butler & Parr, 1999; Duff, 2012) and this will serve to assess the role of spatiality, temporality and its relational dimensions, in the construction of mad subjectivities (Conradson, 2003a; Crouch, 2003). A great emphasis has been placed on the identification of boundaries, transgressed or built, imagined or tangible that un-walled geographies of care embed. Exploring the socio-material elements present in post-asylum practices will help investigate the role of embodied space in the production of both coercive and internalized forms of control, versus acts of resistance, feelings of belonging, positive identity production (Foucault et al., 1991; Lefebvre, 1991; Thrift, 1996). This offers me the opportunity to understand whether processes of harassment and exclusion take place in contemporary mental care practices, outside and between institutions, and to what extent they are acknowledged and resisted. In other words, how power materialises, from above and below, and which coping mechanisms are put in place on a daily basis. This sheds light on the extent to which individuals engage in their own oppression and demonstrates the potential dangers of processes of subjectivation when one's sense of self is defined merely by labels ascribed by others (Butler, 1997). Through the lens of governmentality and sociomateriality, I will then explore the construction of both negative and positive mad subjectivities by questioning which are the embodied, relational, discursive elements that play a role in creating self-disciplined subjects and, vice versa, which ones might enable forms of resistance and self-determination. If we consider power as the often unconscious attempt to influence the behaviour of others, it is not difficult to envisage how psychiatric services can, even with the best of intentions, become geographies of defensive-repressive prevention. In their own way, they mirror an institution and a society that still exhibits paranoid traits, perceiving the mentally ill as a potential danger, to themselves and to others. My research started on the assumption that, even within unbalanced power dynamics, provided that they do not become mere domination and subjugation, it is always possible to create the conditions for forms of counter-power and acts of resistance. To practise and acknowledge this, one must see and live these geographies, in order to identify - and expand - the *“cracks”* of the system, as described by Högström and Philo (2024). While “*staying with the trouble*” (Haraway, 2016; Philo & Parr, 2019), these cracks need to be widened so that madness can find its own place in society, not as something other than reason that belongs to it only as its opposite, but rather by recognising itself as independent by it (Revel, 2024).

In this research, I explore how everyday practices within post-asylum geographies shape behaviours, identities, and senses of belonging. Drawing on Foucault, I understand power as something that circulates - relational, situated, and embedded in discursive, spatial, and affective arrangements. However, it is important to clarify that power and social control are not interchangeable terms. While power refers to broader processes of subjectivation and governance, the concept of social control, as developed in sociological theory, points more precisely to the formal and informal mechanisms through which norms are enforced, behaviours regulated, and deviance managed (Chriss, 2007; Horwitz, 2013). Particularly relevant here is the notion of therapeutic social control (Horwitz, 1982), which invites us to question how psychiatric care, even when embedded in community-based, apparently non-coercive settings, can operate as a subtle, and sometimes internalised, apparatus of regulation. In light of this, and drawing from recent contributions such as *"Controlling Madness"* (Sjöström et al., 2022), I attempt to trace how care and control are often entangled in these spaces; intersecting in ways that blur the line between support and surveillance, autonomy and discipline. This distinction, while analytically useful, is often collapsed in practice, making it even more urgent to ask where and how resistance can emerge within these overlapping geographies.

Given the above, this research has both theoretical and methodological implications. It aims to contribute to the "spatial and ontological turn" advocated by many scholars in mental health geography and Mad Studies and intends to update theories of power, space, grassroot resistance to a post-asylum era. Contextually, a debate on the opportunity and risks of adopting first-person narratives in geography will be explored. Through a geographical perspective, I will assess the role of space and embodiment in the co-construction of mad identities and explore where and how these can be shaped and inhabited in a positive and subversive way.

To sum up, my main research objectives are:

1) to explore how geographies of mental health care in Turin have been adapted to the withdrawal of the state;
2) how those geographies have been expressed spatially (and hence relationally) in the city.
3) which are the implications in terms of power and identity production, with reference to the setting of a residential facility called "group home".
4) how all this is lived, perceived, and narrated from within - by subjects labelled as psychiatric patients as well as mental health workers.

In more practical terms, my research questions are (Qs):

a) What insights can be gained from examining the deinstitutionalisation process at the urban scale?

b) how has power dynamics, from above and below, been transformed through the process of deinstitutionalisation? (Obj. 2; Chap 4, 5, 6;)

c) how is power co-constructed, performed, embodied, narrated in post-asylum geographies of care? (Obj. 3; Chap 5, 6)

d) which are the spatial, rhetorical, relational elements that are likely to exacerbate dynamics of isolation, exclusion and dispossession around issues of madness? (Chap 5, 6)

e) what, vice versa, could promote a sense of belonging, self-determination and acts of resistance? (Chap 5, 6)

TABLE 1.1:

Objectives (OBJs) and Research Questions (RQs)

RQs OBJs	a	b	c	d	e
1	Chap 4				
2	Chap 5, 6	Chap 4, 5, 6			
3			Chap 5, 6	Chap 5, 6	Chap 6
4				Chap 5, 6	Chap 5, 6

To answer these questions and to offer a fine-grained analysis of how geographies of mental care act at the urban level, I decided to restrict my study to the mental health system of the city of Turin, in Italy. My fieldwork, made of a multi-sited ethnography, was defined after a series of preliminary site-visits, speculative meetings and covert participant observation conducted as a user of some services operating in town. In the next section I will illustrate the process and the conditions under which my research design has taken shape.

4| THE FIELDWORK

Turin was initially chosen for its convenience; I moved there for my Phd at DIST (Politecnico and UniTo) and, as a regular citizen with a psychiatric diagnosis, since the first year, I started to navigate, and deal with, the public, private and voluntary sector specifically dedicated to psychiatric issues (see autoethnographic vignettes in Chapter 3). Since the beginning of this speculative investigation, sometimes carried out as an "undercover" researcher and as a volunteer at the archive of a local association (Associazione per la Lotta Contro le Malattie Mentali, ALMM), I realised the case of Turin could tell an interesting story, renowned so far only locally and in specialized circles (Adorni & Tabor, 2024). With this, I do not want to imply that the process of deinstitutionalization and the application of the psychiatric reform in Turin must be considered exemplary or necessarily representative. Its story differs from the one traditionally told on the Italian reform and, as we will see in the third chapter, presents elements that are place-specific but that can still be of some teaching now - here, and elsewhere (Mossa, 2023). Turin, at the same time, is today, for better or for worse, also a reflection of the national reality. I was also aware of how time-consuming and risky this research could be, therefore, I wanted to be close to the field and to my support network over the course of all my Phd.

Methodologically, the research project involved preliminary archival research and an in-depth ethnographic fieldwork that included long-term participant observation, interviews and an autoethnographic account. Drawing on my personal experience as service user and my various "encounters with madness" (Macdonald, 2020), I have been mapping and moving through a constellation of micro-geographies of care and mad identity production. This in the attempt to find where and how mad subjectivities are produced, potentially contested and, in the best scenario, positively embraced (Beresford & Russo, 2022; LeFrançois et al., 2013; Parr & Philo, 2003; Philo & Parr, 2019). This initial and speculative journey, helped me identify the boundaries of the field: through the analysis of archival materials of a grassroot association active in the city since '67 - Associazione per le lotta contro le malattie mentali (ALMM) - I looked at the key events that led to the closure of the asylums and to the birth of community-based services in Turin, getting a more place-specific understanding of the process of deinstitutionalisation occurred there. To explore the micro-geography of some services, the main ethnographic analysis has been carried out, via participant observation and interviews, in a series of group homes run by a cooperative operating in the city - called Zenith. Zenith was not the only cooperative I contacted and, as we will see in Chapter 3, was chosen mainly for the openness its staff showed towards my research and the absence of a direct connection with ALMM, with whom I was already collaborating. Over the course of the study the prominence given to my personal experience has only apparently faded. The autoethnographic element of my research can be considered cross-sectional: it guided the research questions, the choice of the case, the very possibility of being able to access certain services, to talk freely to both users and health staff. Ultimately, sharing my story to participants, although not particularly significant or representative, helped establish a more equal and trustful relationship with them. As argued in the methodological chapter (Chapter 3), all this goes way beyond the practice of expressing your own positionality or engaging in a critical self-reflection on one's assumptions, and makes this research closer to the relatively recent body of literature identified as *“analytical autoethnography”* (Anderson, 2006). The empirical material is the result of different methods that, practically, involved my presence, and therefore my body, notetaking, drawing, a mobile phone used as a tape-recorder and a photo-camera - all used less than I thought I would for ethical reasons. Ethical concerns that have inevitably shaped the research design, how I have approached the field, what I decided to disclose or not.

The thesis has been written following a classical structure: this introduction is followed by a literature review, a methodological chapter and three empirical ones, later discussed in the last conclusive sections – discussions and conclusions. The overview of the following chapters of the thesis will help to get an overall picture of my work by linking theoretical and methodological choices to some initial considerations on the fieldwork.

5|CHAPTER OVERVIEW

In the second chapter – 2| PLACING MADNESS - I briefly trace the developments made by mental health geography in terms of both theory and methodology. This review serves to investigate the nexus between place and mental health having a look at the literature that since the 90s had explored mental health care from a geographical perspective and advocated for a “spatial turn” in mental health studies. This in the attempt of identifying the potentially detrimental or beneficial role played by different socio-spatial dynamics. Here, I also analyse and compare the contributions made by Goffman and Foucault in that respect, while trying to update their theoretical insights to current circumstances. I then present the broader historical context that, from the radical movements of the 60s, led to the process of deinstitutionalization in Italy. This is followed by a brief comparative analysis of the Italian experience with that of Britain and France. This is done through the study of the theoretical and practical contributions of Franco Basaglia in Italy, Ronald D. Laing in the UK and Guattari in France. Current debates on the application of psychiatric reforms and the societal response to madness are also discussed. Afterward, I highlight the theoretical and methodological gaps concerning new geographies of mental health care provision that my research aimed to address through relevant literature and the ethnographic study. After an update on the current debates on the application of the reform to date and a brief introduction to "Mad Studies”, I highlight the theoretical and methodological gaps concerning new geographies of mental health care provision and how being at the intersection of this literature can help shape the problem differently.

In the third chapter – 3| RESEARCHING MAD GEOGRAPHIES - building on what already written in the introduction, I discuss the epistemological and methodological approach that has guided my ethnographic research. I list all the methods used and the rationale behind the choice, or exclusion, of each of them. Limits and potentialities of every method are analysed through my experience in the field and the reading of relevant literature - mainly from anthropology, sociology and geography. I then describe the fieldwork and the process that led me to identify its boundaries (the archive, group homes, the cooperative, the interviewees). For what concerns the autoethnographic account of the field, I describe how I accessed the field, both as a user and a researcher and the advantages that brought out. Finally, in terms of ethical challenges, I discuss my partial and positioned point of view and the potentially complementary perspective of other approaches. I advocate for an increasing depowering of researchers in favour of a more horizontal relationship in which first-hand experience acquires values. I also analyse my mistakes, what went wrong and what could have been done differently.

This fourth chapter – 4| PLACING THE REFORM - is the first empirical one; it addresses mental health geographers’ call for a place-specific knowledge about mental health care and aims to provide an examination of the evolution and diversification of geographies of mental care in Turin. Here I look at different spatialisations of mental health management across time, considering the shifting social attitude towards mental health occurred since the radical psychiatric movements of the 60/70s and the consequent dismantlement of the asylum. While placing the experience of Turin within a wider movement traditionally linked to the work of Basaglia, I want to highlight the specificity of the Turin case. This through the analysis of archival material of a historical association, the study of local policies and site-visits. All this help access the transition occurred since the psychiatric reform and assess the current situation, at the local level. The role of the third, private and volunteer sector is also taken in consideration. Through site-visits, participant observations and some interviews I go beyond mapping the spatial shift that, in relation to political, economic and social drivers has produced the current set of settings and practices, to include new power-dynamics and the intimate, everyday nature of some of these services. This with the aim to build up a micro-geography of mental health care that puts the human and the everyday life at the centre of its inquiry.

For a study of this sort, the choice of a series of spatially bounded locations becomes though both essential and illustrative. In the fourth chapter – 5| RULING THE MAD HOUSE - I narrow down the analysis and focus on a particular typology of residential service, named group homes. The study was conducted in 8 group homes run by the cooperative Zenith in north-west of Turin where I worked as a volunteer from January to September 2023. Group homes are a socio-health facility that combines care and recovery with the provision of supported housing, as a transitory step for a gradual rehabilitation, resocialization and autonomy of psychiatric patients. By using participant observation and repeat interviews I assessed how this semi-independent living program functions in terms of its ability to support individuals' recovery and social inclusion and how users and workers understand and experience daily life within this kind of accommodation. In this chapter I describe the single flats and the wider system that contains and make them function. I then provide a picture of the everyday functioning of the flat, mainly from the perspective of workers. I look at the geographical distribution of the flats, at their spatial and relational elements and to what extent those affect patient's lives and workers' shifts. I had the opportunity to follow two teams with slightly different approaches; in this section I try and list pro and cons of both, according to what I could see and listen to. I focus on the set of rules - external and internal, formal and informal that are usually enforced, followed (or broken) by staff and tenants. This chapter is mainly built on workers' perspective and on the insidious process of infantilisation that some of the rules, decisions and behaviours inevitably cause. Beyond describing individuals' attitude towards the compliance and enforcement of some of these rules, I also highlight the degree of discretion that characterises the management of both the flat and the mental health system in general.

The last empirical chapter – 6| EMBODYING THE MAD HOUSE - is based on narratives and relations, considering both as co-constructed and never detached from discussions on power over the self and phenomena of identity production. Through my observations I had a look at how space mediates and shapes patients' behaviours, how this informs people's relation to others and how this relation has the potential to deny or vice versa enable self-determination, empowerment and inclusion. This in the attempt to clarify the extent to which material and immaterial boundaries contribute to mental distress and to changing forms of identity, (self-)discipline, sense of belonging. This to understand whether processes of harassment and exclusion take place in contemporary mental care practices outside institutions and to what extent they are recognised and countered, when they are instead internalised. In other words, how power materialises from below, which mechanisms are put in place on a daily basis and to what extent individuals consciously engage in their own oppression. Through the lens of governmentality, I explored the construction of mad subjectivities by questioning which are the embodied, relational, discursive elements that play a role in creating self-disciplined subjects and, vice versa, which ones might enable forms of resistance and self-determination. In this context, governmentality takes the shape of a constant effort of looking normal, in an exhausting performance that risks making you lose the sense of safety and belonging that a home should provide with. Based mainly on the point of view of patients, this chapter aims to show how seemingly harmless habits and practices can prove insidious in the long term and how the banality of everyday life, made up of boredom, imposed habits, small transgressions, risks leading both patients and workers to lose sight of one's purpose.

6| CONCLUSION

As part of its main investigation, this study on post-asylum geographies of mental health care tried to go beyond mapping the shift that, in relation to political, economic and social drivers has led to the current set of settings and practices, to include the intimate and everyday response of individuals. This with the aim to build up a micro-geography of mental health care that, by putting the human and its everyday life at the centre of its inquiry, makes individuals' *"embodied and contested subjectivities to emerge more clearly"* (Parr, 2000, p. 226). Through a life-history and a narrative approach enriched by an autoethnographic accounts (Moss in Butler & Parr, 1999; Fixsen, 2023) I have investigated individual everyday struggles, care trajectories and long-term expectations; this always in relation to wider power dynamics and intersectional forms of discrimination in which those lives are embedded (Atkinson, 2009). Any discussion about mental care cannot be detached from the socio-economic and political context based on extreme individualism and privatization that has characterised the process of de-institutionalization in most western countries (Power & Hall, 2018). According to Mills (Mills, 2014, 2018b), mental health support, in depicting mental illness as an economic burden, produces *"individualized and psychologized responses to poverty and distress"* (Mills, 2014, p. 844) that obscures the impact of austerity, precarity and extreme competition (Peck, 2012; Tonkiss, 2013). This narrative overlooks the effects of the current economic restructuring that, ranging from the scaling back of welfare states, to the encouragement of more entrepreneurial and private responses to public needs has pushed towards a privatization and jeopardization of a variety of aspects of urban life; across different countries and income groups (Tonkiss, 2013; Schram, 2015). The resulting wealth inequality, increasingly linked to precarious and unregulated housing and working conditions, has negatively impacted individuals' mental health and produced a permanent state of existential precarity for many (Butler, 2004). The on-going welfare cuts, (Fisher, 2009; Brenner et al., 2010; Peck, 2012; Schram, 2015) has contributed to a gradual fragmentation and decentralization of care services, handed over to the voluntary and private sector (Wolch, 1990; Milligan, 2003; Brenman, 2021). This has further atomised landscapes of care with obvious consequences in terms of accessibility and affordability. Through a study of the everyday struggle for stability of people that live in a precarious psychological state, I claim madness may become one of the possible lenses through which we can look at radical practices for inhabiting precarity and unequal social power relationships. Instead of questioning what drives some people mad, by rejecting an ableist and sanist approach, I wanted to adopt madness as an epistemological tool, and I tried to turn sanity, stability, normality into an object of inquiry. The question will then become: "what makes someone sane, despite all? Madness could then become a political and radical project that, through an intersectional lens and in alliance with other anti-oppressive movements (i.e.: disability, queer, black, feminist, decolonial studies) may resist to the pressure to conform and contribute to envision alternatives to current forms of dispossession.

CHAPTER 2

PLACING MADNESS

1|INTRODUCTION

Over the last two decades, geographic disciplines have seen a growing interest on the role different spatial arrangements play in the everyday lives of people with mental disabilities. This new stream of research constitutes a welcome "spatial turn" in critical mental health studies that, whether concerned with space, have mainly focused on total institutions (Goffman, 1961; Foucault, 1977a; Philo, 1997, 2004; Cohen, 2018). My research sits instead within the literature that looks at the process of deinstitutionalization of the mental health system, through the lived geographies placed outside the "asylum" (Butler & Parr, 1999; Parr, 2000; Conradson, 2003b; Parr & Philo, 2003; Chouinard, 2012). It will seek to respond to the call for a new urban geographical theory that advocates for considering mental care as part of the *"right to the city"* and to full citizenship (Basaglia, 1968; Harvey, 2008; Rovatti, 2013; Basaglia, 2017; Gabauer et al., 2021). By addressing how space is intertwined with process of care, or absence of it, this study will address more general issues of urban marginality, collective agency and the role of the State as a mediator and enabler (Power & Williams, 2020).

As highlighted in the introduction, I have located my analysis of deinstitutionalization within the wider historical, economic and cultural environment that anticipated and shaped the implementation of the Italian psychiatric reform of the 70s. In doing so, particular attention was paid to what happened at the local level, in the city of Turin (see Chap. 4). To link though the Italian experience to a broader and more diversified debate, I have briefly compared the Italian case with movements that took place in the UK and France. I am aware that a comparative analysis of this kind would require a more comprehensive examination than has been undertaken here, but this is way beyond the scope of this study. However, given the initial similarities and subsequent divergences, both in terms of ideas and practices, a brief comparison between Italy, UK and France has served to highlight the distinctive nature of the Italian reform, which, despite its shortcomings, has to be regarded as the most radical and influential in the world (Basaglia et al., 1987). In examining the relationship between Italy and the UK, particular attention will be paid to the work of Franco Basaglia and Ronald D. Laing as the two leading figures of the European radical psychiatric movement who, in the wake of Maxwell Jones' pioneering "therapeutic communities"[3], questioned the oppressive nature of psychiatric institutions and enabled the process of deinstitutionalisation, there and in many other Western countries (Burns & Foot, 2020; Crooks et al., 2018).

Contextually, in order to understand the influence of France, it was essential to briefly mention the experience of "*institutional psychotherapy" in* Saint-Alban (Southern France), where some of the most influential mental health theorists, such as the Catalan Francesc Tosquelles, the Algerian Frantz Fanon, the aforementioned Georges Canguilhem and Felix Guattari passed through. This, in conjunction with the experience of the clinic in La Borde (Loir-et-Cher, south-west of Paris), where Jean Oury and Guattari, previously at Saint-Alban, sought to enhance even more the emancipatory potential of the institution, working at the nexus of psychoanalysis, philosophy, art and politics (Robcis, 2021). Furthermore, in examining the Turin case, it was essential to consider the French model adopted in the 60s, which structured the organisation of the mental health system by sector. Called "*sectorialisation*", it was implemented all over France and subsequently tested by the psychiatrist Edoardo Balduzzi[4] in some Italian cities, including Turin, Varese, and Venice (Lasagno, 2012; Ranza & Manghi, 2017). The attempt to adopt "sectoral psychiatry", as it was called, despite its incomplete and leopard-spotted

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[3] Maxwell Jones, South African by birth but Scottish by adoption, was a social psychiatrist credited with introducing the concept (and practice) of the "therapeutic community". During his lifetime he worked between the USA and the UK, mainly with prisons and military veterans, and tested a community-based mental health system. During the Second World War he served at Mill Hill Emergency Hospital in London, a special unit set up in response to the conflict. In this capacity, he studied the cause of heart disease in military personnel and tested different therapeutic methods to facilitate their return to duty. In 1942, Jones introduced group therapy and methods borrowed from theatre. After the cessation of hostilities, he took charge of a team of sixty to treat mentally ill prisoners of war. It was in this role that he developed the concept of the 'therapeutic community', which later gained international recognition. After his retirement, he started a project for inmates of a local prison who had been diagnosed with schizophrenia (For more, read Briggs (2002).

[4] A contemporary of Basaglia, but trained in France, Edoardo Balduzzi, shared the idea of overcoming the asylum institution but envisaged a more gradual and systemic process. To do so, he had attempted to apply the so-called sector psychiatry, a model that, starting from the condemnation of the asylum, promoted the return of the patient to the territory, involving the families and creating multi-professional teams capable of carrying out continuous and multiple therapies, outside and inside the asylum, according to geographical areas, the sectors precisely. This model was criticised because it did not sufficiently challenge the asylum but strengthened it. It is no coincidence that psychiatric institutions still exist in France.

implementation, its poor capacity to stand in open opposition to the asylum and its eventual replacement by the network of community-based services established by Law 180 in 1978, represented the first practical attempt to propose a restructuring of the mental health system, with a focus on the territory, on multidisciplinary team and communities.

In the following section, I will trace the developments made by mental health geography since the 90s, in terms of both theory and methodology. I will then introduce the main critical approaches to psychiatry and psychiatric institutions that informed the radical movements of the 60s and led to the process of deinstitutionalisation in Italy. I will also analyse the state of current debates on madness and mental health care provision, focusing on a recent strand of research that has emerged from activism, within the mad community. Finally, I will present the conceptual and analytical framework and subsequently demonstrate how these are reflected in the methodological approach, which encompasses archival research and an ethnographic study in some post-asylum geographies in Turin. Particular attention will be paid to the discourses and practices of all subjectivities encountered.

2.1|SPATIALISING MADNESS

The nexus between place and mental health, in other words the attempt of identifying the potentially detrimental or beneficial role played by different socio-spatial dynamics, seems straightforward. Despite the so-called “spatial turn” advocated by many disciplines concerned with mental health and the rich contributions made by scholars such as Philo and Parr, mental health geography still seems to constitute a *niche*, with little implications for practice and policy making. The main contribution appears to be limited to spatial modelling and quantitative research, through which lived experiences are neglected (Crooks et al., 2018). Geographic understandings of mental health through site-specific and ethnographic accounts, have though seen a rise in the 90s, even if the work of the medical geographer John Giggs (1973), still represents an essential reference. Giggs looked at the distribution of people with schizophrenia in the city of Nottingham and arrived to build up a parallel between poor mental health issues and marginalised inner-city neighbourhoods. His research questioned if marginalised communities had higher chances of being affected by mental illness and to what extent poor mental health could lead to be marginalised in cities (Lewis et al., 1992). Nowadays, a lot of studies conducted at the neighbourhood level, both in rural and urban settings, building up on Giggs's "*drift and breed*" hypothesis, have challenged a deterministic approach, abandoned a mere spatial-data analysis rooted in positivism, and highlighted the multi-faced role of place and space (Conradson, 2003b; Philo, 1997, 2005; Chouinard, 2012; Parr, 2008; Crooks et al., 2018a). Madness and geographies of mental care, or absence of it, started to be considered a product of power and discursive relations produced by a medical gaze, embedded in classism, misogyny, racism and ableism (Wolch & Philo, 2000). In this shift, questions of social inequality, diversity and power, have played a major role in putting people at the centre of health geography: everyday experiences of mental illness, seen as objects and sites of place-based processes of discrimination and exclusion, or vice versa potential resistance, have ultimately become the focus of much mental health scholarship. As much as putting people at the centre, a relational and not topographical approach has made space instrumental for an understanding of power and their structures, and human geography the ideal lens for a study of this sort (Pile & Thrift, 1995).

All this considered, the debate on the relationship between madness, social class and its territorializations has often been treated as a "*chicken or egg"* dilemma (White, 2017): the fact that at the bottom of the income scale individuals are more likely to be diagnosed with mental illness, has always been explained either as the result, or the cause of poverty, in a vicious casual circle that the gradual withdrawal of the State and neoliberal discourses have made structural. In many western countries, in the wake of the asylum undergoing closure, alongside proved phenomena of re-institutionalization and homelessness (Dear & Wolch, 2016; J. Wolch & Philo, 2000; Parr, 2008; Scull, 2015) a plethora of practices emerged, each one characterised by a different set of discursive, embodied and affective dimensions (Brenman, 2021; Parr & Philo, 2003). According to many, all this complex range of services constitute an archipelago of dispersed micro-institutional geographies, the walls of which operate through a complex skein of bureaucratic management, family ties, volunteering, philanthropy, exclusive private treatments (Kruger, 1997; Lancione, 2013; Milligan, 2000; Parr, 2008; Sargent, 2012).

By overcoming narratives that see the institution as inherently carceral and the family/community as fully therapeutic (Lancione, 2013; Skott-Myhre, 2020), a growing body of literature has been questioning to what extent post-asylum geographies of mental health care contribute to a transition from a vertical and hierarchical form of control to a model that, despite being perceived as more capillary and horizontal, may act at the individual and collective level as an internalised and embodied panopticon; de facto scattering the “total” trait of the institution into the community and the family (Kruger, 1997; Dale, 2005; Adlam et al., 2013). The asylum was, and other institutions still are, a surrogate solution to social problems (Davis, 2000) and represent the failure of the State to deal with issues of poverty, drug addiction, mental illness. Or rather than viewing it merely as a failure, it can also be understood as a coherent policy of neutralization, in which the powerless are managed, contained, or made invisible by those in power. They constitute the embodiment of a perceived, often unfounded, threat and an attitude that has privileged custody to care, punishment to rehabilitation, crisis management to prevention[5]. This with the intent to make society feel safer. The asylum though, represented the spatialization of an attitude toward madness and psychiatric care that has not always been the same (Philo, 2004; Suzuki, 2006; Scull, 1989, 2015). On one hand, an over-emphasis on spatial isolation and exclusion risks to neglect inclusionary and interstitial practices that took place on the margins inside and outside institutions; on the other hand, seeing the end of the “great confinement” of the “insane” as resolutive, dismisses more subtle and hidden forms of control and marginalization that still take place (Wolpert & Wolpert, 1976; Dear, 1977). In relation to that, some scholars claim that community-based facilities are rooted on the deceptive idea that communities are willing, or able, to care (Foster et al., 1999) and deny that some patients might both benefit and welcome the idea of being treated far from the environment where their mental illness manifested (Donzelot, 1980; Adlam et al., 2013; Högström, 2018; Skott-Myhre, 2020).

Contextually, under the radar of public attention, forms of trans and re-institutionalization have occurred (Scull, 2015; Wolch & Philo, 2000) and practices of constraint and custody pre-empt and prevail over care in many of the institutions we have been left with. In Italy, where the traditional asylum formally disappeared, pseudo-asylum practices still take place, from forensic wards to acute psychiatric hospital wards, from nursing homes to addiction recovery communities (Scull, 2015). In addition to that, very little is known about the practices

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[5] By prevention, I do not refer to risk-based approaches that aim to predict and manage potential threats - approaches often rooted in control-oriented logics. Rather, I use the term to point toward structural and social forms of prevention: addressing the underlying conditions (poverty, housing insecurity, systemic racism, trauma) that contribute to mental distress. This understanding of prevention aligns more with social justice and care ethics than with surveillance or behavioural forecasting.

adopted by private and third-sector providers; providers that, together with the pharmaceutical industry, by turning mental care into a product and patients into consumers, hold an explicit interest in promoting service dependence (Caselli & Rucco, 2018). On top of that, studies of homelessness have shown how mental illness is both a cause and an effect of street life (Desjarlais, 1997; Hopper, 2002). The street is thus, once again, one of the main geographies of madness, characterised by the total absence of mental health care, which is seen as a luxury for those without easy access to food and a shelter. The street is often though the only option for the poor, who, if they are not mad, will soon develop mental health problems. Meanwhile, in the absence of alternatives, the prison, the territorialisation of a historical and generalised association of madness with criminality and dangerousness, represents a de facto substitute for the asylum; with an approach that seems more in line with repressive than curative principles of prevention (Scull, 2015; Ben-Moshe, 2020). While people with psychiatric issues are at higher risk of experiencing homelessness and imprisonment, being homeless or institutionalized has, in turn, an inevitable impact on mental health that, whether acknowledged, does not seem to constitute a priority. Moreover, issues of housing and employment, the access to which could be unfairly allocated, on the basis of mere social and health aspects, should be seen as the key determinants of mental distress; through a combined study of their functioning, different forms of discrimination, or privileges based on a multiplicity of socio-economic and health-related factors, can be explored (Dahlgren & Whitehead, 1991).

Given the above, geographic approaches appear to be well suited for assessing the complex and everchanging relationship between mental health and place and the implications at the level of the individual (Curtis, 2016). The attempt of identifying the intertwined relationship between place and mental health, has often led though to the adoption of a deterministic lens that, in its reductionism, flattens the singularity of places and individual experiences. In *“The metropolis and Mental life”* Georg Simmel (1903) makes some claim about the negative effects of urban life on the minds of city dwellers, claims that, together with the assumptions on the benefits of rural life, still stay with us. Within the field of mental health geography though, rich contributions made by scholars such as Philo, Parr, Söderström, Duff started to challenge this narrative and, by adopting a qualitative approach, put a stress on the heterogenous, relational, embodied and rarely predictable people’s response (Crooks et al., 2018). This increased interest on individuals’ lived experiences, combined with a socio-material and relational understanding of place, has pushed geographic research towards a situated knowledge production, centred on embodied and affective dimensions, this research is keen to explore further (Csordas, 1993; Parr, 2000; Parr & Philo, 2003; Crossley, 2007; Duff, 2012; Crooks et al., 2018; Brenman, 2021).

Over the past two decades, mental health geography has opened up to a set of reflections and practices grounded in narrative, embodied experience, and forms of inquiry that move from within. Among the most resonant contributions in this space is the work of Jacqueline Liggins (2019), whose thesis and related publications offer a committed and stylistically rich example of autoethnographic writing within psychiatric geographies. Hester Parr's longstanding use of oral histories and deeply situated narrative methods has also contributed to a reimagining of how spatial, affective, and embodied dimensions of distress are explored, both in institutional and community-based contexts (Parr, 2008). The doctoral research of Jennifer Laws (2011) and Ed Kiely (2020) further expands this terrain, attending to everyday practices of resistance, relationality, and marginalisation within spaces shaped by policies of care in the community. This thesis is in dialogue with such work, particularly in its attempt to centre a lived, reflexive, and relational reading of post-asylum geographies. At the same time, it draws on an emerging sensitivity to Mad Studies and to the epistemological disruptions introduced by service users and survivor-researchers. Mental health geography, as a field, tends to oscillate between two broad strands: one more aligned with spatial-environmental epidemiology and the mapping of mental distress; the other focused on the spaces, frictions, and intimacies of care - whether institutional or dispersed. This project locates itself within the latter yet seeks to extend its scope by drawing explicitly on autoethnographic method, to unsettle normative binaries - between researcher and researched, cared-for and caregiver, clinical object and speaking subject.

3| PSYCHIATRY UNDER SCRUTINY

3.1|LABELLING SCHOLARS

As a reaction to structural functionalists' identification of mental illness with social deviance (Durkheim, 1952; Parsons, 1951), the work conducted in the 60s by the so-called "*labelling theorists"* (Goffman, 1959, 1961, 1963; Becker, 1963; Scheff, 1966), must be considered the theoretical foundation on the basis of which a critical understanding and practicing of psychiatry was subsequently built. More than in the label, they were interested in the rationale behind the process of labelling and its implications on individuals. Labelling scholars are considered the first to openly challenge the idea of psychiatry as an inherently objective, neutral and benign science. Together with Michael Foucault's work (Foucault, 2003; Foucault et al., 2003; Foucault, 2006a; Foucault & Lagrange, 2006b), their studies shed light on issues of power and inequality embedded in psychiatric practices; they asked to what extent a subjective process of labelling could legitimate medical treatments and whether the designation of someone as mentally ill, and its consequent stigmatisation, was nothing more than a moral judgment towards deviant and marginal groups (i.e.: the poor, working class, unpaired, homosexuals, single mothers, etc.).

Beyond highlighting the inherently aleatory nature of psychiatric diagnosis and looking at the social processes behind the definition of "deviant", labelling theorists where the first to focus on behaviours and interactions induced by the application of a label on individuals and groups (Sjöström, 2017). While the first contributions of these scholars mainly focused on "crime" and "drug addiction" (Tannenbaum, 1963; Lemert, 1951), a study on mental illness finds in Becker (1963), Scheff (1966) and Goffman (Goffman, 1961, 1963) its mayor references. Becker saw deviance as the result of breaking formal and informal rules and through his work he focused on societal reactions linked to the recognition of some behaviours as deviant. Since not every infraction is labelled as such, and norms are broken all the time, according to him, what differs, and counts, is people's response to a violation. He also claimed researchers were much more interested in ruler breakers, while scarce, when null, relevance was given to the rationale behind the birth and the enforcement of a norm (Becker, 1963). According to him, the mediation between ruler creators and enforcers - the *moral entrepreneurs* - creates unbalanced dynamics of control, with a potential feed-back loop, able to reinforce some patterns and create "deviant careers" and "deviant identities" (Sjöström, 2017).

Drawing on Becker (1963)'s work, Sheff (1966) identified the uniqueness of mental illness in the breach of more subtle and unspoken rules. In his book *"Being Mentally ill"* (1966), he defines those rules as "residual" and claims they may tacitly direct everyday interactions, in a rather insidious way. As much as Becker, he believes that being labelled as insane could lead to a form of attachment that reinforces normalization and impede self-determination; the labelled person may embrace the identity assigned by others - in some cases even taking some advantages from it such as getting State benefits, penalty reductions or, more simply, compassion by others. In addition to that, a strong critique on the legitimacy of medical diagnosis, its treatments and dynamics of exclusion and segregation makes Scheff's research an essential contribution for the radical psychiatric movements of the late 60s (Crossley, 1998; Foot, 2015; Scull, 2015).

There is no doubt though, that the most influential labelling scholar in the field of mental health and its institutionalisation was, and still is, the Canadian sociologist Erving Goffman. In "*The presentation of the self in everyday life*" Goffman (1958) built up a theory on the performative nature of everyday interactions, while in "*Stigma"* (1963) he applied this theory in regard of existing stereotypes. Through ethnographic observations, he looks at the way in which people deal with some sort of stigma, and the coping mechanisms that are consequently put in place. His does not consider stigma as something that necessarily concerns the impaired, the poor, the disfigured or the elderly. In fact, he lists three typologies of stigmas: the ones fruit of deficit of character (ex: drug-addicted), bodily impairments, and group identity (being Jewish, being black, etc). He then makes a distinction between the "*discredited*" and the "*descredible*", highlighting that the impression other people have of the latter is substantially different, therefore their reaction. The *discredited* needs to cope with preconceptions others are likely to have of them, whereas the "*descredible*", that could be easily pass "as normal", lives with the constant fear of being un-masked, in an exhausting state of alarm, that acts as an internalised form of control, as it is often the case of the mentally ill. To sum up, more than in the process that leads to the construction of a particular stigma, Goffman (1958, 1961, 1963) was interested in the consequences in terms of management that stigmatised individuals and groups put in place to deal with negative preconceptions. In other words, his focus was on the everyday effort that everyone makes to manage their own identity in front of a particular audience, supposedly, in the attempt to perform as normal as possible and fit the standard behaviour. According to Goffman, the typologies of stigmas, different environment, and character traits, give birth to a set of interactions that may go from compensation and concealment to acknowledgement and embracement. Goffman, together with Foucault, was also interested in the pathologisation of some deviances from the norm and in the tools implemented to suppress them. Among the most obvious, the asylum, one of the spatial manifestations of control belonging to what he named "total institutions".

In the meantime, and independently of Goffman, Michel Foucault wrote his doctoral thesis *"Maladie mentale et personnalité"* (1954)[6], published few years later with the new title "*Histoire de la folie à l'âge classique – Folie et déraison"* (1961)[7]. Strongly influenced by George Canguilhem's conceptualisation of normality, Foucault questions here the meaning of madness and the ways in which its representation has changed. He argues that the representations with which we now interpret madness and think of the insane are the result of historically determined, and therefore mutable, categories. Foucault does not deny the existence of madness, but he does not see it as a natural and immutable phenomenon. He argues that the way madness is perceived, experienced, treated in a given society depends on the categorical apparatus and the cultural and economic structures that determine it (Revel, 2024). He locates various representations of madness across time and space, making them travel; not as a fixed entity but as a mutable product, measurable only by comparison with normality. Normality understood as the pursuit of both the average and the ideal, where the average becomes ideal and abnormality its statistically constructed exception. If, as Canguilhem claimed (Canguilhem, 1978), the abnormal, is understood as a deviation from the norm, it cannot exist apart from the comparison with its opposite. This suggests that reason and unreason are complementary and mutually reinforcing, providing a rationale for their (co)existence. Consequently, when people define themselves as normal, they also simultaneously define those who are to be considered abnormal in relation to them (Canguilhem, 1978). Building on this, Foucault framed madness as the product of a process of objectification, exemplified by psychiatric diagnosis. In Foucault's view, madness, as it has been framed since the 1600s, although excluded from reason, is nevertheless part of it and only in its apparent opposition.

3.2| TOTAL AND DISCIPLINARY INSTITUTIONS

Despite their epistemological, theoretical, and methodological differences, Erving Goffman and Michael Foucault constitute the main references for whatever study focused on spatializations of control, power over the self and, their role in the process of medicalization of *the normal and the pathological* (Canguilhem, 1978). Their work must be considered interlinked and complementary. They both had a look at the socially constructed nature of madness and at the visible and invisible institutions put in place for controlling it. While Foucault

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[6] English translation: *"Madness & psychology".*

[7] English translation: *"Madness and Civilization: A History of Insanity in the Age of Reason".*

concentrates on the history of madness, as it was progressively represented, confined, medicalised, and/or criminalised (Foucault, 1977a, 2003, 2006; Foucault & Lagrange, 2006), Goffman was more interested in the micro-interactions between actors and how the stigmatization of the mentally ill, and their individual response, took place (Goffman, 1958; 1961, 1963). Goffman (1961), through a mix of ethnographic methodologies, that involved also participant observation in a psychiatric ward, looked at the co-constructed behaviour(s) that a series of actors, consciously or unconsciously, perform in a given space; he was interested in the dramaturgical aspects of everyday lives and how individuals, whether aware of the presence of others, acted accordingly. He identified a front versus a backstage, but he was also interested on whatever happened between the two (Goffman, 1958; 1961).

As said above, Goffman is credited for the concept of "*total institution*", term he used for the first time in the essay: "*On the Characteristics of Total Institutions*" and that he developed further in "*Asylums*" (1961). He defines "total institutions" as the spatial and social arrangements where *"all aspects of life are conducted in the same place and under the same single authority"* (Goffman, 1961: 6) *(*i.e.: asylums, boarding schools, prisons, hospitals, convents, cruise ships, etc.). In his ethnographic studies, he highlighted how routine, and absence of privacy, shaped people's attitudes and affected process of group identification. Despite that, he recognised the role played by some interstitial spaces - such as corridors, canteens, etc, - where sub-groups, thinking of not being watched, behaves differently and, some forms of resistance may take place (Goffman, 1958; 1961). Goffman's theorization was instrumental for Foucault's conceptualization of "disciplinary institutions" and the micro-physics of power that, from the institution, spread into society. In *"Discipline and Punish"* (1977a), Foucault uses Bentham's architectural typology of the panopticon as a metaphor for describing a novel form of control that, acting both on "bodies and minds", has become a powerful and pervasive dispositive based on discipline and self-surveillance. Using Bentham's "ideal prison" as a metaphor, he set up the foundations for his well-known, and extensively discussed, theories of "governmentality" and "bio-power"; through which the creation of neoliberal subjectivities has been looked at up until now (Burchell et al., 1991; Barnett et al., 2008).

According to Foucault, the metaphor of the panopticon, later evolved into the concept of governmentality, seen as a socio-material practice, exemplifies the gradual transition from a repressive sovereign power, towards a more insidious and capillary form of control, based on discipline; a new art of government able to shape behaviours and individuals' conducts with a limited use of physical violence and a benign face. It represented the shift towards a new methodological device that, from exercising sovereignty over a territory, aimed to govern populations; through discourses and a multiplicity of seemingly benevolent institutions, above all psychiatry played a major role (Foucault, 1977a, 1977b; Foucault & Lagrange, 2006). The unscientific nature of psychiatry, both in terms of diagnosis and treatments, and the entanglement between psychiatry and the criminal justice system, was at the core of Foucault's first work, since his Phd research. He saw madness as the arbitrary product of various economic and cultural structures, and the asylum as one of the main epicentres of control. According to Foucault, it was in the Classical Age ('600) that the distinction between *the normal and the pathological* (Canguilhem, 1978) was institutionalised and "the mad" definitively confined in medical hospitals. In *Madness and Civilization,* Foucault (2006), provides an unconventional history of madness in western society - mainly using French examples; his approach is likely to disorient a reader looking for a strictly chronological account of how madness was identified and treated over time. Building up on the work of Nietzsche, Foucault adopts a particular historical technique, called "*genealogy"* that will characterise much of his subsequent work (later developed in what is known as "*archaeology of knowledge*" - a kind of "counter-history" that examines phenomena historically but with the intent to assess and question the value we hold today. In so doing, he challenges what is thought as given, stable and unchangeable, in a particular time and space. In this book, starting from the Middle age to the Renaissance, up to the Classical era, period that saw the rise of the "great confinement" of the insane, Foucault concentrates on how madness was experienced, narrated, and treated over time. Foucault describes medieval times as an era where madness, in the person of the "villain fool", was relatively free and even seen as able to provide a privileged understanding of the world. In the Renaissance, madness was associated with passion and as brought on stage by Shakespeare's plays (see Hamlet), also capable of "speaking truth to power" (Taylor, 2012). In the 19th century though, as result of industrialization, western cities started to grow and attract workers from the countryside. In the meantime, the poor, the insane, the impaired, the single woman, in other words the people that were considered unproductive became more visible and started to be perceived either as dangerous or useless (Mumford, 1968). Since streets and workhouses were packed with poor people, the spread of diseases and the increase of criminality, made recall the time of the leper, and the *leprosarium*, built at the outskirts of cities as a space of confinement and now abandoned, was identified as the ideal solution for these issues too. Ultimately, the asylum was born as a specialised institution for those whom the emerging capitalist society deemed useless, and madness finally locked up and silenced (Foucault, 2006; Philo, 2004; Scull, 2015).

As some scholars point out, Foucault almost romanticizes the past, picturing a mythical pre-institutional "golden age" but he omits medieval practices such as witches-hunt or the so-called "Holy Inquisition" (Scull, 2015). Moreover, as Carlo Ginzburg (2012) claims referring to "*Discipline and Punish"* (1977a), Foucault seems to be more interested in prisons, than in prisoners, and the same can be said on his work on madness: he claims that through *the great confinement* madness was definitively silenced, but he never allows the mad to speak out; as Derrida writes in *"Cogito and the history of Madness"* (2020), he aims to trace the history of madness, but he does that "from the side of reason", reinforcing the very structure he was challenging. In addition to that, despite not being explicit, he lets the reader believe that, since the rise of the great confinement, lunatic asylums were the only space of care and control, whereas, as Suzuki (2006)'s study shows, "the family" and the household maintained their historical role. Historians have to some extent neglected the extramural, family, community-based care, mainly due to the absence of private archives and medical records (Scull, 2015). The accounts built on asylum archives tend to omit that many patients were institutionalized for short periods and that before, after, or in-between their interment it was either the family or the community to take care of them[8].

However, Foucault himself, in the lectures given at the College of Frances from 1973 to 1975 (Abnormal and psychiatric power), shifts his interest towards the institution of the family by delineating the difference between sovereign versus disciplinary power. In this effort, it recognizes "the family" as the dispositive where sovereign power, in the figure of the *pater familiar*, and a surveillance power intersect and interact, while working through a disciplinary apparatus (Taylor, 2012). Within the private sphere, the family, despite not being based on exclusion - apparently free from constraints - acts as a proper agent of disciplinary power and turns the home to a space of continuous surveillance (Foucault et al., 2003). While within the institution the controller might not

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[8] Unfortunately, a history of mental care outside the walls of the asylum, could rely only on diaries and private doctors' records, material that is luckily to provide an insight merely on more privileged contexts. The asylum has mainly been a solution for the poor.

be seen, and may change, in the family the watchman is not anonymous, but individualised and visible. As Foucault points out (Foucault, 2003; Foucault & Lagrange, 2006; Sullivan, 2021) families have often mediated the relationship between the mad and the doctor: they identified abnormal behaviours in the first place and reported them to the psychiatrists who, for their part, highly relied on their judgment, perceptions of insanity and potential support (Foucault et al., 2003; Foucault & Lagrange, 2006; Taylor, 2012). A more critical understanding of the potentially toxic role of the context of origin, as suggested by Laing (Laing & Esterdon, 1964; Laing, 1976) would have problematised a little bit more an unconditional return of the mad to the family and the community; a return that was, understandably, idealised in the process of deinstitutionalisation.

3.3|MITHS ON ANTY-PSYCHIATRY; ITALY VS UK

These studies, by underlining the arbitrary nature of mental health diagnosis and dynamics of control inscribed in psychiatry, pushed some practitioners to put into question their own profession, in terms of epistemology, methodology and praxis (Cohen, 2018b). This was certainty true for Thomas Szasz's (1961) social constructionism and for the radical movements led by Basaglia in Italy, Cooper and Laing in the UK, without whom a process of deinstitutionalization in the West would have not been possible (Foot, 2015; Scull, 2015). Coming from different perspectives, and reaching slightly different conclusions, both in terms of theory and practice, all of them identified the role of psychiatry and institutions as an ideological apparatus that, on behalf of the State, worked as a tool of control of deviant populations (Basaglia & Basaglia Ongaro, 1971; Basaglia et al., 1987; Rovatti, 2013). Szasz claimed that since there was no scientific evidence of madness, it had to be treated more as a metaphor than a proper illness; he blamed the State and the psychiatric profession to have their own agenda, and an equal interest in the incarceration of the mentally ill (Szasz, 1961). Nevertheless, embracing a libertarian and market-based perspective, he was not against voluntary private consulting (Szasz, 1961); anticipating what later became a trend for wealthier classes.

On the contrary, Basaglia and Laing's work laid in Marxist and existentialist philosophy and recognised in the psychiatric profession itself an agent of the State (Laing & Esterdon, 1964; Cooper, 1967; Basaglia, 1968; Laing, 1976; Crossley, 1998;). From within their own institutions, they began to publicly denounce the horror and ineffectiveness of the confinement of the mentally ill; they questioned their own profession and, identifying the unbalanced power dynamics present in the doctor-patient relationship, sought to overturn them, opting for a more dialectical approach. As noted above, the Italian and the British psychiatric reforms of the 70s and the theoretical and practical approach promoted by their charismatic theorisers, Basaglia and Laing, remain the most important contribution to the social and institutional response to madness in Western countries. The radical movements led by Basaglia in Italy and Laing in the UK were indeed the first to initiate a systematic critique of mental health institutions in practical terms (Basaglia, 2017; Basaglia et al., 1987; Foot, 2015; Scull, 2015). In alignment with other social movements that came together in 1968, they looked at the structural bases of mental illness through an anti-capitalistic lens. They intended mental illness as a socio-political issue that the institution contributed to exacerbate and questioned the power relationship at the core of the institutions and of psychiatry at large. They started a process of self-reflection that turned psychiatry inside-out and led to the gradual dismantling of the large asylum era, both as a building and a concept (Burns & Foot, 2020). Based on similar theoretical premises, but with rather distinct practical implications, Basaglia and Laing's theoretical and practical work is still an inescapable starting point for establishing a different relationship between madness and society and for turning the mad into a political subject.

> *"The inmate knows that their only possibility for liberation is to go beyond the walls and enter into a situation of dialogue with the other. This is where the problem of knowledge is expressed: it is precisely when the internee makes this leap, that is the moment of complicity, the moment in which the technician becomes babbling because he does not understand the action of the internee, he does not know the culture of dissent, because he has always catalogued it with his power and his knowledge".*
> (Basaglia et al., 2008, p. 119; my own translation)

As already said, they were both influenced by existential philosophy and, in an open conflict with the prevailing psychiatric orthodoxy, held the view that patients' feelings and irrational thoughts were something more than mere symptoms of mental illness. They wanted to prove that the manifestation of madness was often a response, a call for help, an adjustment to toxic or dysfunctional environmental factors.

The movement led by Basaglia in Italy made public the violence that had been taken place within the walls of the asylum, and it could not imagine a reform of mental health system without the complete dismantlement of those walls, seeing the open-door and no restraint asylum as a mere moment of transition. On the contrary, Laing's ideas, despite being based on similar premises, recognised in the social environment, and in the family in particular (Laing & Esterdon, 1964; Laing, 1976), a potentially pathogenic role and advocated for the creation of "therapeutic communities"; with the belief that the institution could be reformed from inside. Therefore, while the process of deinstitutionalization in Italy aimed to reintegrate people into society, without ifs and buts, Laing experimented a form of cohabitation between patients and therapists, where rules were co-produced, and psychosis was left free to express itself, even with the help of psychedelic drugs[9]. Basaglia looked to the experiments of Jones, Laing and Cooper to find a model to be applied only in the short term, for the day-to-day management of the asylum and the creation of a renewed therapeutic relationship with patients. He was less inclined to share Laing's idealisation of madness, seen by the Scottish psychiatrist as a temporary and necessary journey to find the true self. Despite these differences, their efforts were based on a constant and twofold evaluation of the patient-doctor relationship, considered as a committed encounter. Both approaches aimed to capture, through patients' stories, the meanings that individuals attach to their experiences of mental illness. Patients were called to make sense of their circumstances, to re-create notions of otherness devoid of judgement and get into a deeper understanding of suffering from within. Being exposed to madness in that way, created a moment where power dynamics were temporarily inverted: by sharing their knowledge, patients provided an un-sanitised vision of the reality that a medical gaze could not fully grasp otherwise[10] (Basaglia et al., 1987; Scull, 1989; Burns & Foot, 2020; Basaglia, 2017).

A common misunderstanding, around which the subsequent, and very much alive, rhetoric on antipsychiatry has been built, is that those movements denied the existence of mental illness or were against any forms of

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[9] In 1965, together with David Cooper, author of the book *"Psychiatry and Anti-psychiatry"* (1967), Laing founded the Philadelphia Association and set up a therapeutic community in London, the Kingsley Hall, where patients and doctors lived together and helped to run the place with a collaborative approach. Considered one of the most ambitious experiments of radical psychiatry, due to the lack of rules and the concomitant abuse of LSD that attracted drug addicted, it had to face the hostility of local community that hardly accepted this island of freed madness in its back yard. After a series of complaints, after only 5 years, the building (and the project) was closed for poor standards of hygiene and safety.

[10] The reference to Freud, Marcuse, Sartre, and Foucault was evident in Basaglia's work.

medicalization or pharmacological treatments. Both Basaglia and Laing rejected the label of being part of the antipsychiatry movement, if not by going against predominant psychiatric ideas and practices - such as the use of lobotomy, electroshock, insulin therapy, physical and chemical restraint. This misunderstanding likely grounds on Szasz's claim that mental illness was a myth (1961); however this statement has never been embraced by any of the leaders of the radical movements of the 70s. Franco Basaglia's famous mantra "*let's place disease into brackets*" (Basaglia, 1968) did not mean that mental illness was not real, it meant that mental illness was not the meter through which a society should have measured the value of a person. Besides, as already mentioned, the Italian group believed that mental illness was masked and exacerbated by the effects of institutionalisation, thereby making treatment impossible. For Italian reformers, any forms of confinement, typified by the psychiatric and criminal systems, implied dehumanization, and could not be justified, but rather be considered the failure of both the health and justice systems (Basaglia, 1968; Foot, 2015).

Moreover, it cannot be omitted, that the process of deinstitutionalization was also enabled by the increase in the use of psychiatric drugs. None of the supposed fathers of antipsychiatry denied the benefits of medicines and they all acknowledged their role in the process of deinstitutionalization. A legitimate critique about drugs though, still valid today, is represented by the risks of its indiscriminate use that has often led to simply replace physical restrains with, equally carceral, pharmacological ones (Scull, 2015; Cipriano, 2018; Cohen, 2018). This also leads to take into serious account the interests represented by the so-called Big-pharma that has incentivized, with the collusion of doctors, the worldwide increase in psychiatric diagnosis (Leader, 2013). Another aspect that is often dismissed is a parallel narrative that contributed to push towards a process of deinstitutionalization linked to the common belief that public mental health care was too expensive and not worthy[11] (Robcis, 2021). Quite a powerful argument even today, as Turner et al. write: "a historical narrative structured around rights (to health and liberty) is now complicated by the rise of new organising categories such as "costs", "risks", "needs" and "values" (Turner et al., 2015, p. 600).

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[11] It should not surprise that the British psychiatric reform *"Care in the community"* was finalised in 1983, under Thatcher's government.

At the time, in Italy economic interests coincided with a general climate of social demands and with the growing indignation of public opinion following constant scandals (for the case of Turin, see Chapter 4). Furthermore, within the Communist Party's efforts to reach a political agreement with the Christian Democrats, all this led to the promulgation of the Law 180[12]. The law still represents a crucial moment in the history of mental healthcare, as the Italian State, first in the world to do so, decreed the definitive closure of asylums, established mental health centers throughout the country and regulated compulsory treatment (TSO[13]) as an exceptional measure (see Chapter 4). The United Kingdom was less successful in getting rid of the centrality of the hospital institution. In the Anglo-Saxon context, despite community-based experiences started since the 40s, several revisions of the Mental Health Act had a reformist and incremental nature, aiming to achievable and gradual improvements, without any radical and utopian attitude. The UK did not truly complete the process of deinstitutionalization and its system is based on a systemic continuity between de-hospitalisation and community-based services, with the idea that such a model could respond in a more flexible and efficient way to ever changing needs. Underlying this approach is a perspective based on efficiency and effectiveness, which has no illusions that hospitalisation is avoidable.

3.4| REFORM OR REVOLUTION? FRANCE VS ITALY

If, on a theoretical level, the contributions of Foucault and Sartre have been identified as a key influence on anti-institutional discourses (Jopling, 1987; Zahavi & Loidolt, 2022), in practical terms, two French experiences have been particularly influential in Italy. Firstly, the case of *Institutional Psychotherapy* tested at Saint-Alban and La Borne - together with the further contributions developed by those who had worked there, such as Tosquelles, Channigham, Fanon, Oury and Guattari. Secondly, the so-called *sector psychiatry,* the public mental health system that has been in place in France since the 1960s. Both models, by failing to adequately challenge the

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[12] The law, named the Basaglia Law, despite the psychiatrist's reservations regarding its adequacy, was promulgated few days after the assassination of Aldo Moro, a member of the Christian Democrats, who had been kidnapped and killed by the Red Brigades in the context of a climate of fear and intimidation, commonly referred to as the “anni di piombo” (Year of lead). The law was passed in haste, for fear that the agreement between the various parties would falter because of Moro's murder.

[13] TSO stands for “Trattamento Sanitario Obbligatorio” which means “compulsory health treatment” and includes either or both involuntary admission and involuntary medication.

institution of the asylum – which, in fact, still exists in France –were partially at odds with Basaglia's premises. In fact, despite sharing the critique of the psychiatric system, they differed in some theoretical foundations, goals and practical approaches.

Italian and French radical psychiatrists thus had a shared interest in the socio-political dimension of mental health and believed that theory and practice were inextricably linked. However, while Italian reformers believed that institutional care should be decentralised and intergrated into the community, the French school, focused more on the structural and philosophical dimension of psychiatry and psychotherapy. More inclined to frame mental illness as a product of capitalist structures, and less focused on individual treatment or integration, French radical psychiatrists never identified the institution as the root of the problem and aimed to change psychiatric theory and practice at a deeper level, by focusing on the hierarchical, diagnostic and pathological framework of psychiatry. While acknowledging the concentrationary nature of psychiatric institutions, theorists and practictioners as Guattari remained highly sceptical of an abolitionist approach (Guattari & Lotringer, 2009).

The assumption was that, from the family to the school, there was an inherent risk of abuse and misuse of power in all kinds of institutions. It was argued that the elimination of such institution would only superficially address the underlying issue, as another would inevitably emerge to fill the void; while leaving the mad and their families unassisted. As argued by Felix Guattari (2009), the idea of suppressing the asylum as advocated by Basaglia was irresponsible and would ultimately amount to a form of denial of mental illness and its impact on both individuals and communities. The work in Saint-Alban and La Borne was based on the belief that the environment was co-responsible of the illness, hence the idea to explore the emancipatory potential of the institution, seen in its social and political dimension. In places such as Saint Alban and La Borne, known for being the first to adopt institutional psychotherapy, the emphasis was placed on the quality of the place, the range of activities and the presence of a multi-disciplinary staff; with the idea that the interaction among patients was therapeutic in itself and patients could participate in their own healing process (Robcis, 2021). The two clinics constituted a proper laboratory where innovative and creative therapeutic practices were tested, with the intent of subverting the system. Institutional psychotherapy meant the integration of psychoanalytic theories and artistic practices within a collective therapeutic environment, facilitating personalised and relational care. The use of a psychotherapeutic approach within the context of an institution wanted to emphasize the importance of community living and relational dynamics in mental health care. Saint-Alban and La Born, together with the theories built up by all the practitioners who worked there, are definetevely significant in the history of psychiatric reforms and continue to influence contemporary practices in mental health therapy. They contributed to highlight the role of the environment in mental health, encouraging creativity, social interaction, and a democratic approach to patient care. However, as said above, did not actively oppose the institution that, outside Saint Alban and La Borne, continued to operate without really questioning itself (Robcis, 2021).

Meanwhile, starting from the 60s, France has organised its mental health care system through the so-called “sector psychiatry”, known as "*psychiatrie sectorisée”.* In other words, it has created community-based services and encouraged a gradual decentralization of psychiatric care, in order to make it easier to access mental health care and to reduce the reliance on large psychiatric hospitals - whose existence, though, was never put into question. This model tries to provide care within the community, by integrating mental health services into general health care and social services, enabling patients to receive support in their own neighbourhoods and reducing the number of people who needed hospitalisation. The system is organized by sectors, each responsible for providing comprehensive mental health care to a defined population in a specific geographical area. Each sector includes a team of psychiatrists, psychologists, social workers, nurses, and other professionals who collaborate and work across different services within a specific catchment area (Petitjean, 2009). Sector psychiatry emphasizes ongoing care and support, allowing patients to transition between different levels of service as needed; it aims to reduce hospitalizations and promote recovery, through continuous therapeutic relationships. Overall, *sector psychiatry* represented a significant shift in mental health care in France, aligning with broader trends in psychiatric reforms that advocated for more humane and community-oriented approaches to mental health treatment. As already mentioned, it has influenced mental health policies in Italy too, serving as a model for decentralized and integrated care services, that the Italian reform of ‘78 has though made redundant (Lasagno, 2012) (see Chapter 4).

Basaglia looked at psychotherapy and institutional psychiatry with a mixture of interest and scepticism similar to that with which he observed the therapeutic communities of Cooper and Laings in the UK. He borrowed some elements, but did not see them as the ultimate goal of his project. Rather, he regarded them as provisional and insufficient measures, pending the complete and definitive de-institutionalisation. Basaglia looked at his work in

Gorizia without illusions, precisely because he knew how the British and French experiments had evolved. On the other hand, the French and the British reformers, accused the Italian group of being *naive* and demagogic. According to Felix Guattari, while denying the institution and blaming society, Basaglia was also showing little interest for the desease. By focusing on the impact of asylum life on individuals, regardless of their illness, Basaglia was accused of denying mental illness - *"refusing the mad the right to be mad"* (Guattari & Lotringer, 2009, p. 20) - and for his abolitionist approach, of throwing the baby out with the bathwater. However, as Basaglia claimed at the Brasilian Conferences (1979), there was no baby to save: faced with a madman who did not respond to treatment, istitutional psychiatry resorted to mere methods of torture, by turning "*the patient into a vegetable, taking away all residual will and emotions"* (Basaglia, 2018, p. 63).

However, in assessing the Italian case against the British and the French ones, it is important to acknowledge that the material conditions of the asylums throughout Italy, were among the most deplorable in Europe. Result of two decades of fascist rhetoric about "eugenics" [14] and the subsequent welfare cuts due to the second World War. Consequently, there was very little to save in the Italian mental health system, predominantly populated by the poor and marginalised - regarded as problematic or simply inconvenient (Bertolo, 2021; Ongaro & Basaglia, 2024). Moreover, during fascism and the war, neglect and lack of resources affected most asylums, which suffered more than other types of hospitals. During that time, false diagnoses were used to intern dissidents or "inconvenient" people, turning both the asylum and psychiatry into an openly fascist instrument of political and social control[15]. Hence, what greeted the newly appointed director Franco Basaglia in 1961 in the

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[14] As defined by the Encyclopaedia Britannica, eugenics is the "desired heritable characteristics in order to improve future generations, typically in reference to humans". Coined by the British scientist Francis Galton in 1883 and influenced by Darwin's theory of natural selection, it was at the core of the Nazi extermination project of disabled people and other races.

[15] Moreover, the neglect of the mentally ill corresponded to a specific political project that can be traced back to the principles of eugenics and racial hygiene, ideologies that aimed to "improve the race" by getting rid of, or sterilising, the impure. Let us not forget that in Nazi Germany, through a project called "Aktion T4" (Paolini), the mentally and physically handicapped were the first to be subjected to this "reclamation". More than 250,000 disabled people were killed in what was referred to as involuntary euthanasia. From 1939, disabled people were used as "guinea pigs" to test technologies such as poison gas, later employ in concentration camps. In addition to the rhetoric of racial purity, there was also an argument on economic efficiency: disability was portraited as a burden. Killing, or letting disable die, would have reduced the need for dedicated institutions, such as the asylum, depicted as too expensive and de facto useless

asylum of Gorizia, was very different from the idea of a hospital but rather close to a very fresh personal[16] and collective memory, that of prisons and concentration camps. As Basaglia wrote:

> "*The asylum is akin to a concentration camp or a prison, where inmates are unaware of the reasons for their incarceration or the duration of their stay, entrusted to the arbitrariness of subjective decisions. In these circumstances the degree and stage of the disease often play a relative role"*
>
> Preface for the book *"La marchesa e i demoni"* - The Marquise and Demons - (Marsigli, 1973)

Talking about Gorizia he used to say that there were 600 internees, but no one was left. Unsurprisingly, Basaglia and his team had different priorities from the Philadelphia Association, run by Laing and Cooper and the French Institutional psychotherapy movement. The Italian radical psychiatrists wanted to demonstrate the detrimental effects of asylum life on the health and behaviour of patients; they claimed that mental illness within a total institution had become a secondary concern, gradually losing its meaning and relevance (Basaglia, 2017). According to Basaglia, in the attempt to address the "asylum effects", which made it impossible to identify - and therefore treat - individual issues, the asylum, as the main spatialization of psychiatric care, was both ineffectual and harmful. Hence, the urgency to abolish it as a prerequisite for any possible renewal of psychiatric care. His project, from the very beginning, was as simple as revolutionary and ambitious: the asylum had to go, it could not be reformed, modernised or changed; rather, got rid of it by aiming for a society that no longer needs it. The intellectual and practical commitment of Basaglia and his team made Italy the first country in the world to close its asylums by law, proving that it is possible to go mad in a society without asylums.

4|CURRENT DEBATES

4.1|MENTAL ILLNESS AS A GLOBAL BURDEN

Debates around the psychiatric reforms that, starting from the 70s, led to the end of the big asylum era in most Western countries, have been therefore rather polarised. In Italy, while there is a tendency to idealise that

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[16] In 1944 Basaglia was arrested for being antifascist and stayed in prison until the end of the war (Colucci & Vittorio, 2020)

period, tinging it with epic traits and seeing it as definitive, there is also who suggests that if the alternatives did not work as expected, an alternative to internment is not possible at all (Foot, 2015). Both approaches tend to simplify the past and appear not to be effective in envisioning future developments (Acharya & Agius, 2017). In the meantime, in Italy, as in other Western countries, radical psychiatry's assumptions have been partially neglected, misunderstood, or in many cases, openly ignored, while a biomedical and market-driven approach has pushed towards an ambiguous alliance between psychiatry and the pharmaceutical industry (Scull, 2015). Because of that, a short-term and emergency-based approach, emptied of any theoretical and ideological connotations, appears to constitute the norm, at least in the public sector. Approach that, given the nature and chronicity of most mental illnesses, is unlikely to be effective. This while the private sector acts undisturbed.

Any discussion about mental care cannot be detached from the socio-economic and political context based on extreme individualism and privatization that has characterised the process of de-institutionalization (Power & Hall, 2018). Given the impact on people's ability to work and the consequent economic burden on families and governments, mental illness has been recognised as a significant driver of poverty worldwide and a cause of human rights violations (Patel et al., 2018). Notwithstanding, mental health treatments are still perceived as a luxury and accounts for less than 2% of global health expenditure[17] (Kesner, 2021). Over the last decade though, mainly thanks to the active role of a network of institutions and individuals called Movement for Global Mental health (MGMH), psychiatric disorders passed from being an "invisible problem" (Chambers, 2010) to be included in the Sustainable Development goals of the United Nations (SDGs, 2014); and to be framed as "a global human rights emergency" (WHO, 2012).

Considering mental health as a global issue and a particularly concerning one, has contributed to increase political attention and people's awareness; followed by institutional and voluntary help: it was therefore needed and welcomed (Thornicroft & Patel, 2014a). Said that, this framing of mental health as global, being primarily based on a pretence of universality appears to be intrinsically rooted on colonial, ableist, and racist structures

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[17] International aid, due to the reliance on donations and consequent market-driven nature, is inevitably concerned about the marketability to the public and it should not be a surprise if physical illnesses as HIV, TBC and malaria are still perceived as primary concerns and get more funding (Chambers, 2010).

(Mills, 2014; White & Sashidharan, 2014; White, 2017); with little understanding of local needs and cultures. As White et al. (2017) assert, even when local knowledge has been valued and used to implement policies, it is rarely instrumental for questioning the rationale, in terms of motives and values, behind global mental health interventions. The effort of linking mental health to international development in the Global South has been mainly informed by quantitative evidence: from prevalence rates of common mental disorders to the so-called "treatment gap" - the assessment of the difference between what is supposedly needed and what is provided on the ground. This through an understanding of mental disorders and psychiatric care inscribed in western definitions and through processes of "scaling-up" inscribed in a discourse of universality (White & Sashidharan, 2014; Mills, 2014, 2018b). This alongside discourses on the economic cost of mental health illness, that becomes depicted and perceived as a global burden. This framing has for sure attracted political attention for action and increased the "marketability" of mental health support (Thornicroft & Patel, 2014). This economic reductionism though constructs a rather dangerous narrative that, while focusing on the impact of mental health on global wealth, dismisses the psycho-social distress created by inequality, marginalization and precariousness (Mills, 2018a; Standing, 2011). A quest for a more "nuanced understanding of the interplay between mental health and development" (Mills, 2018b: p. 843) has eventually attracted academic attention across different fields; with implications both in terms of theory and practice (Cohen, 2018a).

We have then seen, a proper decolonial turn in mental health studies that questions to what extent is useful and legitimate to apply and export univocal and largely Eurocentric psychiatric categories worldwide (Mills, 2014). The Global mental health movement has been criticised for not taking into serious account the contextual nature of mental distress and different cultural meanings given to it (Mills, 2014). Based on false assumptions and generalizations, discourses of "trauma", "resilience", "normalization" have travelled uncritically and so their treatments and mental health policies. In this move, traditions have been often dismissed as trivial and either misunderstood or ignored, despite their active and instrumental role in the identification of madness and in its society's response.

As Rabaia et al., (2014) highlight:

> *"In mental health, what is understood in some cultures has no meaning in others. This is not an issue of finding the right word in translation, or semantics, it is about a way of being, of living, of reacting to stress and trauma linked to a mindset where meaning, culture and context are of the essence."* (p. 179)

We should not forget that in some cultures, madness is still considered a divine punishment or a supernatural phenomenon; a form of possession or magic spell, mainly treated by faith healers, and often object of physical and psychological violence (Kale, 1995; Ng, 2021). If this is definitively more common in the so-called Global South, as the emblematic case of the Ghanaian "witch camps" shows (Roxburgh, 2018), we should not underestimate the role that religion and traditions continue to play in some communities of the Global North - the Vatican offers annual exorcism courses, and a renewed increase in the demand for this controversial practice has been reported in Italy, Spain, US and even in the UK (BBC News, 2018).

Derek Summerfield (2013) defines the universality of mental health as an oxymoron and a proper act of medical imperialism; a form of domination that despite being less evident is not, nonetheless, less powerful and disruptive. Narratives of suffering are imported and used to re-write local stories of oppression, but always from a Eurocentric point of view (Mills & Fernando, 2014; Sheehi & Sheehi, 2022). On the other hand, advocates of Global mental health, despite sharing some warnings about medicalization and extreme generalizations, see these criticisms as dismissive of the influence of social studies in psychiatry and, more importantly, their inability to turn their claims into action. If it is certainty true that racism was inscribed in the colonialist refusal to provide mental health care, this argument, ignores the role played by psychiatry during colonialism and dismisses current institutional racism that we can see today. This makes wonder to what extent global mental health is global and what "local" means in contrast to "global" (Hailemariam & Pathare, 2020) and which methodologies and theoretical frameworks should be applied in order to build up evidence and policies. The global/local dichotomy around which both Global mental health research and its critics base their claims, is constructed on a binary imaginary that does not consider whatever is in-between and goes beyond this divide. Most importantly, it negates the relational geographies that are fundamental to the very concept of global and local (Bemme & D'souza, 2014).

Geographic disciplines appear then to be well suited to bridge these two poles, however, the lack of interaction between the predominant epistemological and methodological tools of inquiry adopted by mental health geography, has so far reinforced this divide. Quantitative research on mental health geography has identified some common patterns, contributed to inform policies and to mobilise investments, both at the national and global level. While qualitative research has been dismissed as a mere academic exercise, with very little impact. This with an inevitable set of problems that a multi and mixed method approach could potentially contribute to solve (Crooks et al., 2018).

4.2|INTERSECTIONAL FRAMEWORK

In conjunction with the decolonial turn advocated above, in order to assess to what extent structural violence is responsible for setting the terms by which people are pathologized, marginalised and/or criminalized, there is also the need to acknowledge the entanglement of mental health with other dynamics such as racism, misogyny, xenophobia, transphobia, classism (Morrow & Halinka Malcoe, 2017). Gender, race, social class, have all unpredictable effects on mental health and the use of an intersectional framework as introduced by Kimberlé Crenshaw (1989) and further developed by other black feminist scholars such as Audre Lorde, bell hooks, Patricia Hill Collins, becomes essential (Nash, 2017). Whereas the concept has been extensively used by geographers in relation to spatialised forms of discrimination, it has not been fully incorporated in mental health geography. Despite the growing scholarship (Bambra, 2022), mental health institutions and practitioners still pay little attention to the impact of what Rosenfield (2012) defines a “triple jeopardy”, in other words the implications of multi-layered and intertwined forms of privilege and disadvantage, such as gender, class and race[18], that are common in our society.

Mental distress is likely to produce forms of inequality and marginalization that creates a vicious circle, the chains of which are often difficult to break, regardless of class, race, gender. However, this may lead to

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[18] Here, race is understood not as a biological reality, but as a social construct that organizes access to power, resources, and care, and which operates through both structural inequalities and everyday forms of discrimination (see Omi & Winant, Crenshaw and Fanon).

underestimate how differential conditions of disadvantage and privilege shape experiences of mental illness, thereby exacerbating discrimination. Intersectionality constitutes then a well-suited theoretical and methodological framework for identifying power dynamics embedded in mental health and their impact on individuals (Mills, 2014). As a matter of fact, a multiplicity of identities shapes our lives, and this should make us question to what extent and how these identities affect our mental health (Hill Collins, 1990). As Crenshaw (1989) shows, different combinations of discrimination create different forms of oppression, which are never one-dimensional, but can extend, as in the case of gender, race and class, to religion, sexual orientation, disability, and so on. The intersections between some of these identities creates subgroups that can either take advantage or be negatively affected in terms of income, opportunities, and, eventually, health (Morrow & Halinka, Malcoe, 2017). However, if inequality is to be seen as an overlapping of mutually constituted categories, these should not be viewed simply in quantitative, cumulative or exclusive terms. Adopting an intersectional lens should not result in the prioritisation of categories of disadvantages or privileges, nor in their equalisation. Rather, it should engender sensitivity to all social forces that contribute to shaping experiences in diverse ways. With both theoretical and methodological implications for research.

However, a recent liberal turn, putting an emphasis on identity and individual differences, has reduced intersectionality to a tool for collecting and commodifying differences, turning intersectionality into a mere ornamental approach and a “tool of diversity management” (Nash, 2017, pag. 18). The adoption of an intersectional lens has thus become an uncritical sampling exercise that examines forms of subordination as an indistinct sum of identities rather than as a relational and contextual matrix (Hill Collins, 1990); with the risk of equating unequal forms of oppression and reproducing prevailing discourses and systems of domination. In this framework, mental health could easily be used to flatten discrimination, at the expenses of other layers. A lack of consideration towards intersectionality and discrimination among mental health practitioners is often followed by the assumption that mental health affects people equally and that a one-fits-all approach is possible; whereas levels of mental health can find an explanation within multilayered dynamics of oppression (Bambra, 2022). While recognising this risk, we must both seek to understand how insanity affects different categories, and how these categories contribute to shaping and experiencing it.

Within the broader field of mental health studies, the concept of intersectionality has already emerged, both as a theoretical and methodological lens, to examining the concomitant and interacting influences of multiple forms of inequality on health. For what concerns health geography, the concept is considered useful for studying how forms of social oppression constitute each other, interact or are produced by and in space (Fox & Powell, 2021). The intersectional lens could help consider the role of place more explicitly and contribute to a better understanding of the effects a place has on the individual, in terms of social position and identity, and how, in turn, place can be considered a constituent of inequality (Abrams et al., 2020; Cummins et al., 2007). However, the belief that *poor people produce poor places* or conversely that *poor places produce poor health,* are statements often considered in exclusive, rather than interconnected, terms (Bambra, 2016). Both compositional and contextual factors contribute to the complex relationship between health and place. Therefore, to understand how factors interact to produce geographical inequalities in health, a relational geography approach is required (Cummins et al., 2007). Inequalities are culturally specific and vary over time and space: social groups therefore experience different amounts of disadvantage and privilege associated with their different characteristics, but also due to the specific context in which they are (Nash, 2008). Attention has often focused on the health disadvantages that members of minority groups face due to the discrimination they experience, however, the literature on health inequalities appears to be developed rather separately from socio-economic, racial/ethnic or gender dimensions; when the role of space has been taken into account, it has been studied as independent of the other dimensions. Whereas to what extent place shapes the experience of other social categorisations (Hopkins, 2019) should also be considered in relation to health inequalities (Kapilashrami & Marsden, 2018; Roy et al., 2020; Alvarez & Evans, 2021).

Another aspect that is often dismissed when approaching intersectional research is the role of the researcher in the matrix. While using intersectionality as a lens to explore how social, political and cultural categories come together to become markers of inequality or privilege, we cannot help but see each individual life experience as co-produced by these intersections. From this standpoint, adopting the self as a point of departure for an intersectional study is beneficial for evaluating one's own position with respect to real or perceived privilege or disadvantage. Within this framework autoethnography becomes one of the possible methods at the disposal of an intersectional lens, and intersectionality an integral part of a proper autoethnographic methodology. The relevance of the researcher’s personal experiences as a lens through which broader cultural narratives are examined, allows for a multi-layered understanding of the self that transcends a mere personal storytelling. Intersectionality and autoethnography, when combined, become a way of studying individual daily experiences, able to elucidate the complexity of identity and social categories. By combining intersectionality and autoethnography, one could examine identity and culture not only as a contextual background but as a direct embodied experience. The interplay between personal narratives and broader cultural contexts sheds lights on the significance of intersectionality within autoethnographic research, revealing how individual stories can reflect and challenge systemic inequalities. All this thanks to an autoethnographic approach that not only documents personal experience but also engages critically with the socio-political landscapes that shape identity. This dual perspective, grounded on a feminist approach, is crucial, as it enables the exploration of the self in relation to larger societal structures that shape individual identities. By incorporating the two approaches, it is possible to investigate how overlapping identities can generate experiences of privilege and oppression in a unique way. This integration highlights the importance of diverse voices, reinforcing the notion that personal experiences can illuminate broader cultural phenomena. This makes autoethnography not a mere method for documenting personal experiences but also a means of engaging with the socio-political landscapes that shape identity[19].

4.3| MAD STUDIES

First-person narratives become then essential if one wants to investigate the multi-layered nature of mental illness. In this regard, at the end of the new millennium, out of a sense of frustration at a lack of direct representation of psychiatrised bodies, a new strand of research, called “Mad Studies”, has emerged (Ingram, 2021). Although built on the theoretical and practical work of radical, feminist and critical practitioners that have recognised the multiple oppressive nature of psychiatric practices, Mad scholars claim that a knowledge that forgets to include psychiatrised voices is built on an epistemological and methodological lens that conceals the discriminatory power of ableism and sanism (Poole et al., 2012). Even in the process of letting the mad

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[19] The limited nature of the sample, however, rendered it challenging to adopt a classical intersectional lens. From the outset, it was evident that the majority of patients were local and not completely cut off from their family. Almost all belonged to a middle class, whose knowledge allowed them to access certain types of services and support. Using myself as a yardstick and listening to the patients' stories, it quickly became clear how a combination of privilege and luck had spared me their journey, and how a mix of factors, rarely related to illness, had kept them in the group home. All making wonder which channels others end up in.

speak, is possible to glimpse the permissive nature of the gesture - granted temporarily, as long as it is deemed appropriate. As Basaglia himself admitted (1968b), the act of letting the patients being themselves often became a simple reshaping of the same power dynamics that they were attempting to dismantle.

Mad Studies does not consider a critique of psychiatry and the fight against discrimination sufficient; it wants to emancipate the mad with a movement from below and alongside a range of allies, who are, however, asked to take a step backwards (LeFrançois et al., 2013). Mad Studies was born with the specific intention of shaking up the academia, making it undisciplined (Ingram, 2016); it does not belong to a single field but brings a spark of madness and revolutionary potential to every subject, with the hope of adding a further, and so far, neglected, level of understanding of social phenomena (Beresford & Russo, 2022; LeFrançois et al., 2013). In addition to provide with new sources of knowledge to redress epistemic injustice, Mad Studies aim to unmask the violence hidden in traditional representations of mental illness and psychiatric narratives, which continue to suppress and pathologise alleged abnormal behaviours or thoughts (Daley et al., 2012). To psychiatric narrative, understood as a real technique of power, mad scholars are called to counter a different way of narrating and evaluating mental illness. This without falling into the trap of being defined merely by it or romanticising it. By including first-person narratives as a privileged source of knowledge, throughout an ontological twist, it questions the primacy and legitimacy of rationality. The epistemic privilege of self-knowledge provides the benefit of an advantaged access to internal struggles and individual perspectives that, devoid of ableism and prejudice, offer more truthful insights on embodied states of being, or getting mad (Chouinard, 2012).

Although narrative and autoethnographic approaches are to some extent a prerequisite, there are no specifically recommended methods for conducting Mad Studies. The precondition is to examine the factors that contribute to shaping mad subjectivities from a perspective other than the medicalised ones. Perspectives which, whether one likes it or not, base everything on the rational/irrational, normal/abnormal dichotomy. This requires an ontological reversal, with obvious epistemological and methodological implications, that looks at rationality and normality as something fluid, unstable and, above all, devoid of any superiority - except a statistical one. What is considered a normal behaviour may not necessarily be preferable, but rather what is adopted by the majority or by the most powerful, in a specific time and space. What we perceive as deviant may simply be a desirable denunciation of the injustice of a particular social norm; a violation of the rule that we instinctively find dangerous for our survival. It is therefore questionable whether it is short-sighted to silence or suppress the alarm raised by the mad and whether the danger, when real and not just perceived, is merely the result of oppression rather than a symptom of madness (Leader, 2012). Symptoms are often the clumsy attempt individuals make to find a solution to a problem or simply an unconscious defence tool. By pathologizing and silencing symptoms, mistaken for illness, we deprive ourselves of the possibility to understand the person and their request for help. Putting “the disease in brackets”, as Basaglia suggested, served not to deny the disease, but to avoid being conditioned by everything that was considered its symptoms. The asylum was often the real culprit for these symptoms: from a place of care, it turned into a “factory of madness” (ALMM, 1971). A mental illness that changed its characteristics outside the walls could only be identified and cured by destroying the asylum, as a building and as an idea.

5|CONCLUSION

Despite the relevance of social and physical processes in the distribution and occurrence of the dynamics described above, the “spatial dimension” of mental health is still mostly dismissed (Crooks et al., 2018). The same can be said of the relevance granted to the so-called mad voices, and for the attention paid to how different components of individuals' identity converge to influence their personal experiences. The interaction between individuals and the attributes of their social and physical environment affects mental states in several ways and this experience is highly subjective. As noted above, this entanglement makes essential the need of thinking spatially, and individually, at mental health issues and its treatment. In that respect, mental health geography has adopted a variety of approaches that goes from “spatial and locational analysis”, informed by quantitative methodologies, to ethnographic studies of individuals’ everyday life, opening opportunities for viewing mental health issues in its multidimensional and multi-scalar nature (Curtis, 2016). Through a geographical perspective, place-related implications of mental illness can be investigated in their full complexity, encompassing scales and contexts and via a culturally sensitive approach (McGeachan & Philo, 2017). Approach thus that needs to look at the micro-scale and to be grounded in a specific context. Context that should not be considered as the mere container of the experiences that take place within it, but rather as a spatial and relational product (Tucker, 2010).

Concerns over how space mediates and shapes user's behaviours, how this informs people's relation to others and how this relation has the potential to deny or vice versa enable self-determination, empowerment, inclusion, are all themes that tend to be dismissed in the literature (Lefebvre, 1991; Massey, 2005; Thrift, 2006). Therefore, the premise of this study was that space, self-narratives and relations being co-constructed, cannot be detached from any discussion on power over the self and identity production. As already said, geography of mental health is still a *niche*, and still mainly confined to the British academia. Excluding the notable achievements in certain regions, such as Friuli Venezia Giulia and Umbria, which as exceptions are not representative of the national reality, to date, in Italy there is very little research that looks at the implementation of the psychiatric reform at the local level, even less through a geographical lens, and the role of space, when taken into consideration, involves only studies on total institutions, merely conducted from a historical perspective. Historical perspective that cannot be ignored, as it is crucial to understanding how the social - and spatial - response to madness has changed over time, but which must serve above all to understand the present and prevent a return to the past. Therefore, the premise of this study is that space, self-narratives and relations, being co-constructed, cannot be detached from any discussion on power over the self and identity production.

In conclusion, to contribute to the already rich literature on the geography of mental health, I have structured my work around an analytical framework based on:

1) the need to situate the past of mental health reform at the local level; to contextualise the present by reading the past through the lens of today, and to explain the present as the result of a certain continuity and some moments of *caesura*;
2) the necessity to comprehend the urban as a network of relations and spaces, rather than as a singular and monolithic entity. This by emphasising the relational perspective of urban studies within the field of mental health geography;

3) the willingness to go beyond the work of Foucault and engage with a feminist and intersectional approach
4) an ethnographic study focused on discourses and practices of both those considered mad and the practitioners who interact with them.

All this is reflected at the methodological level (see Chap. 3), where I combined archival research at a local grassroots association with ethnographic research on a series of post-asylum geographies of mental health care. Combined with a light, but cross-sectional, autoethnography. From time to time, my voice found the space to emerge and explain itself to recount something that the lives of others had evoked or, more simply, to explain how my direct experience, for better or for worse, influenced the research. The result is a less touching or emotional narrative and a document with seemingly less clear and controversial political value. However, this was done in order to go beyond a binary and sided discourse and to create the conditions for a dialogue in which all sides can feel welcome to have their say.

CHAPTER 3

RESEARCHING MAD GEOGRAPHIES

1| INTRODUCTION

As already mentioned in the introduction, the core of my methodological approach consisted in a multi-sited ethnographic fieldwork conducted across a series of micro-geographies of mental health care in Turin. It involved a combination of archival research, long-term participant observation, semi-structured and unstructured[20] interviews[21]. My participant observation was conducted from an autoethnographic standpoint, guided and shaped by my own lived experience of mental illness and psychiatric care. In the following sections, I will discuss the research design, describe the nature of my fieldwork and critically assess my methodological approach, including challenges and issues encountered, for both practical and ethical reasons. This ethnographic study, given the nature of the topic, the characteristics of the fieldwork, the methods used and my personal inclination towards a subjective and human-centred epistemology, aimed to create a situated and diversified ensemble of positioned points of view. Viewpoints fruit of lived experiences of mental illness and treatment that, although overlaid by my own, add different perspectives on issues of psychiatric power and its subtle way of crafting mad subjectivities - and mad careers (Goffman, 1959). With this study I aim to legitimate first-person narratives, while advocating for a gradual depowering of an ableist and normative understanding of both madness and its care. This, though, without dismissing the indispensable contribution that doctors, nurses, social workers, educators, family members and researchers, as allies, may provide. What will be presented here is not intended to be an alternative voice to others, but one that, having been disregarded for so long, legitimately asks to be heard. As a starting point, I will examine the epistemological and methodological

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[20] Life-history interviews or informal chats

[21] Interviews were either audio recorded and then transcribed, or, when recording was not possible, I registered information through detailed note taking.

challenges posed by Mad Studies, which qualitative research on madness and space can no longer ignore (Ingram, 2016; LeFrançois et al., 2013; Cohen, 2018b).

TABLE 3.1

Research design: aims, methods, sites and outputs

MAIN AIM/RQ	METHODS	WHERE	CHAPT.	OUTPUTS
How did the process of deinsitutionalization take place in Turin?	Site-visits	Collegno; Turin (Via Giulio); 'spedale dei pazzerelli; Grugliasco	3, 4, 5, 6	Pictures, drawings, videos
	Archive research	Associazione per la lotta contro le malattie mentali (ALMM)	4	Pictures, archiving
	life-stories interviews	Oral History School. Torino | Collegno 23 e 26-28 maggio 2023	3, 4	pictures, audio-recording, notes
How have geographies of mental health care been adapted to the process of deinstitutionalisation and the withdrawal of the state?	Site-visits; informal chats	Local Cooperatives (Zenith, ProgettoMuret, il Margine, Bluacqua, Di.A.Psi, Casa Bordino; Progetto Itaca, Associazione Arcobaleno)	3, 4	Notes, pictures.
		Puplic sector (CSM, Daily Centre)	3, 4	Notes, pictures, drawings
	Autoethnography	CSM C.so Francia, Private psychiatrist, Group Therapy, GP, laboratory of analysis.	Intro 3, Concl.	Notes, pictures, drawings
	Participant observation; semi-structured interviews; informal chats;	Groups homes & staff meetings (Zenith); ALMM(volunteering & staff meetings)	3, 5, 6	drawings, notes, audio-recordings, pictures

How have they been expressed spatially (and hence relationally)? which are the spatial, rhetorical, relational elements that are likely to exacerbate dynamics of control, exclusion and dispossession around issues of mental health care?	Participant observation; semi-structured interviews informal chats	Groups homes & staff meetings (Zenith); ALMM (volunteering & staff meetings)	3, 4, 5, 6	drawings, notes, audio-recording, pictures
	Autoethnography undercover observation; informal chats. Site-visits	CSM, associations, festivals	3, 4, Concl.	drawings, notes, pictures
Which are the everyday, conscious or unconscious, practices put in place by workers? to what extent and how all these practices shape the mad subjectivity?	Participant observation; semi-structured interviews; informal chats;	Groups homes & staff meetings (Zenith); ALMM (volunteering & staff meetings)	4, 5, 6	drawings, notes, audio-recording, pictures
how is the mad identity lived, performed, embodied by patients? To what extent this subjectivity is acknowledged, contested, used?	Participant observation; semi-structured interviews; informal chats;	Groups homes (Zenith)	5, 6	drawings, notes, audio-recordings, pictures

TABLE 3.2

The presented material was collected using various ethnographic methods. To avoid intrusiveness, I chose not to bring a camera. I instead used a mobile phone for pictures and recordings. I always carried a notebook, but I noticed that writing in front of patients and staff affected my interactions with them. In the quoted or rephrased text, I used the following reference format: (Name, Month, year, Type of interview). The material was gathered in one of the following forms:

** **TI**; Taped interviews: semi-structured or life-history interview that have been transcribed, with written informed consent.*

** **WI**; written interviews: semi-structured or unstructured interview that have been precisely reported, with written or verbal consent.*

** **SN**; sketched notes: post-field notes, used only when the maximum degree of fidelity with the original words could be provided.*

****PR;** paraphrased interviews: post-field notes of informal chats, used when the degree of fidelity could not be provided.*

The author translated all interviews from Italian.

The name of participants has been changed to protect their privacy.

INTERVIEWEES	BASIC INFO	CHAPTER	TYPE OF INTERVIEWS	FIELD
Rojita	40s woman - patient	6	Semi-structured –TI, WI, SN	Sansovino
Alberto	Mid 60s man - patient	6	Semi-structured – TI, SN	Sansovino
Ubaldo	Mid 50s man - patient	6	Semi-structured – TI	Lecce A
Crystal	60s woman - patient	6	Semi-structured – TI, SN	Lecce B
Alcin	Mid 50s man - patient	6	Semi-structured –TI, WI, SN	Crevacuore
Giovanni	Mid 50s man - patient	6	Life-history interview - WI	Orta
Giuliano	60s man - patient	6	Life-history interview - WI	Lecce B
Ugo	50s man - patient	6	Life-history interview - WI	Lecce A
Adriano	70s man - patient	6	Informal chats - SN	Lecce A
Enzo	50s man- patient	6	Informal chats - SN	Orta

Anna	30s F - educator	5	Semi-structured – TI, SN	Team Regina
Luisa	50s F - educator	5	Semi-structured – TI, SN	Team Orta
Alessandro	40s M - educator	4, 5	Informal chats – SN	Team Orta
Livia	40s F - OSS	5	Semi-structured – TI, SN	Team Regina
Noa	50s F – Oss (educator)	5	Informal chats – SN	Team Orta
Aldo	50s M - Oss	5	Informal chats – SN	Team Regina
Elia	40s F - Oss	5	Informal chats – SN	Team Orta
Nadia	Mid 20s F - TRP	5	Informal chats – SN	Team Regina
Coordinator A	40s M – TRP / coordinator A	5	Informal chat - SN	Zenith Residential services
Igor	30s M –SW/coordinator B	5	Walking interviews – WI	
Dr. Public	40s F - Psychiatrist	3	Informal chats – WI	CSM - C.so Francia
Dr. Private	50s M - Psychiatrist	3, 5	Informal chats – WI	Self-employed
C. Corbascio	Psychiatrist	4	Life-history interview - TI	Oral History School
A. Crosignani	Psychiatrist	4	Life-history interview - TI	Oral History School
M. Luciano	Psychiatrist	4	Life-history interview - TI	Oral History School
L. Maffi	Ex member	4	Life-history interview - TI	Oral History School
AD	Educator	4	Life-history interview - TI	Oral History School

2| RESEARCHING AND REPRESENTING MADNESS

2.1| MAD GAZE

As mentioned in Chapter 1, Mad Studies arouse at the end of the new Millennium because of a feeling of frustration over a lack of direct representation of psychiatrised bodies (Ingram, 2016). Although built on the theoretical and practical work of radical, feminist and critical practitioners that have recognised the oppressive nature of psychiatric practices, Mad scholars claim that a knowledge that forgets to include psychiatrised voices is built on an epistemological and methodological lens that conceals the discriminatory power of ableism and sanism (Poole et al., 2012). Even in the process of letting the mad speak, is possible to glimpse the permissive nature of the gesture - granted temporarily, as long as it is deemed appropriate. As Basaglia himself admitted

(Basaglia, 1968), the act of letting the patients being themselves often became a simple reshaping of the same power dynamics that they were attempting to dismantle. Although narrative and autoethnographic approaches are to some extent a prerequisite, there are no specifically recommended methods for conducting Mad Studies. The precondition is to examine the factors that contribute to shaping mad subjectivities from a perspective other than the normative ones. Perspectives which, whether one likes it or not, base everything on the rational/irrational, normal/abnormal dichotomy (Canguilhem, 1996). This requires an ontological reversal, with obvious epistemological and methodological implications, that looks at rationality and normality as something fluid, unstable and, above all, devoid of any superiority - except a statistical one.

I started my Phd with the idea of legitimatising knowledge produced by the mad and of looking at the institutions that treat them, through a mad gaze. Unfortunately, I have now realised that an internalised sanism (see Chapter 2) was constantly at play within myself and also among study participants, in a way I was not aware of. I am still far from a maddening process of academic research, despite recognising its revolutionary potential. I have been diagnosed with bipolar disorder, but I have spent much more time in equilibrium than in manic or depressive phases. This makes me partially function in this society, at the cost of not knowing what else I might be or what is behind my symptoms. It is not difficult or painful for me to call myself mad, but at the time of writing I am definitively not. Unless the mere fact of being in psychiatric care makes me so. I am temporarily sane; I am aware of the risk of getting mad and I am not that scared of getting manic because I have acquired the tools for getting back in my current and socially accepted box. However, I still struggle daily to keep the pendulum in the middle of the two poles. This represents an unpaid daily work often invisible to those deemed "normal people". While many health conditions involve forms of invisible labor, in the case of mental distress this work is often compounded by social stigma, institutional control, and normative expectations of emotional and cognitive performance. As Foucault (2003) suggests in his discussion of *the abnormal*, this labour is not just medical but deeply political, tied to broader mechanisms of normalization and exclusion. Although I no longer judge my extreme ups and downs, I take stabilisers, anxiolytics, antidepressants, I do psychotherapy. All signs of an internalised sanism that in spite of the best intentions has marked my PhD research. Notwithstanding, I believe that this awareness is in any case instrumental for the paradigm shift Mad Studies advocate for, making my research lie within that field. With this in mind, I started looking for semi-institutionalised settings where I could encounter psychiatric patients to involve in the research, exploring a variety of options. In the next sections, I will introduce “my personal journey” across the mental health system in Turin and the rationale behind the identification of its “boundaries”. After listing all methods used, I will discuss how I engaged with them, pointing out to what extent my ethical concerns shaped my fieldwork, in both theoretical and practical terms.

2.2| CRAFTING THE FIELDWORK

Once Turin was chosen as the context of reference, I explored a variety of sites and institutions belonging to the public, cooperative or voluntary sector. Aware that it would not be easy to gain access as a researcher at some of these institutions, I wanted to look at different options and have an alternative plan in case something went wrong. The fieldwork was then divided in two phases, further subdivided into different stages, accordingly to contexts or methods used. The first phase included a speculative investigation, with site-visits of past and present geographies of mental health care, followed by the identification of institutions willing to accept volunteers. In parallel, as a volunteer member, I helped archiving and titling the documents kept in the Centre “Maria Luisa Bedogni Valletti” [22] at the Associazione per la lotta contro le malattie mentali (ALMM). This work, along with attending the Oral History School (in May 2023) on the process of deinstitutionalization in Turin helped me to reconstruct the historical framework and to gain a place-specific understanding of the events surrounding the psychiatric reform (as explored in chapter in Chapter 3).

The main ethnographic study was carried out, over a period of 8 months, with a local cooperative called Zenith in its residential facilities located in Northwest Turin. There, I shadowed a member of the staff during their regular shifts and participated to weekly staff meetings, since January to September 2023. During my observations, I engaged in informal conversations and established relationships with both patients and workers. From this group, I selected 10 individuals to interview in a more structured manner (see Chapter 4 & 5). Transversally, my own experience as a psychiatric patient implicitly shaped - for better or for worse - every choice I made and every interaction I had in the field. The autoethnographic elements woven throughout the thesis are not mere illustrative anecdotes or detached emotional recalls, but methodological tools that allow for critical reflection on the epistemic affordances and limitations of being "mad" while studying madness. Writing

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[22] https://almm.it/attivita/centro-documentazione-maria-luisa-bedogni-valletti/

and thinking autoethnographically forms the backbone of this approach, not only to reflect on my positionality but also to question the relational dynamics between myself and others in the field. While I was a member of the group I was studying, my own case is not presented as especially emblematic in comparison to other participants, rather, it is one case among many, offering insight while remaining situated and partial. If I represent anything, it is the privilege of belonging to a social class that allowed me to receive long-term private care and financial support when I was not able to work. The cultural environment in which I have been living and working has helped me develop a deeper awareness, gradually freeing me from internalized feelings of shame and stigma. That said, as my father reminded me during a recent conversation, nearly twenty years after my first manic episode, “It wasn’t exactly easy.”

2.3| THE CONTEXT: TURIN

As I have already mentioned, Turin was initially chosen for mere convenience, since I felt the need to be as close as possible to the field over the course of my PhD. I moved to Turin in 2021 but I had the opportunity to visit the first capital of the former Kingdom of Italy three times before that: in 1998, in 2008 and in 2013. At the end of the 90s the image of the city I remember reflected the collective imaginary of the rest of the country: grey and sad, because of its weather and industrial vocation, northernly austere, but with a southern soul due to the massive presence of migrants from the South of Italy. Turin, no longer capital since 1865, at the turn of the new century was asked to reinvent itself and with what is considered the first modern strategical plan ever, decided to become an industrial city[23]. To do so, it had to create the ground for attracting workers from elsewhere and, in the 70s, as one of its mayors, Diego Novelli, used to repeat, it was the “third largest southern Italian city by population after Naples and Palermo" (Ollister, 2018) (Figure 2.1).

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[23] The car manufacturer Fiat was founded in 1899.

Fig. 2.1: (1,2) Stills from the documentary “Torino amara” by Gino Brignolo (1963); (3) Factory FIAT in Mirafiori, 1957. Source: Archivio Storico Fiat.

I went there again in 2008, when, named World design capital of the year, Turin was enjoying the benefits of the well planned and organised winter Olympic games of 2006; thanks to that international event the FIAT’s city could implement several actions, identified at the end of the 90s in a forward-looking strategic plan (Turin 2000), and offer to the world the image of an elegant, creative, recreational and welcoming destination (Ave, 2004). That couple of years represented a real watershed: its citizens started to appreciate their own city while the rest of the country begun to consider Turin differently. In 2013, within the Regional and Urban planning studies programme at the London School of Economics, we organised two fieldtrips, one in Manchester and one in Turin. Two European examples of industrial past, post-industrial crisis and planned urban regeneration, abruptly interrupted by the global financial crisis of 2008 [24]. The comparison with my previous visit was inevitable: some buildings refurbished during the Olympics were abandoned or badly used, representing the material expression of this unfinished renaissance. Many of my classmates, although surprised by its beauty, diversity and complexity, noticed the lack of vocation and the worthlessness of a competitive approach with Milan, compared to which a feeling of inferiority and jealousy appeared to remain, although veiled by a blasé attitude of French legacy. An aspect that some of my classmates made me notice was the interesting mix of sophistication and simplicity in the architecture, in the cuisine and in the people too. In terms of landscape, they really enjoyed the extensive presence of urban green areas, the very much lived river Po, the hill, and the Alps as a background. The invasive and ubiquitous presence of the car was identified as a major issue, especially given the relatively small size of the city; the public transport underutilized and mainly by migrants. Overall, almost all of us, thought Turin was an interesting, vibrant, and pleasant place to live in (Figure 2.2).

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[24] https://www.lse.ac.uk/geography-and-environment/assets/documents/rups-newsletter-29.pdf

Fig.2.2: Turin, RUPS fieldtrip, 2014.

2.4| MENTAL HEALTH SYSTEM IN TURIN: HOW I APPROACHED IT.

Eventually, I moved to Turin for my Phd in October 2021, with little more than this knowledge - fruit of stereotypes, impressions, and second-hand sources. Regarding the history of psychiatric institutions there, I only knew about an asylum located in Collegno, at the outskirt of the city[25]. I soon discovered that the asylum complex in Turin was one of the biggest in the country and the presence of so many labour migrants was indissolubly related to that (Equipe Psichiatria di Settimo Torinese, 1978; Cardano et al., 2018). In medical

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[25] This due to two nationally famous episodes linked to that place: the ‘20s news story of the so-called “amnesiac man from Collegno”, a man hospitalised with apparent lack of memory about his identity (but claimed by two different families) and the first torture trial against a psychiatrist, Giorgio Coda, who worked there since the 50sThe case became so famous that it is still used all over Italy as an epithet for a dubious forgetfulness. Both episodes were depicted in two rather popular films: Lo Smemorato di Collegno, by Sergio Cobucci (1962) and “La meglio gioventù” by Marco Tullio Giordana (2003).

reports, one can find many diagnoses where “city life patterns”, “distance from the family”, “nostalgia”, “different cultural models”, “work rhythms” are identified as causes or triggers of mental illness (Source: AOPT)[26]. Among the hospitalised migrants there were many single women that worked as housekeepers and ended up there because of abuse, mistreatment, and lack of a support network. Very long is the list of women whose only fault was that of being adulterous, libertine, lesbian or more simply in someone’s way (Bertolo, 2021). The asylum “treated” also many forms of disability and neurodiversity, unrelated to psychiatric diseases; many people, perfectly healthy, spent years, often until their death, to “atone” for the guilt of being poor, gay, adulterous, or simply unwanted - as a child, wife, brother, parent, employee, neighbours (ALMM, 1971).

By law you could have ended up in an asylum for being “dangerous to self and others and of public scandal” (Art.1, Law 36, February 1904)[27]. It is not difficult to imagine how easily unconventional or unwanted behaviours could fall under the umbrella of public outrage. Physical disability, neurodiversity, homosexuality, mere revenge, inheritance issues, lack of economic resources, ignorance could all be reasons behind lifetime internment. As it was made obvious by radical psychiatrists in the 60s, psychiatric diagnosis and internment were often the result of discretionary practices and, if madness was not present in the first place, it would have developed and made chronic by the institution itself (Goffman, 1961; Basaglia, 1968). All these pieces of information have emerged from both archival research and the accounts of those who worked in Turin asylums before or around the time of its definitive closure. Accounts collected in books, documentaries, blogs, but above all through group life-history interviews conducted during the Oral History School, when, retired psychiatrists, nurses, social workers, educators, activists, representatives of historical cooperatives, reconstructed their personal memories of that period.

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[26] Source: Archive Ospedali psichiatrici di Torino, 1685 -1987 (AOPT). Carte da legare, archivi della Psichiatria in Italia: https://cartedalegare.cultura.gov.it/home?navId=0&cHash=b2afc9b67faad48ce4d73189b048b398
There was also a rather big number of Sardinians, sent to asylums in Turin when there was no availability in those of the island (Cagliari and Sassari). Archivio Storico Rizzeddu Sassari, (ASRiSS)

[27] First national law on mental health care. Among other things the Law makes mandatory for every Italian Provinces to take care of the "mentally ill" by building hospitals.
https://cartedalegare.cultura.gov.it/fileadmin/redazione/Materiali/Legge_14_febbraio_1904.pdf

Moreover, to get a more place-specific understanding of past and present mental health system of the city I started a twofold speculative investigation. In the first place, I visited all the asylums in the city and in its outskirts (Figure 2.3), I gathered background information about their opening and gradual closure and, finally, I looked for local archives that could help me trace the history of deinstitutionalization from a less institutional angle - finding in the one kept by ALMM the ideal source.

ASYLUM COMPLEX IN TURIN (1729 – 1999)

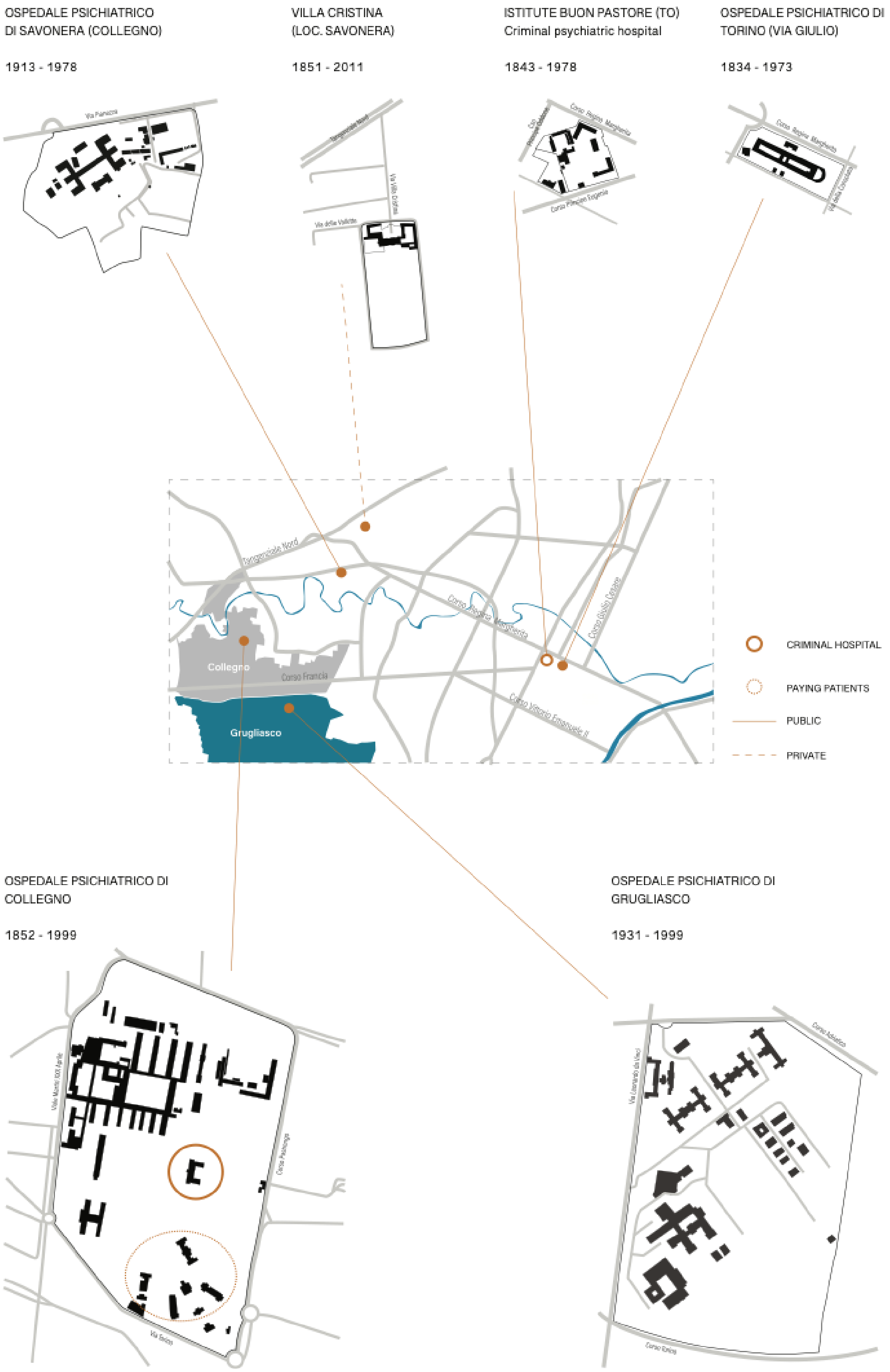

Fig. 2.3: Plans of the main psychiatric institutions of Turin. Elaboration of the author from the material provided by the Dipartimento di Studi Storici for the Oral History School.

Turin had 6 asylums ('Spedale de'pazzerelli, Via Giulio, Collegno, Grugliasco, Savonera, Istituto Buon Pastore). The 'Spedale de' pazzarelli (fools' hospital) was one of the oldest institutions in the country, built in 1729, it was placed in the city centre between Via Piave and Via San Domenico, on the land donated by the King to a Catholic confraternity (Ss. Sudarium and Blessed Virgin), that still owns the building; now among other things it is home to two voluntary associations that provide support to psychiatric patients (Casa Bordino) and their families (DIAPSI). The *'Spedale* housed around 100 patients; because of its limited capacity, it was replaced in 1836 by the Regio Manicomio (Royal Asylum) placed in the same area. The asylum of Via Giulio, as everyone used to call it, despite having a maximum capacity of 400 beds, accommodated up to 500 patients. After the Charterhouse of Collegno was converted into an asylum and expanded, Via Giulio was designed for women only. Today the seat of municipal offices, it was the first psychiatric institution to open its gates to the patients, with the establishment of a therapeutic community; it definitively closed in 1973. In Collegno, what has been an architectural model for many other Italian asylums, 2/3 storey-pavilions accommodated up to 5700 patients. In Savonera, the wards were intended for women with less serious conditions and treated with occupational therapy. Meanwhile, in Grugliasco, there was a self-contained citadel of 1500 people, including staff, with a ward specifically dedicated to children called Villa Azzurra. To these must be added private clinics (ex: Villa Cristina, Istituto Buon Pastore) and villas within Collegno intended for paying patients.

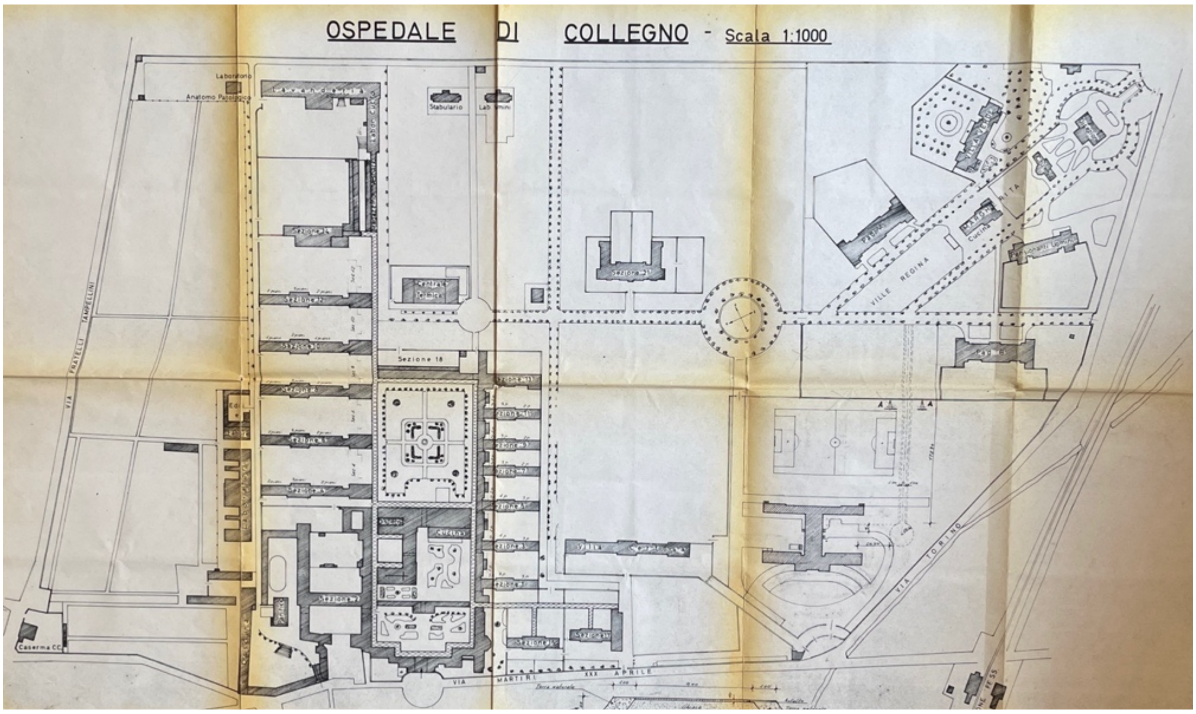

Figure 2.4: Plan of the asylum of Collegno. 418,000 sqm. Covered area: 44,300 sqm. Max accommodation capacity: 4000 beds. At top centre (Section 21) the criminals' ward, at the top right-hand corner, together with Director's offices, church, the kitchen, "villas" for paying patients or with insurance. Source: Archive ALMM.

In parallel, as a beneficiary of bipolar disorder, PhD student and taxpayer I explored what public mental health services I was entitled to[28]. As described in the following autoethnographic vignette (2.2.1), the attempt to get access to NHS was successful and quicker than I thought; thanks to some tips received from ALMM members, instead of passing through the general practitioner, having already a certified diagnosis and a fixed residency, I directly went to the Centro di Salute Mentale (CSM, centre for mental health), what is considered the local clinic for psychiatric issues (for more details on the structure of the mental health system in Italy check Chapter 4).

2.2.1 AUTOETHNOGRAPHIC VIGNETTE N.1

In the first place, you are assigned to a CSM based on your place of residence and I was lucky enough to get the CSM located in Corso Francia[29] *which, according to both patients and staff, is considered one of the best, in terms of efficiency and courtesy. Located between two relatively wealthy neighborhoods, Cit Turin and the southern part of San Donato, and not far from the station of Port Susa, it has a fairly affluent "catchment area"*[30]*. Not far from square Bernini, you can access the Centre after ringing the doorbell, passing through two doors and introducing yourself to a lady for the so-called triage: there you will be asked whether you have got an appointment, the reason of your visit and if you got any flu symptoms (covid legacy). All innocent and legitimate questions but that do not take into consideration a very simple aspect: if you do not have already an appointment you are there to ask for help for yourself or a third party, with respect to something that you are most likely ashamed of and you cannot really explain. Sometimes what is missing is even just the right*

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[28] In parallel, I looked for a private psychiatrist who charged me 70 euros/hour, below the average price in the city, which ranges from 80 to 120 euros. He recommended to get a psychologist too, that after 2 months of weekly individual sessions, at a cost of 60 euros, offered me to join a group therapy, for the modest sum of 180 euros/month.

[29] https://www.aslcittaditorino.it/sedi/centro-di-salute-mentale-c-so-francia/

[30] Consideration made being aware of the fabric and the real estate values of the area but that has been confirmed by my empirical data: the only three patients that have their psychiatrist in Corso Francia were the ones with a family belonging to the upper middle class (see Chapter 5).

vocabulary. As a person with a 10-year-old diagnosis, under pharmacological treatment, seemingly in "balance" and there mainly for research reasons, I should have found this first access a mere formality. However, I walked around the block twice before ringing, I hesitated to step across the threshold, and I found myself stammering "I would like an appointment with a psychiatrist" with more effort than I had imagined. The second lady I had to talk to at the entrance was more welcoming and less outspoken. After listening to me and checking the documentation, she confirmed I had the right to get a psychiatric there and, after a look at the agenda, gave me an appointment with a psychiatrist in a month (by paying a fee of 20 euro). It was easy and fast; I wondered why being so suspicious about the public sector. The fact I knew the procedure, what I was looking for and how to express it, helped and it definitively constitutes a discriminating factor[31].

I was very curious and hopeful about my first appointment, although I was not so sure about leaving my private psychiatrist. After passing through the same procedure, they let me sit in the waiting room. Chairs are kept far away from each other. I wondered why my parents never approached the public sector for my psychiatric issues. Beyond a general mistrust about public psychiatry which must be recorded, and I reckon is common in wealthier classes, I wonder if one of the issues was also to sit in a place like that, so exposed to judgement and shame, seeing mad people like me and being seen by relatives like them. In my first psychiatrist's office, there was a "door game" that prevented from meeting patients from previous or subsequent sessions. In the fee it was somehow included your privacy. The waiting room is nice for being a public health service, there are plants, some drawings on the wall, antique furniture, it is bright. From time to time groups of three or four ladies walk briskly, occasionally greeting some patient. You can tell they are members of staff, presumably psychiatrists or

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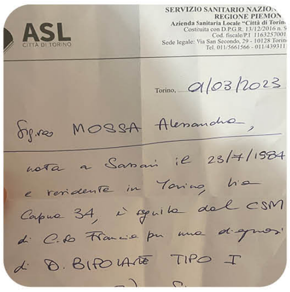
[31] I later discovered that changing the psychiatrist, unless one changes the residence and the CSM associated with it, (the doctor moves/retires), is very difficult and not particularly well regarded.

educators, mainly by the confidence and haste of their walk and by their smiles. During my visits, I met just a man among the staff. The psychiatrist, a lady on her mid-forties, with 20 minutes of delay called me and asked to follow her in an office where, behind a desk, invited me to explain again the reason of my visit. Something that distinguishes a psychiatrist from a psychologist/psychotherapist is definitively the desk, used as a partition and likely to signify scientificity, professionalism, formality, a physical and human distance. The visit was instrumental to get the so-called 044, an exemption for psychiatric sessions at the CSM, drugs and tests related to the disease. To persuade me to make the request she highlighted the fact that only my GP and the pharmacists could have known. I wonder why for 15 years my doctor was more concerned about my pharmacists' opinion than my finances.


ASL
CITTÀ DI TORINO

SERVIZIO SANITARIO NAZIO
REGIONE PIEMON
Azienda Sanitaria Locale "Città di Torin
Costituita con D.P.G.R. 13/12/2016 n. 9
Cod. fiscale/P.I 1163257001
Sede legale: Via San Secondo, 29 - 10128 Torin
Tel. 011/5661566 - 011/439311

Torino, 01/03/2023

Sig.ra MOSSA Alessandra,
nata a Sassari il 23/7/1984
e residente in Torino, via
Capua 34, è seguita dal CSM
di C.so Francia per una diagnosi
di D. BIPOLARE TIPO I

She soon realized I was not as mad, or not mad anymore, or not mad at the moment; she repeated twice that after a shift in prison and a section with a bipolar guy "Really out of mind" with me she was resting. As much as it helps to know that there are people who are worse off, it was natural for me to minimize my issues or perceiving in her little interest. The private psychiatrist's attention and concern looked more heartfelt, or at least better performed. After all, Dr Public has at least 150 patients, of which many live in prison or in psychiatric residential facilities or, more simply, are less privileged, less educated, less aware of their illness. I started wondering if I was stealing time and space to these people and how useful would have been for me to share my white middle-class problems to a white middle-class woman that did not think my problems deserved particular concern. I have kept going there every 3 or 4 months, just for double-checking my private psychiatrist's decisions and conduct a regular undercover observation in the waiting room.

Thanks to my status, in the attempt to define the limits of my fieldwork and find a case to explore deeper, I also visited two Day Care Centres (DCs), an occupational laboratory (Itaca) and a series of voluntary organizations (Casa Bordino, DIAPSI, Associazione Arcobaleno, IlBandolo). Knocking to some of these doors was not as successful. People that welcomed me were in part surprised of my requests, even of my presence, and always sent me back to other bodies or associations. I thus discovered that the right to attend activities in DCs and occupational labs requires to be granted by the CSM psychiatrist. I often heard the words *"they work in the territory"* that resonated as *"they are never here*", making the concept of "territory" elusive and mysterious.

As anticipated in the introduction, while I was not feeling well, I mainly stayed with my parents, with the unexpressed, and also unspeakable, desire to be treated elsewhere - by strangers and surrounded by people like me[32]. I therefore maintained a certain interest about what was available in terms of residential facilities. From therapeutic communities that, looking at their websites and reviews, ranged from decadent to luxurious hospices, to the seemingly more human reality of group homes. My initial research questions were rather simple: what has replaced the asylum? Where do individuals without family or financial support go? What happens if your family is the toxic environment you need to be kept away from? How do these spaces look and to what extent they differ from an asylum After a discussion with my private psychiatrist, on the basis of potential psychological repercussions on me and the concrete possibility of entering into some of these facilities, we decided to opt for the last step of the psychiatric residential ladder: the SRP3.2[33] known as *Gruppo Appartamento* (GA, group home) with 6- or 12-hour coverage (low or medium intensity). Before I started the search, he told me "Also, do not delude yourself…many people are just parked there" (Dr Private, January, 2023; visit, TC)[34].

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[32] Right after my first manic episode I spent 10 days at the hospital for gynecological issues, I remember these days as the best of the recovery and the periods spent at the hospital, if brief, are often remembered with a degree of nostalgia by other patients too (see chapter 5).

[33] SRP3, Servizi Residenziali Psichiatrici a media e bassa intensità: Psychiatric Residential Services - medium-intensity

[34] Every single time I met my doctor, we talked about my fieldwork and my research in general. He often shared his point of view or his personal experience on what I was reporting to him. Having spent a lot of time in a variety of residential facilities, including flat homes, his insights were very interesting and useful, I therefore, consider his contribution to this research essential.

I therefore started to look for cooperatives, with whom I had no ties whatsoever, that, on behalf of the public sector, where running group homes in the city. I picked three that accepted volunteers within their services. Two of them, replied inviting me to have a speculative chat with some members of the staff. While the first cooperative offered me to visit one of their "group homes", having a small office within the flat, the second one welcomed me at their headquarter. I came out of these two meetings with different vibes. At the Coop A the educator I had the meeting with was nice, but I did not really like the way she described her patients, depicted as unfortunate children. I managed to speak just with a middle-aged patient, guest of the cooperative since 2011. I perceived immobility and disillusionment, and the Group home did not really look like a home but rather as an inn, inhabited by ghosts that were either lying on the bed or fleeing away. The first meeting at Zenith was much more formal. I met with two women, not directly involved in the residential services but responsible for volunteering. They introduced me the cooperative, asked me to explain my research and promised to explore the possibility of getting me in touch with the coordinator of all the group homes. I could perceive both cooperatives were understandably skeptical about my presence within the service, but while Coop A did not contact me again, the coordinator of Coop B offered to meet to explore a potential collaboration. She began the conversation by saying that she had "*doubts about the possibility of carrying out meaningful research within the service*" (Coordinator A., November 2022, WI). However, once she had heard more about my project, my intensions, the ethics that would have guided them and, above all, that I had a diagnosis too, she saw the potential benefits that my involvement could bring for both patients and staff; she saw me more as an "*expert by experience*" than a researcher. After 2 staff meetings with one of the three teams that run the service, at the end of January I started my shifts within the flats (Chapter 4,5).

3| MULTI-SITED AND MULTI-METHODS ETHNOGRAPHY

As stated above, to avoid the risk of not being able to access certain settings, I explored multiple paths and a variety of methods, that, as I will explain later, I increasingly simplified and streamlined for both practical and ethical (Verhallen, 2016). As Denzin and Lincoln specify, “*qualitative research is inherently multi-methods in focus*” (2005, p. 5) and I have never privileged a particular methodology over another or considered a method always applicable. As Denzin and Lincoln (Denzin & Lincoln, 2005) I intend qualitative research as a series of partial and practical attempts social scientists adopt to interpret realities; attempts by which a montage of subjectively constructed meanings can be created - with the intent of making visible, coherent and meaningful a particular phenomenon or a minority voice. This through a diversified and continuous process of assembling, layering and hybridisation of methods thanks to which individual and collective narratives become an open-ended story left to multiple understandings. This multiplicity of narratives, despite their potential contradictions, serve to diversify and prevents us from having a univocal storyline, whose risks have been well mapped out by the black and indigenous literature from which Mad Studies have drawn inspiration (Adichie, 2009; Slowey, 2021).

While the historical analysis was a mix of archive research and interviews to professionals in neutral places, my main ethnographic analysis at Zenith involved participant observation and interviews to psychiatric patients and workers, in what served as a temporary home for some and a workplace for others. In addition to that, I had to deal with an archipelago of micro-geographies, institutions and organisations. Being the reflection of the dispersion and fragmentation produced by the psychiatric reform, although limited to a specific district (North-west Turin), my fieldwork was, as Marcus (1995) called it, multi-sited. It was constituted by the micro cosmos kitchens, balconies, waiting rooms, parks, coffeeshops and their surroundings; all linked together by the flux of staff members' shifts and intertwined with other areas to which participants were, in a way or in another, related. The *multi-sitedness* here does not consist in the attempt of linking the local to the global or to make a comparison study between very distant places (Marcus, 1995) but it defines the constituent element of the fieldwork, made of nodes, relational spaces, and movements (Candea, 2007)**.** The apparent thinness and superficiality of conducting a multi-sited ethnography, is therefore compensated by the punctual thickness reached at the scale of the flat and at the level of the individual (Bourlessas, 2023). The field has not therefore been conceived as a fixed and locally bounded entity but rather as a co-constructed site and method itself, constantly made rather than found (Gupta & Ferguson, 1997).

To sum up, the core of my methodological approach was a multi-method and multi-sited ethnographic fieldwork conducted across a series of geographies of mental health practices in Turin: it involved several stages that, through archive research, long-term participant observation, interviews and brief autoethnographic accounts have helped to understand better the *status quo* of the mental health system in the city. The combined use of this set of methods, analysed in more detail below, makes the methodology of this study innovative and able to fill the gaps of the current literature. In the following sections I will focus on every method chosen describing the context in which they were used, the usefulness (or necessity) of adopting them, and, finally, the difficulties encountered.

3.1| ARCHIVE RESEARCH AT ASSOCIAZIONE PER LA LOTTA CONTRO LE MALATTIE MENTALI (ALMM) [35]

The Associazione per la Lotta contro le Malattie Mentali (ALMM) was founded in Turin in 1967, in the wake of the experiments initiated in Gorizia by Franco Basaglia and his team. The association was founded by the psychotherapist Piera Piatti, close friend of Franco Basaglia and his wife as well as co-writer Franca Ongaro, co-founders of Psichiatria Democratica[36]. Since its foundation, ALMM has carried out awareness raising work that, starting from a Marxist analysis, denounced the repressive nature of the asylum system in the city and contributed to the gradual dismantling of the traditional psychiatric institution. As the name of the association recalls, madness was seen as the result of this oppressive model and its dismantling was then part of the fight against the very idea of insanity, at least as it was meant at the time. As we will see in Chapter 3 the process of deinstitutionalisation in Turin differed from the cases of Gorizia, Trieste and other Italian realities invested by the Basaglian diaspora. Its history is little known and this, as Davide Lasagno points out (2012), was probably due to the absence of a real leader. An absence that has unfairly contributed to obscure the relevance and scope of the Turin experience. While not wishing to underestimate the contribution made by some doctors, nurses, social workers and local politicians, the psychiatric reform in Turin was mainly promoted outside the walls of the institutions. It was a grassroots movement that, in the wake of the claims of the 1960s, saw ALMM playing a coordinating, guiding and supporting role for both patients and their families (see Chapter 3).

The long history of ALMM and the recognition of the role it has played, and still plays today, in the Turin area is well represented by the wealth of archival material that the association holds[37]. The association's headquarters houses a Documentation Centre[38] set up in the 1980s to combine research and dissemination work with practical support activities. Its archive contains documents produced or collected by its members from 1968 to the present day. Most of the material concerns studies and reports on the application of Law 180, but also the

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[35] Association for the fight against mental illness. https://almm.it/

[36] Psichiatria Democratica (Democratic Psychiatry) is a movement founded in 1973 to liberate psychiatric patients from segregation.

[37] https://archivi.polodel900.it/scheda/oai:polo900.it:249239_associazione-lotta-contro-le-malattie-mentali-almm-onlus

[38] https://almm.it/attivita/centro-documentazione-maria-luisa-bedogni-valletti/.

dense correspondence that former internees of psychiatric institutions had with ALMM in the early 1970s, as well as the reports of the "Protection Commission". The reports on the state of mental health care facilities are enriched by accounts of inspections, testimonies, correspondence with patients, families, staff, institutions and associations.

Through ALMM, I have therefore got access to one of the richest archives dedicated to the process of deinstitutionalization in Italy. The archive research helped to trace the transition occurred since the psychiatric reform and assess the current situation, both at the national and regional level. Working at ALMM, seen their historical role as coordinator of other mental health charities and organizations, also served to explore the functioning of the voluntary sector at the urban level. There, I volunteered on a project called "Memorie che curano/memorie da curare" led by Daniela Adorni and Davide Tabor, from the Department of History at Unito that involved a variety of associations and cooperatives that agreed to systematise and share their own archives[39]. The archive research conducted at ALMM allowed to build up a wider picture about the process of deinstitutionalization in Turin through the analysis of unpublished material produced by members of the association since 1968. Spending time at their office has also offered me the opportunity to talk to psychologists and psychotherapists, while observing their activities, hear their stories, listening to their concerns.

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[39] Il bandolo, Il margine, Associazione Arcobaleno, Diapsi, Casa Bordino, Cooperativa Muret.

3.2| ORAL HISTORY SUMMER SCHOOL

Fig. 3.1: Poster of the event. Picture by Renzo Miglio, 70s

As a member of ALMM, I attended a summer school of oral History run by the Department of Historical Studies of the University of Turin that took place in May 2023 between Turin and Collegno, titled: "*Riprendere/Restituire la parola*" (resume/return the voice)[40]. Beyond offering me the opportunity to meet and listen to protagonists and witnesses of the application of the reform, this course provided me with a different methodological approach useful for the use and analysis of life-stories narratives. All interviews made during the workshop,

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[40] https://www.dipstudistorici.unito.it/do/avvisi.pl/Show?_id=ox5y

(often walking interviews) were conducted by groups of 5/6 people and lasted around 90 minutes. The recordings were all uploaded online to make them accessible to all the participants of the school. I therefore thank the organisers of the school, Prof. Daniela Adorni and Dr. Davide Tabor, the interviewees, all the cooperatives that supported the initiative and AISO (Italian association of Oral History)[41], for the opportunity of being able to use the material produced at the school. I also thank the other participants for all their inputs, questions, curiosities (Table 3.3).

This method, as well as giving access to diverse experiences and to the language, representations and ways in which individuals describe and think about themselves, allows to focus on interconnections between people, ideas, values and happenings. Narratives and life stories are a powerful means through which processes and experiences can be understood, and through which individual experiences can be related to either wider socio-economic or political factors and/or historical change. A great deal of work lies in the process of making sense to these kinds of data: interpreting, "reading" and "working" the story-based data is the most critical aspect of narrative and life story analysis (Cortazzi, 2001). What has been said and how it has been said, how people seek to construct and present their lives, how they make meaning through the telling of their stories. These are just few questions that should lead the interpretative process; process "that entails brooding and reflecting upon mounds of data for long periods of time until 'it makes sense' and "feels right", and key ideas and themes flow from it" (Plummer, 2001, p. 152).

All the interviews were carried-out using a life-history and narrative approach that emphasises participant's subjectivity, as something fluid and interactionally produced. This method wants to move away from a generalisable definite reality or "the biographic illusion", for researching perceptions, performances, and representations (Järvinen, 2000; Miller, 2011). The focus moves then from a historical conception of how representative a story is towards, what a story represents and reveals, the meaning attached to it, how it has been told. Notions of truth, representativeness, external validity are therefore set aside in favour of subjective, situated and experiential knowledge seen as the product and producer of subjectivities. A narrative approach does not consider problematic the idea that a unique, definite, and truthful reality cannot be comprehended in

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[41] https://www.aisoitalia.org/scuola-aiso-restituire-parola-riprendere-parola-torino-collegno/

its totality but prefers to consider the experiential and relational aspect(s) as the purpose of its research (Miller, 2011). Narratives, although, being built around personal and collective memories, are inherently selective, fragmented and partial. However, the memory fallacy and the fictional elements present in a self-representation are not devoid of interest and value: their interpretative and symbolic nature may be more meaningful than historical facts (Cortazzi, 2001). As the Thomas Theorem claims *"If a person believes a situation to be real, it can become real in its consequences*" (Miller, 2011, p. 142) and this is particularly true when dealing with people's perceptions of space in time.

TABLE 3.3

Oral history school: list of interviewees used

INTERVIEWEES	BASIC INFO	CHAPTER	TYPE OF INTERVIEWS
Caterina Corbascio	Psychiatrist	4	Life-history interview - TI
AD	Educator (Collegno)	4	Life-history interview - TI
Annibale Crosignani	Psychiatrist	4	Group Life-history interview - TI
Mario Luciano	Psychiatrist	4	Life-history interview - TI
Lidio Maffi	Ex member ALMM - doctor	4	Life-history interview - TI

3.3| PARTICIPANT OBSERVATION AND INTERVIEWS AT ZENITH

(https://www.cooperativazenith.it/)

As said above, since January 2023 I have conducted participant observation in 7 group homes run by the cooperative Zenith. As can be read in its website, the cooperative Zenith "offers educational, social and welfare services aimed at people with psychiatric disorders, with disabilities, minors, the elderly, and foreign asylum seekers". Funded in 1996, its main objective is to combine care and recovery with the provision of supported housing, as a transitory but necessary step for a gradual rehabilitation of the patients. It runs residential and semi-residential facilities or provides support at the user's place. At the time of my ethnography, the cooperative was also running a series of mental health centres (CSM) on behalf of the public service: members of the staff of Zenith were working as social workers or educators within these services, alongside public psychiatrists of the NHS[42]. With regard to psychiatric residential facilities, the cooperative currently runs 11 flats in Turin (SRP3)[43], with the "accreditation" of the public sector (ASL Città di Torino).

By using participant observation and interviews, I have tried to assess how semi-independent living programs functions in terms of their ability to support individuals' recovery and social inclusion and how users understand, experience, embody, narrate their daily life within this kind of accommodation. This with the intent of exploring processes of place-making and inhabitation enacted by their users. Forms of interaction, relationships and routines put in place to transform or appropriate a place, have been the main object of the study. My observation at Zenith lasted 8 months and involved spending between 4 to 8 hours per day for a maximum of 3 days per week during which I "shadowed" one or two members of the staff in their daily activities, inside and outside the flat (ex: routine visits, grocery, walks, coffee, staff meetings).

Spending time in ordinary conversations and interactions and listening to people in their own terms, challenged my assumptions, in a gradual process of unlearning able to make me better understand events and processes on the ground (Shaw, 2002). Informal interviews collected during participant observation proved to be more genuine, being the fruit of a relationship and more thoughtful questions (Tonkin, 1984). However, I realise not every patient, and neither did part of the staff, was fully aware of why I was there and what I was doing. Doubts and scepticism about my role and my work in the flats that, at times, I shared too, not being completely sure about what was appropriate to ask, say and do. The fear of invading people's space or simply imposing my presence led me to censor my questions and, in some cases, limit the interaction. My mere presence was considered an invasion, let alone the questions. Through time I managed to build up trust with both, even if I did not always succeed. A long-term engagement with them has allowed to shed light on individual perspectives, so rarely explored.

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[42] This is no longer true, as the last tender was won by another cooperative.

[43] SRP3: (Strutture residenziali psichiatriche di tipo 3). Supervised residential units, with a maximum of 5 patients.

and the presence of at least 1 caregiver from 6 to 12 hours per day.

TABLE 3.4:

Zenith's residential services structure. Teams and Gas

	TEAM	WHERE	TYPE	USERS	HOURS of PO
1 COORDINATOR	**Team R**	Via Sansovino; 1st floor	12 H.	4/5 (mixed)	84 h
		Corso Regina; 1st floor	6 H	4 F	12 h
		Corso Lecce; 1st floor	6 H	4 M	48 h
		Via Crecuore; 1st floor	6H	4 F	52 h
	Team O	Corso Lecce; 3rd floor	12 H	5 (mixed)	42 h
		Via Orta; ground floor	6H	3/4 M	30 h
		Via Piria; 2nd floor	6H	3M	0
		Via Fagnano; 3rd floor	12 H	3/4 F	24 h
	Team T	Via Rosselli; 3rd floor	6 H	4 (4M)	6 H (1 shift)
		C.so Palermo; 1st floor	12 H	4 (mixed)	0
		Via Tunisi; ground floor	6H	4 (mixed)	0

Details about the location of the group homes are public and can be found in "la carta dei servizi" (the service charter) of the cooperative at this link: https://www.cooperativazenith.it/index.php/strutture-residenziali-psichiatriche-di-tipo-3/

Among the patients that were not non-cooperative, I selected a sample of 6 people I interviewed more deeply through a semi-structured approach. The number of the sample might appear too small but the nature of their illness, the stigma attached to it, the depth of the interview that my research implied, the constraints due to the limited access to the field and the lack of privacy, made a bigger number unrealistic. Since the beginning I was aware that some of the people that showed interest in participating to the study could change idea or might not feel good enough by the end of the observation period, and so it was. Despite my initial intention was that of collecting only users' testimonies, over the course of the fieldwork I decided to interview 5 members of the staff. Having spent with them so much time and having to some extent experienced the everyday frustration of their job, I felt it was necessary and dutiful to hear their opinion too.

While informal interview followed a narrative and life-history approach, I opted for a semi-structured interview for two reasons: Firstly, I realised that patients would have perceived a life-history interview too similar to therapeutic sessions and to the informal chats we were having on a weekly basis. I wanted to stress that the main interview was something different, an opportunity to talk about their everyday challenges and perceived injustices, not a way to dig in their personal drama. Informal interviews collected during participant observation were more genuine, being them the fruit of a natural interactions and more thoughtful questions. Although some topics were rarely covered through a spontaneous conversations and semi-structured interviews served to cover that. The second reason is linked to the fact that, once I expressed the will to interview few people outside the flat and without the presence of a worker, the cooperative, agreed provided they saw the questions and the ethical forms. This phase was not as straightforward and generated some tensions. While the majority of the staff did not see the problem, some considered the concerns of the cooperative legitimate. This has led to a list of questions that the cooperative may not have found particularly problematic, through something that could be identified as "self-censorship". Self-censorship that has characterised my interactions since the beginning, due to my personal concern on the possibility that some of my comments could have unwanted consequences for the patients (Chapter 5).

Participant observation was carried out then through an extensive immersion into a series of small-scale settings; this with the intent of exploring processes of place-making and inhabitation enacted by their users. The main object of the study were all forms of interaction, relationships and daily practices put in place to transform or appropriate a place. Said that, the type of knowledge that can be gained from participant observation cannot be reduced to a collection of observed activities and informal interviews. The paradoxical nature of participant observation, that sees the researcher as both a participant and an observer, implies the contextual use of different stances and activities that will require an in-depth reflection over insights and knowledge produced. In this method, the body, of both the researcher and the researched, becomes a methodology itself and, to transcend forms of objectification, the "self", in the move towards intersubjectivity, turns into part of the picture observed (Tonkin, 1984; Csordas, 1990). Participant observation is not although a mere voyeuristic practice: observing should be instrumental for learning, revealing, and interpreting meanings, while embodied participation "*as an indeterminate methodical field defined by perceptual experience and mode of presence and engagement with the world*" (Csordas, 1993, p. 12) implies the embodiment of values, behaviours, habits, and subjectivities of the other members. Through participant observation, thanks to a continuous presence in the field, both explicit and tacit knowledge are more likely to be revealed (Crossley, 2007).

3.4| ACCESS TO THE PUBLIC SECTOR AND AUTOETHNOGRAPHIC ACCOUNTS

As already said, part of my ethnographic inquiry was partially drawn on my personal experience as a service user, making my research fall into the body of literature referred to as autoethnography. My attempt to navigate through the public health system here in Turin involved a mix of autoethnography and covert ethnography and served to explore the socio-spatial dynamics co-produced in drop-in centres, waiting rooms, etc. This with the intent to investigate the potential barriers and the nature of the intricated network of spaces dedicated to mental care. Self-narrative approach has become a type of ethnographic research that, despite the criticisms, has been acquiring more and more legitimacy and theoretical grounds (Reed-Danahay, 1997; Ellis, 2004; Ellis et al., 2011; Gariglio & Ellis, 2018). Within this scholarship, "*"evocative and emotional autoethnography"* has so far ruled the roost, to some extent obscuring different approaches, such as the one that I am keen to adopt, defined by Anderson (2006) as "analytical autoethnography". What makes "analytical autoethnography" different is its scope: its purpose is not simply to document personal experience, to provide an "insider's perspective," or to evoke emotional connections with the reader. Rather, the defining characteristic of analytic autoethnography is to use empirical data to gain insight into some broader set of social phenomena. Being the researcher's personal experiences part of the data, but a part, nevertheless. It refers to any ethnographic work in which the researcher is:

- a full member in the research group or setting
- visible as such a member in the field and in the text
- committed to an analytic research agenda focused on improving theoretical understandings of broader social phenomena (L. Anderson, 2006).

Even though an autoethnographic account, if not always evident, is present in each ethnographic research, autoethnography has been blamed to lack rigour, to be self-indulgent and self-absorbed. But more than that, to have lost sight of the other, in other words to have dismissed the ethnographic mandate to make sense of social wider dynamics (Atkinson, 2006). For what concerns my research, the advantage of adopting autoethnography lies in the epistemic privilege that I enjoy and that puts me in the position of accessing and understanding knowledge more deeply and easily. Moreover, my personal insights were used in the attempt of creating a more mutual exchange and trustful relationship with the patients I engaged with. Through the sharing of my personal experience, I positioned myself in a direct dialogue with patients, with the hope to:

1) give something back
2) establish a more equal power dynamic
3) be more able to understand what can be asked/if the person is not willing or able to participate to the research despite the informed consent.

Behind the choice of a particular topic is not rare to find, in a more or less evident way, part of what we are. If we care about something is because it affects us in a way or in another. From time to time, when our experience has something important to add and comes out, implicit autoethnographic approach (Gariglio, 2025) emerges. When your own experience is the meter through which you measure participants' ones, we can definitively talk of autoethnography. The weight to be given to my personal stories was not predefined. As the research progressed, it slowly lost relevance in favour of the material gathered during the observations and the interviews. However, my presence, albeit in the background, is always there, only through the looks of those I interacted with - complicit, compassionate, sometimes judgmental. Also considered the stylistic difficulty of writing autoethnographically, my own voice emerged only when my personal experience of illness had something to add, had clearly modelled the lens through which I interpreted events, or, when having a diagnosis, opened some doors.

Said that, the autoethnographic approach adopted in this research does not stand as one method among others but rather constitutes the overarching methodological and epistemological framework through which the entire study was imagined, developed, and carried out. While in the methodological chapter I distinguish between different techniques—participant observation, interviews, and autobiographical vignettes—I want to clarify that these are not separate tools operating in parallel. Instead, they are integrated components of a broader autoethnographic paradigm, within which my own embodied and situated perspective played a central role.

This resonates with Anderson's (2006) concept of *analytical autoethnography*, in which the researcher's positionality is not only acknowledged but actively used to frame both access to the field and the interpretation of data. My dual position—as a researcher and as someone who has experienced psychiatric care first-hand—shaped every phase of the research process: from how I entered the field, to how relationships were formed, and how meaning was produced. Rather than simply recounting my own story, I have aimed to use personal experience as a methodological entry point into the broader socio-political and spatial dynamics that characterise post-asylum mental health care. In this sense, the autoethnographic approach allowed for a form of inquiry that is both critical and embodied—where knowledge is co-produced through lived experience, affective proximity, and shared vulnerability. My presence in the field, far from being incidental, was fundamental in shaping both the content and the texture of the knowledge that this research was able to generate.

4|ETHICAL CONCERNS

In a more or less explicit form, in a more or less mindful way, researchers are always part of the picture. There is something about them in the topic, in the research questions, in the research design. The epistemological and methodological lens, when not imposed by circumstances, represents the lens through which we look at every phenomenon, and how we interact, react to, interpret what we are studying tells more about us than anything else. Researchers' awareness about their own role in the field has been widely acknowledged and considerations on issues of positionality and reflexivity have become the norm, in almost every qualitative study. This with the risk of becoming a mere tick-box exercise, inevitably followed by one-size fits all solutions. This matter concerns qualitative methodologies in general but tend to be amplified in interactions fruit of a close relationship and/or a long-term participant observation (Plummer, 2001; Miller, 2011). Obvious ethical concerns arise when transparency and reflexivity are dismissed and a thoughtful discussion about the tensions and contradictions related to the use of these techniques cannot be taken for granted or reduced to a mere acknowledgment. Issues of power and subjectification must be continuously questioned and appraised, methods put into questions; this implies considering the relationship between the researcher and the researched as a dynamic co-production. Said that, it is the researcher that takes the ultimate decision, in terms of questions, selection and interpretation of data and this is where the power imbalance lies. Reporting personal narratives or observations is an inherently selective and subjective act through which researchers arbitrary decide what deserves to be heard or, alternatively, hidden and in relation to those dilemmas, the informed consent seems not be always enough (Kvale, 2006). In order to reduce power asymmetries and make a more genuine mutual dialogue I preferred to incentivise informal conversations within the flat rather than single semi-structured interviews. This allowed to put a stress on the contextual nature of social interactions and to "*avoid focusing on the individual in isolation, cut off from relationships with other people"* (Wilkinson, 1999, p. 3). As well as in focus groups, observing patients and workers and stimulating conversations while supporting them in their daily activities had contributed to reduce power hierarchies. This at the cost though of losing control over the direction of the conversation. Moreover, in order to reduce feelings of being observed and "studied" I avoided to take notes or pictures in presence of patients.

Something I reckon it is important for me to consider is that being part of the group I was studying led to build stronger relationships that inevitably created a degree of confidentiality that I would have not reached otherwise. A potential "tyranny of intimacy" and "pseudo-dialogical techniques of manipulation" (Alro & Kristiansen in Kvale, 2006, p. 490) that could push participants to share more that they should or would have done with someone else. A proper form of involuntary manipulation I was aware of and that I could not anticipate but that has unfortunately led me to censor myself, more than other researchers would have done. The fear of being too invasive and to trigger some discomfort led me to wait for them to address certain topics. This extreme caution has probably made 8 months of participant observations not enough and my empirical data less rich that I thought at the beginning. I also avoided to engage the patients in some sort of participative or collaborative practices, such as keeping a diary. Over the course of my fieldwork, I have realised that patients are way too used to obey or to answer to unwanted or unnecessary request. They would have accepted to write a diary perceiving it as an "activity" like the ones they are incentivised to perform in Day Care Centres, and I did not want to reproduce a dynamic of this sort.

Another aspect, when involving people, is how to minimise the extractive nature of your research and to think how to give something back. In this process there is often the risk of building expectations that will turn up not to be realistic (Lancione & Rosa, 2017). Some patients were already happy with the fact I was there as a sort of intermediary figure with which they could complain about life, staff, or other patients. More simply, I was a distraction from the routine or, even better, a distraction for the staff who were less rigid in my presence. For some that was more than enough. As some patients told me, they understood that I was not judging them and that I was not observing what staff is supposed to notice as an alarming sign of imbalance (Rojita, May 2023, TI). Some members of the staff, used me as a "relief valve" or as a "facilitator" - with patients or with the members of the other team. I do not hide the fact that some patients and operators were uncomfortable with my presence. In some cases, I have reduced my interactions with them, decided to exclude some flats from the research, chosen shifts with the ones who considered me a support rather than a nuisance or a distraction. If there were workers that did not like me, I also disliked the *modus operandi* of some of them, or better, the atmosphere generated by that. The same can be said about patients. With some it was very hard to establish a bond and since I did not want to be intrusive or to force anything, with these I eventually gave up. I also decided not to involve further in the research those that it was clear would have expected something back (ex: dating, regular calls, money, etc). I also excluded the flats that were too close to my own, seen the higher risk of meeting patients.

Related to this is the possibility of building friendships or becoming attached to participants. If with some I managed to maintain a certain distance, I admit that I got closer to others, whom I continued to meet even after leaving the fieldwork. Through them I kept hearing stories about dramas, dismissals, love stories, relocations, hospitalizations. These are all things that were said to me in confidence and which, in respect of a different type of relationship, I decided not to report. This unless I was explicitly asked to do so, and third parties were not involved. An exception was made as I thought it was useful and not disrespectful to give an update on the current situation of some.

For what concerns the autoethnographic element of my analysis, further considerations need to be done. There are endemic problems related to this method. Autoethnography leads you to look back in time. It is retroactive and it implies a memory work that is hardly reliable. Writing autoethnographic accounts of self-experience necessarily involves others. "*Every story of the self is a story of relations with others*" (Bochner, 2017, p. 76) and anonymity is much more difficult to maintain. If I talk about my experience as a Phd student, it would not be hard to identify my supervisor, or my doctors, and my parents will be inevitably involved. What is often done is to ask for a retrospective informed consent: you come back and talk with people you decided to involve, and you ask for consent. This practice though could be coercive and may undermine people's autonomy. While my doctors knew about my research since our first meeting, much of my *autoethnographic accounts* are fruit of covert ethnography through which I observed and took notes about people unaware that I was not only a user but also researcher. Ongoing reflection is therefore necessary to consider how to include others in an ethics of research practice that ensures accountability, agency, and care. The potential future vulnerability of individuals should be considered by the researcher and anonymity maintained as much as possible anyway. The guiding principle that has influenced all my decision-making process was the following: I did not write anything that I would not show to the people I mentioned.

Finally, it should be admitted that the mere act of making people speak is not in itself empowering given the fact that academic work "removes the ability to control the dissemination of knowledge" (Parpart, 1999 in Cornwall, 2003, p. 1333). The researcher chooses the questions, the methods, goes away with the data, interpret, and report them without any further discussion (Ennew & Beazley, 2006). Giving voice remains then in the sphere of concessions from above, a step that is necessary and hopefully instrumental to make individuals take their voice and space back but that is not inherently participative or emancipatory.

4.1| DATA MANAGEMENT

Data were collected from participants through interviews and observations. All the participants interviewed were asked to give written informed consent. They were asked to confirm that they received and read the information about the study and if they preferred to maintain anonymity and confidentiality. In any case, with very few exceptions (table 4) the data was anonymised. If they agreed and gave me written consent the interviews were recorded. The records from this study have been kept as confidential as possible. Only I got access to the files and any audio tapes. All digital files, transcripts and summaries were given codes and stored separately from any names or other direct identification of participants. Any hard copies of research information were always kept in locked files.

CHAPTER 4

PLACING THE REFORM

FROM THE ASYLUM TO COMMUNITY CARE

1| INTRODUCTION

As already said, the Italian psychiatric movement was one of the first in the world to initiate a systematic critique of mental health institutions and still represents an essential and inescapable reference for the history of contemporary psychiatry and critical mental health studies, both in practical and theoretical terms (Pivetta, 2012; Foot, 2015; Scull, 2015; Cohen, 2018b). However, the Italian experience has often been reduced to the work of Franco Basaglia in Gorizia and Trieste and to its most obvious, but not unique, achievement: the closure of the asylum - namely, with the passing of a reform law (Law 180/May 13, 1978) which introduced some restrictions to compulsory hospitalizations, the ultimate dismantlement of psychiatric asylums and the contextual set up of community care, on which I will expand later (Basaglia et al., 1987). While Basaglia's influence on the country's institutionalisation and reform process is undeniable, ascribing the entirety of the reform to his work is, to some extent, misleading. Such an interpretation would suggest that Basaglia operated in isolation, that the reform could be reduced to the mere contestation of the institution as a building and that its implementation could be achieved with the simple closure of that architecture. Moreover, this narrative suggests that the whole of Italy has followed the same path. The result of this shared storytelling is that in Italy itself there is little research that critically examines the local implementation of the reform and while telling local stories, the role of space in its material and relational nature is often overlooked, despite the emphasis placed by psychiatric reformers on the inseparable relationship between the two.

As Julia Jones (1996, 2000) highlights, despite the growing interest in mental health geography, few are the studies that question the multifaceted role played by the specificity of a context. The implementation of the reform "*did not occur in a social vacuum*" (Jones, 2000, p. 173); its effectiveness was influenced by several attributes that are place- and time-specific, as well as fruits of political, economic, social and cultural differences. That being said, the story of the Italian reform has been narrated extensively, and the anniversary of the law 180 in 2018 offered the opportunity to expand this literature further by putting on the map a rather rich and diversified set of cases, all across Italy (see the whole Collana 180, by Edizioni Alpha&Beta). As said above, the limit of this scholarship seems to lie though in the scarce relevance and sensitivity given to the socio-spatial specificity of each context (Jones, 1996, 2000), and in the marginal role assigned to patients' experiences.

In the next sections, through a geographical understanding of the process of deinstitutionalisation that took place in the city of Turin, I will fill in these gaps. In the attempt of going beyond the traditional narrative of Italian psychiatric reform, the case of Turin will be told through the analysis of archival material from a grassroots association, still active in the city - Associazione per la Lotta contro le Malattie Mentali (ALMM)[44]. All enriched by a series of interviews conducted in 2023 during a summer school of Oral history[45] (for details on these, see chapter 3 on methodology). All this will serve to expand the narrative of the Italian experience, so far mainly built around the figure of its leader Franco Basaglia. As we will see below, Italian processes of deinstitutionalisation did not always follow a unidirectional path and, however fascinating and simplifying it may be, these cannot be reduced to the direct or exclusive influence of Basaglia and his team. Basaglia himself did not want to offer a universally applicable model, but rather a range of values that asked society to take responsibility over the mentally ill and accept madness as a way of living (Colucci & Vittorio, 2020).

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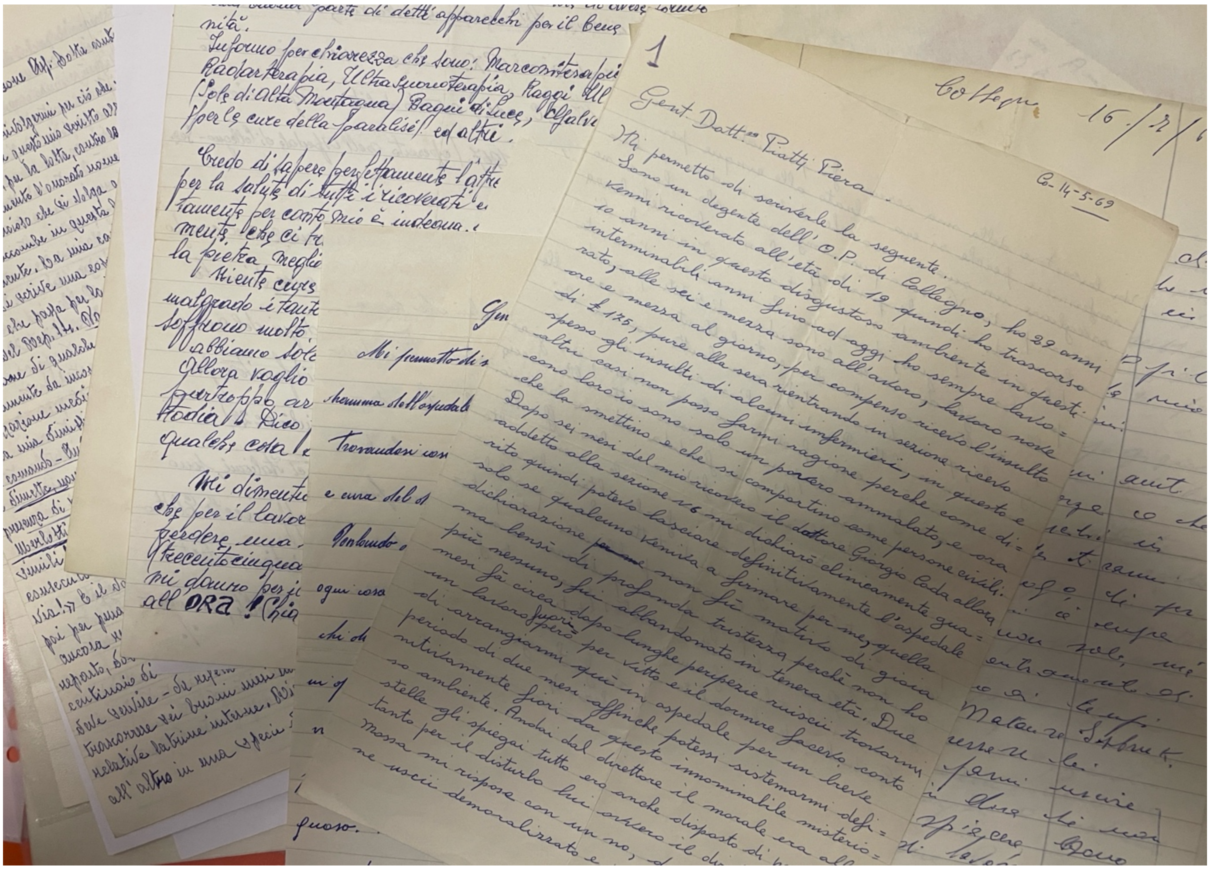
[44] Association for the fight against mental illnesses. Founded in 1967 by Piera Piatti, psychotherapist, community activist and Basaglia's friend. Since its institution, members of ALMM have advocated for the rights of psychiatric patients and their families, playing a constant role in terms of support and advocacy.

[45] https://www.dipstudistorici.unito.it/do/avvisi.pl/Show?_id=ox5y

The specific cases of Trieste and Gorizia, where Basaglia was based, are emblematic but not comprehensive and, as the case of Turin exemplifies, what was revolutionary in the initial transition from the asylum to the network of community-based services was the space and visibility given to the mad and their first-person narratives. Other experiences and practices, being interstitial or simply out of the spotlight, have been unfairly disregarded, despite their meaningful contribution from which we still have to learn. To explore the implementation of the Italian psychiatric reform far from the direct influence of Basaglia, my analysis will focus on the major events that drove the process of deinstitutionalization in Turin between the end of the 60s and the entry into force of the psychiatric reform (Law 180); with the goal of understanding how these events have played out spatially.

The archival research described below made me look at the processes of deinstitutionalization from an unusual angle: the analysis of the material kept at ALMM, including patients' letters, memoirs and testimonies, allowed me to narrate the end of the asylum era through the voices and actions of both patients and ordinary citizens rather than, as it is often the case, through the work and words of psychiatrists and medical staff (Figure 4.1).



parte di detti apparecchi per il bene
nità.
Informo per chiarezza che sono: Marconiterapia,
Radarterapia, Ultrasuonoterapia, Raggi Ul
(Sole di Alta Montagna) Bagni di Luce, Galva
(per le cure della paralisi) ed altri.

Credo di sapere perfettamente l'attre
per la salute di tutti i ricoverati e
tamente per conto mio è indecoroso.

1

Collegno 16/2/6

Gent. Datt.ssa Piatti Piera.

Co-14-5-69

Mi permetto di scriverle la seguente.
Sono un degente dell'O.P. di Collegno, ho 29 anni
venni ricoverato all'età di 19 quindi ho trascorso
10 anni in questo disgustoso ambiente in questi
interminabili anni fino ad oggi ho sempre lavo=
rato, alle sei e mezza sono al lavoro, lavoro nove
ore e mezza al giorno, per compenso ricevo l'insulto
di £ 175, pure alla sera rientrando in sezione ricevo
spesso gli insulti di alcuni infermieri, in questo e
altri casi non posso farmi ragione perche come di=
cono loro io sono solo un povero ammalato, e ora
che la smettino e che si comportino come persone civili.
Dopo sei mesi del mio ricovero il dottore Giorgio Coda allora
addetto alla sezione 16 mi dichiarò clinicamente gua=
rito quindi potevo lasciare definitivamente l'ospedale
solo se qualcuno veniva a firmare per me, quella
dichiarazione ~~per me~~ non fù motivo di gioia
ma bensì di profonda tristezza perchè non ho
più nessuno, fui abbandonato in tenera età. Due
mesi fà circa dopo lunghe peripezie riuscii trovarmi
un lavoro fuori però per vitto e il dormire facevo conto
di arrangiarmi qui in ospedale per un breve
periodo di due mesi affinchè potessi sistemarmi defi=
nitivamente fuori da questo innominabile misterio=
so ambiente. Anche dal direttore il morale era alle
stelle gli spiegai tutto ero anche disposto di
tanto per il disturbo lui avrebbe il
Mossa mi rispose con un no,
ne uscii demoralizzato e

Fig. 4.1: Sample of letters sent to ALMM in 1969. (Archive ALMM)

Through this case I advocate for a return to the Italian experience that, through the lens of Basaglia's radical ideas, could explore the micro-geography of deinstitutionalisation from the perspective of the mad and community members. Stories of grassroots mobilisations, like that of Turin, constitute a learning opportunity and an inspiration for the much alive debate on mental health geography that, in the attempt to rethink post-asylum healthcare, aims to adopt a human and patient-centred approach (McGeachan & Philo, 2017).

Fig. 4.2: Demonstration in front of the asylum in Via Giulio, Turin. Poster made by ALMM: "Asylum = lager; It can happen to you too". Source: ALMM Archive.

2 |THE TOPOLOGY OF THE ITALIAN PSYCHIATRIC REFORM

As seen in Chapter 2, Italian psychiatric reform of the 70s and the approach promoted by its charismatic leader, Franco Basaglia, still represents a milestone in the change of societal and institutional responses to madness in Italy and in many other Western countries, having made dramatic innovations both in terms of space and power dynamics (Burns & Foot, 2020). By questioning the oppressive nature of the psychiatric institution, in both its spatial and relational nature, Basaglia's work was responsible for a substantial change in the institutional topography; with the closure of the asylum, the scattering around of services, as well as in the topology of mental care, with an emphasis on a more balanced relationship between patients and doctors. The anti-institutional movement preceded 1968 but it was able to draw strength from it, by stressing the tight relationship between psychiatry and a wider class struggle. Basaglia's work showed to what extent mental illness and its management pertained power dynamics and, in the attempt of controlling deviant behaviours, assumed political significance. The process of labelling and the identification of mental illness were therefore identified as a tool of control towards disadvantaged classes and a systemic source of discrimination.

> *"The fact that the inmates of our asylums all belonged to a single class, the proletariat and the under-proletariat, bore witness to the existence of a double psychiatry that resorted to different scientific definitions and sanctions, depending on the social and economic status of the patient. In this sense the function of the asylum became clear in an explicit action of containment and control of the elements of social disorder, where the disease played a very marginal role".*
>
> (Basaglia in Colucci & Vittorio, 2020, p. 118; my own translation)

As a director of the asylums of Gorizia and Trieste, in the northeast of Italy, together with a group of doctors, nurses, and social workers, Basaglia started a process of self-reflection that challenged their own role and entire profession. From within their institutions, they publicly denounced the brutality and inefficacy of the confinement of the insane; they questioned the rationale behind their own profession and, by challenging the imbalance of power embedded in the relationship with their patients, they aimed to establish a dialectical approach that helped monitor the potentially detrimental impact of their everyday decisions (Basaglia, 1968; Basaglia et al., 1987; Rovatti, 2013; Cipriano, 2018).

> *"Starting from the needs of the sick person, we try to create around him the living space he needs in order to develop and realise what is the primary assumption of the therapeutic community: the therapeutic power that each member of the community unleashes on the others. The patient, the doctor, the nurse, the administrative staff, everyone in the institution is involved in this task. Everything is geared to a single objective: to create an environment in which it is possible to approach each other in a human relationship which, precisely because it is spontaneous, immediate and reciprocal, becomes therapeutic."*
>
> (Basaglia, 1968, p. 33; my own translation)

> The closure of asylums constituted a revolutionary moment in the history of psychiatry, causing the perception of madness and its institutional response to change profoundly. Reformers' political and ethical endeavours were placed in the biunivocal assessment of the relationship between patients and doctors, seen as engaged encounters. Through patients' narratives, aimed at grasping patterns of meanings embodied in individual experiences of mental illness, they created the terrain for listening to individual and plural stories of madness, told by patients in their own terms. Coupled with the commitment to rethink public services outside the walls of the asylum, this process of listening, disciplinary un-learning and incessant questioning must be considered the most important, and to some extent the most neglected, political and clinical contribution of the Italian experience (Basaglia et al., 1987; Pivetta, 2012; Foot, 2015).

However, in light of the problems encountered in the aftermath of these closures, the assumptions at the core of that decision have been simplistically labelled as idealistic, revealing a lack of memory (or knowledge) of the *status quo* they challenged. Nowadays, on one hand, there is a tendency to romanticise that aforementioned period, perceiving it as decisive. On the other hand, there is an alarming tendency to suggest that if the alternatives to asylum do not work, there is no choice but to return to the asylum (Cipriano, 2018). The dismantlement of the asylum was supposed to be replaced by a variety of differentiated spaces that were only partially implemented, making the reform incomplete and one-armed. Moreover, in challenging the value of their own work, critical practitioners lost influence and an institutional base—in other words the source and the laboratory of their constant interrogations (Pivetta, 2012; Burns & Foot, 2020). The processes of deinstitutionalization have slowly reduced the moral and economic responsibility of the State and triggered the elimination of a safe and stable place where the discipline could be constantly challenged, its results monitored and, more importantly, the mentally ill asked to speak out (Cohen, 2018b). In telling the case of Turin, I will then give resonance to the role played there by patients themselves and civil society, represented by family members, voluntary associations, students, and labour unions. While stressing the need, still pressing, of opening spaces of encounter, dialogue and co-presence between the two.

3|BEING OUT OF PLACE

3.1| ASSEMBLIES AND OCCUPATIONS

As mentioned above, the process of deinstitutionalization in Turin differs from the cases of Trieste and of other cities that pursued the same path, following the Basaglian diaspora[46]. It is also, unexpectedly, a story that is not particularly well-known. The absence of a clear leader has probably obscured its relevance and underestimated its reach; this despite the fact that in the 70s Turin was the site of the biggest mental health apparatus in terms of size and number of hospitalised patients (Lasagno, 2012)[47]. A description of key events, briefly sketched below, will serve to highlight the specificity and values underlying this experience, the product of a cultural and political, rather than scientific, endeavour.

In Turin, the substantial indifference around the conditions of mental patients and their everyday lives within the institution was partially broken by a report published in 1968, where, for the first time, inmates' claims were made public, following assemblies between staff and patients held in the asylum of Collegno[48], the biggest asylum, located on the outskirts of the city (Figure 4.3). That report offered a worrying picture of the situation in which psychiatric patients found themselves, making it become a matter of public concern. The document, "Rapporto dalla Sezione 12"[49] (Report from Section 12) was the account of several meetings that took place in 1968 in the ward n. 12, run by the Doctor Enrico Pascal. During these meetings Dr. Pascal gathered complains,

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[46] Many doctors who worked with Basaglia later moved to other cities to bring change to other psychiatric institutions (ex: Slavich in Ferrara).

[47] Turin, in northwest of Italy, was the first capital of the country, one of the most important industrial centres and a major destination for migrants from southern Italy. At the end of the 60s the Province of Turin listed 4 asylums, one in the city centre (via Giulio) and 3 at the western outskirts of the city: Collegno, Grugliasco and Savonera. In 1966 the total number of patients reached 4733 hospitalisations (the figure must be doubled if we consider the private sector).

[48] The asylum of Collegno, with its 20 pavilions, was the biggest psychiatric hospital in Italy. A former charterhouse, it hosted psychiatric patients since 1853; it stopped being a total institution in 1978, with the application of 's law and the complete conversion of pavilions into "host communities". It was definitively closed in 1997.

[49] https://www.ilmargine.it/enrico-pascal-1-rapporto-sezione-12-collegno-31-ottobre-1968/

observations and proposals from both patients and staff, building up a picture of everyday life in the asylum as it was perceived and narrated by their users.

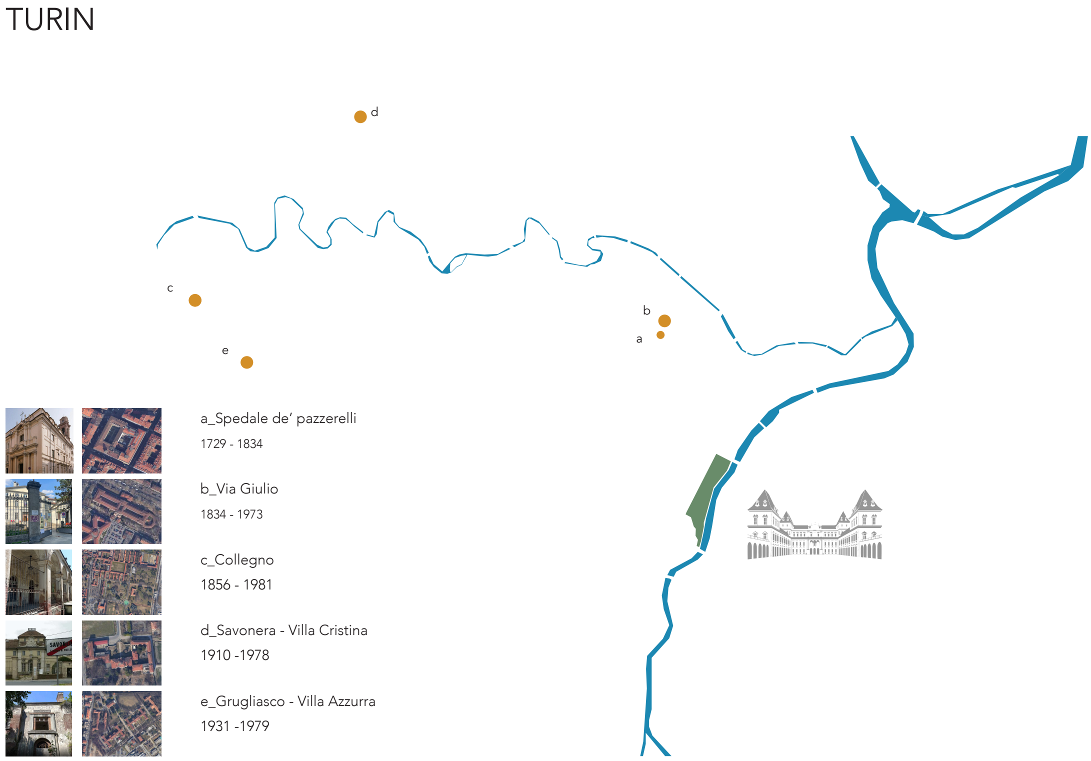
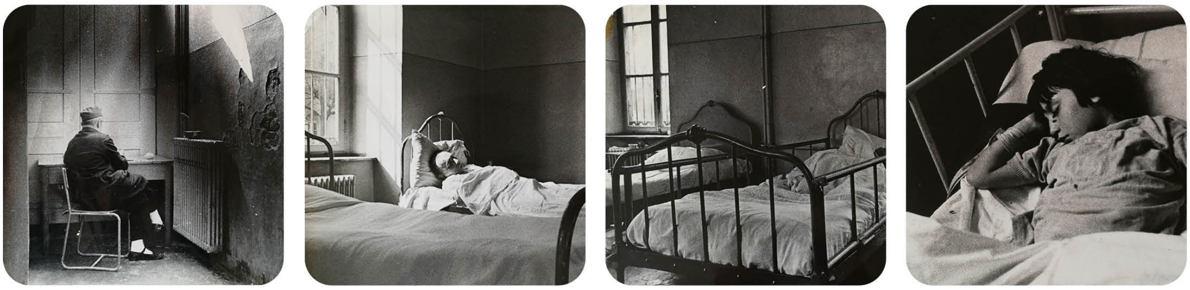


Fig. 4.3: Map of all psychiatric hospitals in Turin.

Complains concerned the quality of food, hygiene issues, abuse of violence, while requests focused on the possibility of moving more freely. Assemblies and the report, presented as a collective and participative effort, were the first attempt to give space and voice to patients, and by associating the asylum to a lager, constituted a proper denunciation that, despite being openly ignored by the provider, Opera Pia, and local authorities, opened the door for future experimentations, demands and protests. The simple fact that assemblies took place, and their results made public, testified the presence, not at all obvious, of some doctors within the institution already engaged in a process of renewal that encouraged other members of the staff to slowly introduce some innovations, not without difficulties and opposition from colleagues (Lasagno, 2012).

Contextually, the association ALMM, the role of which was prominent for the reform, started to operate in town. Through awareness campaigns, petitions, depositions of patients and relatives, ALMM has since managed to exercise a continuous political pressure. In coalition with student and labour movements close to left-wing parties, they have organised exhibitions and assemblies, written articles, reports and books, kept the debate alive and made public what was until then confined to the walls of the institution and the margins of society (ALMM, 1971). Headed by the psychotherapist Piera Piatti, , Basaglia’s friend, wife of Giulio Bollatti, director at the time of the publisher Einaudi - with which all Basaglia’s books went out - the association could rely on the economic, moral and cultural support of the city’s intellectual class, including the newspaper “La Stampa” that has sustained the anti-institutional struggle and given space to the work of the association since the beginning. What makes the story of Turin exceptional is the combination of two major events that provoked disruptive incursions of outsiders into unconventional spaces: ordinary citizens crossing the boundaries of the asylum, and mental patients accessing one of the most noble of all institutions—the courthouse. Both groups were claiming their right to unwaveringly occupy these places. The result was a set of opposite movements that temporarily inverted the status quo and allowed distant worlds to meet and get to know each other. It all started with a public assembly titled “Is building a psychiatric hospital a crime?” held at the department of Architecture in December 1968, that turned into a peaceful occupation of the hospital in Collegno (see poster, Figure 4.4).



LETTERA AI DIRETTORI DEI
MANICOMI

LA REVOLUTION SURREALISTE
1925

13 - 14 - 15 DICEMBRE 1968
CON INIZIO ALLE ORE 17 DEL VENERDÌ
ALLA FACOLTÀ DI ARCHITETTURA DI TORINO
(CASTELLO DEL VALENTINO)
ASSEMBLEA PUBBLICA

SUL TEMA:
« È UN CRIMINE PROGETTARE UN OSPEDALE PSICHIATRICO?
Se c'è un rapporto tra il ricovero in manicomio e situazioni sociali di oppressione quale significato assume curare ed assistere dei malati di mente e progettare dei nuovi ospedali psichiatrici? ».
SI sottopone all'approvazione dell'Assemblea il seguente ordine del giorno:

Fig. 4.4: Poster of a public assembly at the Valentino Castle, 1968. The red title on the right reads "fight to the institutions" while the main body of the text is a letter to the directors of the asylums, accused of being "cogs of the system". The title of the event (bottom left corner) was "Is it a crime to build a psychiatric hospital?". My translation. Source: ALMM Archive.

It was the first time ordinary citizens could cross the threshold of an asylum, becoming aware of the material and psychic conditions under which mental care was provided. If until then the asylum was an abstract and almost invisible institution for many, since this occupation, the doors of public psychiatric institutions had to be kept open to the members of a Committee, created on this occasion (ALMM, 1971). The committee, made of 35 ordinary citizens, was granted the right to inspect buildings, interview patients and report back, and constituted an instrument of guarantee before and after the closure of the asylum, when the so-called "host communities" were set up (ALMM, 1971; Lasagno, 2012). Through regular site-visits, its members started to gather direct testimonies that were then used for a book—“The factory of Madness” (ALMM, 1971) - which constituted the main material for a plea to the court. The testimonies were grouped together with a photographic reportage by Mauro Valinotto, a photo-journalist that managed to get into the children’s asylum (Villa Azzurra, in Grugliasco) without being noticed, and whose work was published in the magazine L’Espresso (Invernizzi, 1970; see Figure 4.5).

Un documento agghiacciante / Manette, lacci, camicie di forza, bavagli: così vengono curati i bambini subnormali negli ospedali psichiatrici della più ricca città d'Italia. Come si giustificano i responsabili?

MA E' PER IL SUO BENE !

di GABRIELE INVERNIZZI

Timori infondati

Futuro incerto

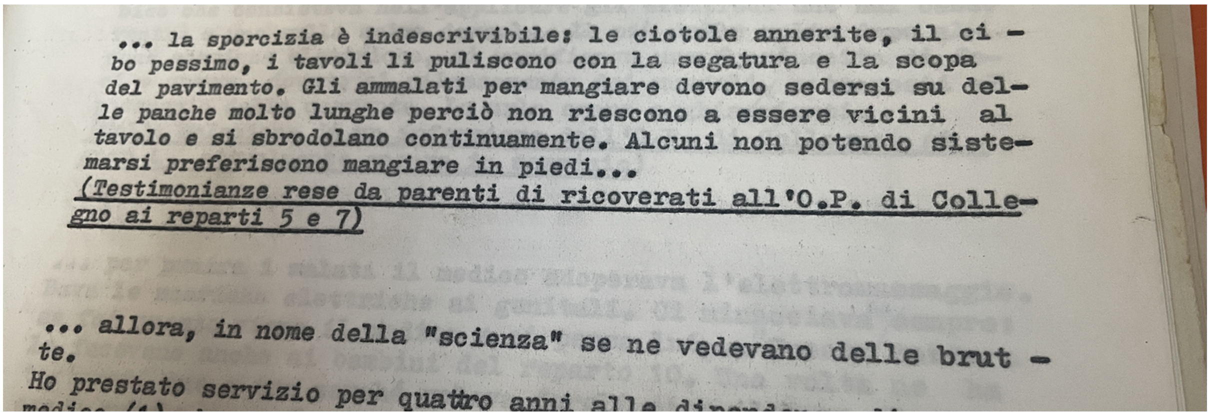
Legati anche per i giochi

Mancanza di affetto

Un arnese senza volto

Fig. 4.5: Article titled “But it’s for her own good” by Gabriele Invernizzi, pictures taken in Villa Azzurra by Mauro Vallinotto. Source: ALMM archive. Although they were not present in the original version, faces and intimate parts were blurred by me out of respect for the photographed children, who never gave their consent for their photos to be released.

As we can read in the reports and testimonies held in the archive, the everyday was made up of dirtiness, overcrowding, squalor, negligence and violence; people tied in bed, patients forced to sit too far from the table while eating, beds 30 cm apart, filthy toilets, the constant smell of urine and peeling and wet walls (Figure 4.6).



... la sporcizia è indescrivibile: le ciotole annerite, il cibo pessimo, i tavoli li puliscono con la segatura e la scopa del pavimento. Gli ammalati per mangiare devono sedersi su delle panche molto lunghe perciò non riescono a essere vicini al tavolo e si sbrodolano continuamente. Alcuni non potendo sistemarsi preferiscono mangiare in piedi...
(Testimonianze rese da parenti di ricoverati all'O.P. di Collegno ai reparti 5 e 7)

... allora, in nome della "scienza" se ne vedevano delle brutte.
Ho prestato servizio per quattro anni alle

Fig. 4.6: Manuscript of "*La Fabbrica della Follia*" (The factory of Madness). Testimony given by patients' relatives admitted to the psychiatric hospital of Collegno:"...The filth is indescribable, the bowls are dirty, the food is awful, they clean the tables by using sawdust and the broom. While eating, patients have to sit on benches far from the table and they constantly spill. Some, unable to settle down, prefer to eat standing up..." My translation. Source: ALMM Archive.

3.2| A TRIAL AGAINST A PSYCHIATRIST

Thanks to all this evidence, a trial against the conduct of the psychiatrist Giorgio Coda began, leading to a conviction. The trial lasted 3 days, (4th, 10th and 11th of July 1974), and saw 14 patients testify, 12 against and 2 in favour of Coda, accused of mistreatments and torture while he was directing the asylums of Villa Azzurra and Collegno. Coda admitted of practicing around 5000 electromassages, a variety of electroshock he was considered an expert of. Homosexuality, alcoholism, onanism were all "problems" treated with this technique, as well as being used as a punishment for all kinds of infractions, as was established during the trial. The appeal to the scientific nature of his actions, he used as a defence, turned up to be weak and the lack of repentance or afterthought towards his approach did not help to earn the sympathy of the court. Coda defined his educational methods as legitimate and merely led by research purposes that, although later disproved, were generally accepted and widespread at the time. He tried to involve his colleagues and to show to be part of a system and a medical culture that did not exclusively depend on him and his decisions. In the words of patients, on the other hand, the asylum was depicted as a lager and therapies received there as a proper torture, mainly used with punitive purposes. Giorgio Coda was found guilty and sentenced for mistreatment to five years in prison - never served - a perpetual ban from public service and a five-year stop from medical profession. The judges stated that he did not act for therapeutic purposes but rather for punitive ones, that his treatments were illegitimate, and that a psychosis of terror had been created due to that in the hospital (Papuzzi, 1977).

Regardless of the outcome, the instrumental role played by patients is meaningful and noteworthy; for the first time in history, they could testify in person and their voices were heard and taken into consideration despite their illness had identified them as unreliable, and therefore "unfit to plead" (Papuzzi, 1977). "*Faces, eyes, tears of the patients that crowded close to students and workers in that courtroom of Turin remain unforgettable. […] The madmen were given the floor, perhaps for the first time in their lives, they were heard, considered by judges trustworthy, citizens like others*" (Corrado Stajano in Papuzzi, 1977; pag.XII). On that occasion, the mad left the clandestine state and, by simply standing in the witness box, earned back their identity, while gaining the right to speak. With the sentence against Coda the acts of violence within mental institutions were eventually punished and the outside world stopped being perceived as hostile or indifferent. In that courtroom, patients, thanks to the mere fact of being there, gained solidarity and a feeling of belonging that they were being denied while hospitalised.

As Corrado Stajano writes in the preface of Papuzzi's book (1977):

> "*the sentence of the Judges of Turin does not annul the suffering of many men, but those men, in the courtroom of the Palace of Justice, felt and experienced the warmth of solidarity, affection, human attention, hope. A trial, perhaps, served as a therapy*"

Crossing the walls of the asylum in both directions allowed for an outward projection of the image of the asylum; it initiated the building of a bridge between the inside and the outside and created the opportunity for a dialogue.

> *“The insane come out of eternal hiding, as if from a deaf imprisonment. They regain their lost identity in the halls of the lager of Collegno, they are given rights on a par with others: of those who are sane; whatever the verdict may be, it cannot erase this achievement: of men who regain - from themselves - the right to call themselves men. There, on the defendants' bench, sits Coda. He is alone, while among the sick, the friends, the audience, a bond of solidarity is aired and fills the courtroom”.*
>
> (Papuzzi, 1977; pag.5; my own translation)

3.3| OPEN-DOOR COMMUNITIES

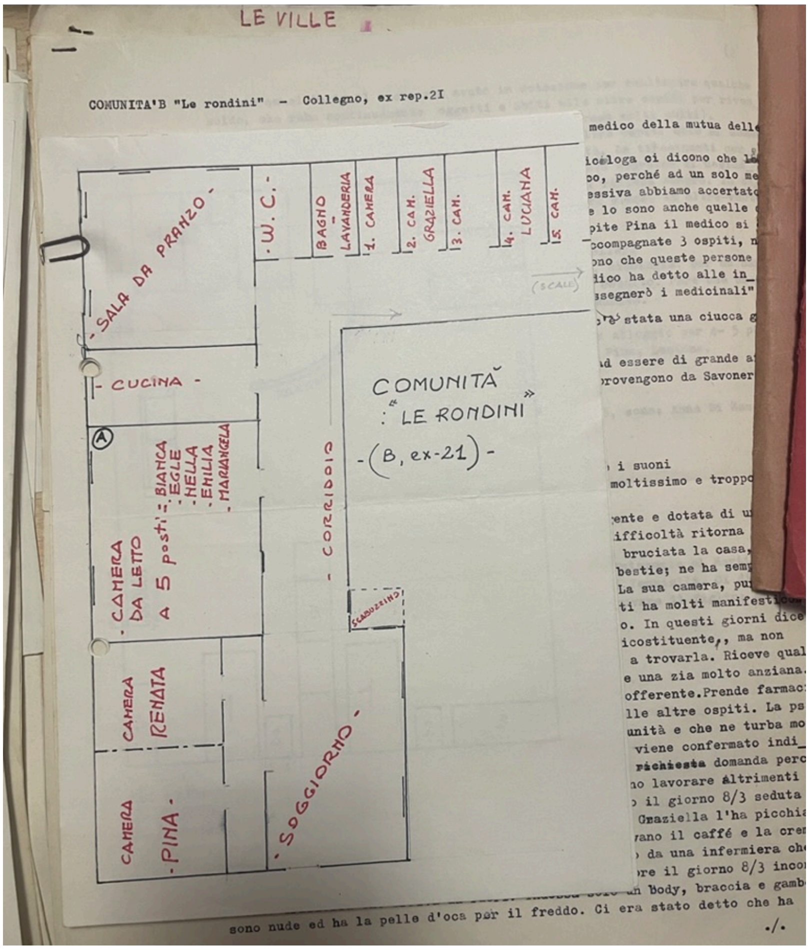
In the meantime, some doctors had already started to experiment open-door wards and, slowly, the dismissal of the asylum began, way before the introduction of Law 180. The most influential was the experiment conducted in Via Giulio by Dr. Annibale Crosignani and Dr. Giuseppe Luciano in 1969; not without hostility from within but encouraged by the protests led by students and with the external support of ALMM:

> “*We were not at the top, we were not directors but normal doctors…we did not have any power, we were like in the second line…but we had the opportunity to have the support of external forces, social and political ones, that believed it was time to put an end to the shame of psychiatric hospitals*”.
> (Interview Dr. Luciano, 27/05/2021)

> *“At some point unions asked to fire us because we wanted to set up a therapeutic community but the population intervened in our defence with a march”.* (Interview Dr. Crosignani, 27/05/2021)

Thanks to this external support they promoted non-coercive methods and with an *équipe* of 30 volunteer nurses they set up the first open-door ward, that became the model for future therapeutic and guest communities in Turin and constituted the preliminary step in the process of deinstitutionalisation in Turin. Based on Maxwell Jones and Franco Basaglia’s experiences, open-door communities, beyond allowing free movement, incentivised collaboration and a collective organising of spaces, activities and duties. At the core of this new model there was certainly the assembly where every decision or concern were discussed and where everyone, patients and staff, could speak openly.

What makes the experience of Turin remarkable even now is the instrumental role played by both patients and civil society and how the embodiment of unusual places empowered both. If it is true that without the progressive doctors mentioned above no change would have ever happened, the closure of the asylum in Turin was not exclusively led by doctors from within the institution, but rather initiated from the outside, as a grassroots movement. The external support of ALMM, of the press, of left-wing parties, combined with a concern over public opinion, offset the lack of solidarity that these doctors experienced within the institution from other members of the staff and protected them from dismissal or charges they were regularly threatened with (Lasagno, 2012). After a first period of renewal, together with the grassroot movement that had lost its push, reformist initiatives slowed down and the process of deinstitutionalisation had a gradual stop, up until the reform came into force. In the meantime, ALMM and the committee never stopped to monitor and inspect hospitals, reporting both improvements and cyclical worsening, alternated by periods of equally worrying stagnation (ALMM, 1973, 1980) (Figure 4.7).



COMUNITA'B "Le rondini" - Collegno, ex rep.2I

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icologa ci dicono che l
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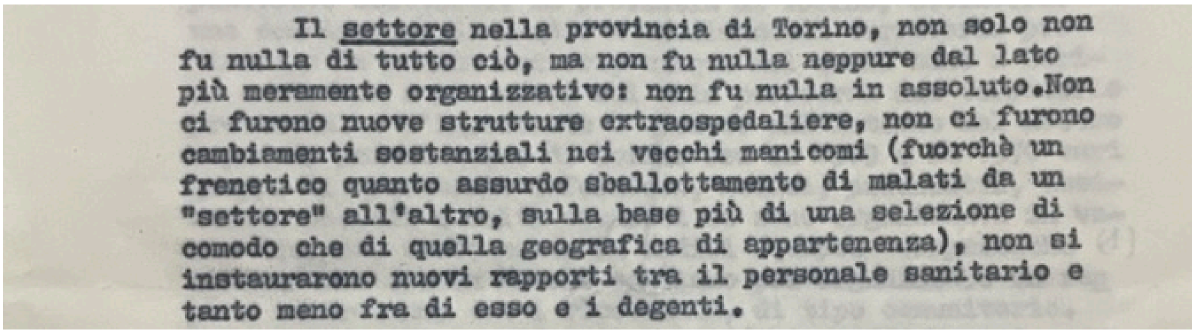
re il giorno 8/3 inco
n body, braccia e gamb
sono nude ed ha la pelle d'oca per il freddo. Ci era stato detto che ha
./.

Fig. 4.7: Plan of one of open-door community "Le rondini" in Collegno. Source: ALMM Archive.

3.4| SECTOR PSYCHIATRY

Contextually, at the political level, the hypothesis of using a model, imported from France, based on sectors, started to attract consensus. As already mentioned in Chapter 2, “sector psychiatry", was an organizational model, initially implemented in France during the 1960s. It foresees a network of territorial services operating in conjunction with psychiatric hospitals, where inpatient wards are associated to outpatient services, serving a specific geographic region and a given population. This to facilitate alternative and post-hospital interventions by the same team. The city is therefore divided into sectors, understood as independent units, in which all psychiatric services are provided by a single multidisciplinary *equipe,* rooted in the territory. In 1969 the province of Turin tried to introduce this model, finding consensus in a number of working groups, within psychiatric hospitals. The “*Psichiatria di settore*”, as it was called in Italy, was seen as the natural development of the open-door communities but not necessarily as an alternative to the asylum, that in the mind of some could coexist to deal with the most severe cases. Sectors could represent the application of a more capillary mental health system, able to allow a better relationship with the area and more participation from the users; however, according to ALMM (1971) it did not constitute a proper change, rather a casual “*moving around*” of both patients and staff, into services that differed from asylum by size, but not necessarily by nature (Figure 4.8).



Il settore nella provincia di Torino, non solo non fu nulla di tutto ciò, ma non fu nulla neppure dal lato più meramente organizzativo: non fu nulla in assoluto.Non ci furono nuove strutture extraospedaliere, non ci furono cambiamenti sostanziali nei vecchi manicomi (fuorchè un frenetico quanto assurdo sballottamento di malati da un "settore" all'altro, sulla base più di una selezione di comodo che di quella geografica di appartenenza), non si instaurarono nuovi rapporti tra il personale sanitario e tanto meno fra di esso e i degenti.

Fig. 4.8: “The sector in the province of Turin was not only nothing of this sort, but it was nothing even on the organizational side: it was nothing at all. There were no new out-of-hospital facilities, there were no substantial changes to the old asylums (except for a frenzied as well as absurd jostling of patients from one sector to another, based more on convenience than on the geographic area to which they belonged), no new relationships were established between the health personnel, much less between them and the patients.” Source: ALMM Archive. My own translation.

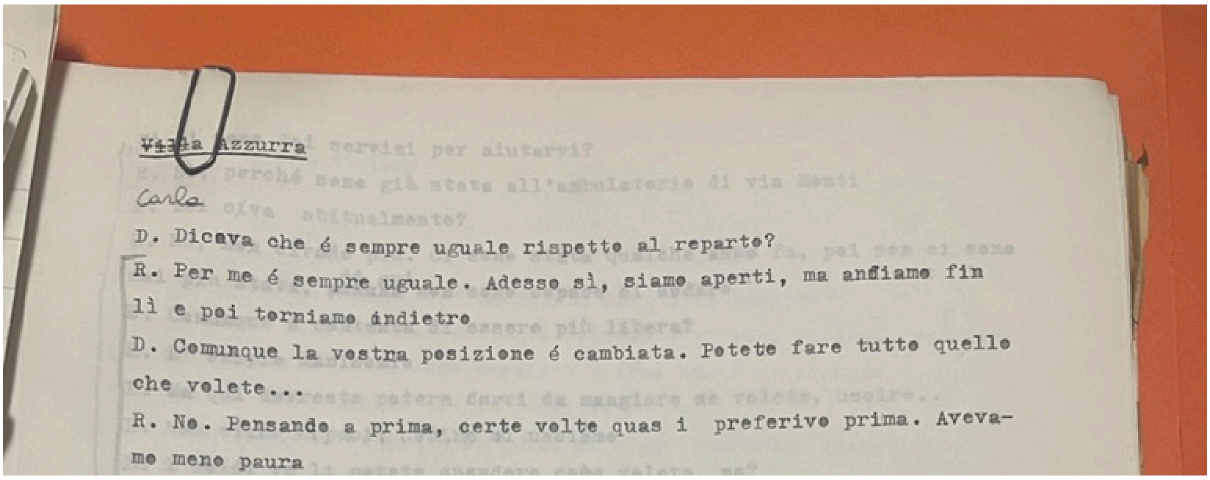
The only good practice was that of the team assigned to a sector in the north-eastern outskirts of the city (Settimo Torinese), led by Enrico Pascal and his team, from the aforementioned “ward n. 12” of Collegno. The reform though was indeed only partially applied across the city and, by Pascal's own admission, had often produced a wild and purely bureaucratic displacement of patients (Il Margine, s.d.). It was later fully replaced by the national law of 1978 that made the sectorization redundant.

4| LACING LAW 180

The entry into force of the law in 1978 made regain momentum to the process; the dismantling of the asylum assumed a different form and speed. At the beginning, it proved necessary to opt for a hybrid solution, able to facilitate a smooth transition and to constitute a bridge with the external world. Here the birth of the so-called “guest communities”, sited within the old asylum but planned for gradually preparing patients to go out (ALMM, 1980). Patients were usually responsible for cleaning and cooking; they got a pension they could freely administer; they were free to move around. On a semantic level, they were considered guests; they were hosted rather than hospitalised, therefore free to leave the open-door community at their convenience. The “guests” were all patients for whom no alternative had been found outside or for whom a further period of accompaniment proved necessary.

> *“These services were supposed to be propaedeutic to the discharge. The risk was that they were nothing more than small asylums, a little bit sweetened…but still. It was not simple, there were ingrained habits, professional behaviours almost impossible to change…Undoubtably the environment was getting better, we had the perception we were doing something useful; people were getting better…”*
> (Interview to Dr. Caterina Corbascio, 26/05/2023).

Life was definitively less regulated and more autonomous even if many patients seemed not to be fully able to enjoy the increase in freedom. In the interviews conducted by members of ALMM, some of the guests appeared not to be as affected by the changes and, in some cases, even scared. The increase of freedom seemed to equate with a decrease in protection, and therefore fear. As we can see in the transcriptions of the interviews conducted in the communities (Figures 4.9, 4.10) to the question: “*Did you say that is always the same?*”, Carla, a guest, replied: *“For me it’s the same. Now we are open, but we go until then and we come back”.* She even added: *“Thinking about before, sometimes I almost prefer before. We had less fear”* (Figures 9). In the attempt of making them identify differences with the previous life in the asylum, not everyone managed to recognise and acknowledge the change, and it is not rare to find answers like “*I would not even know*” such as the one given by Maurizio. The aspect that stands out is the availability of a small pension. Pension that is not always administered by the guests but by the staff (Figure 4.10).



Villa Azzurra

Carla

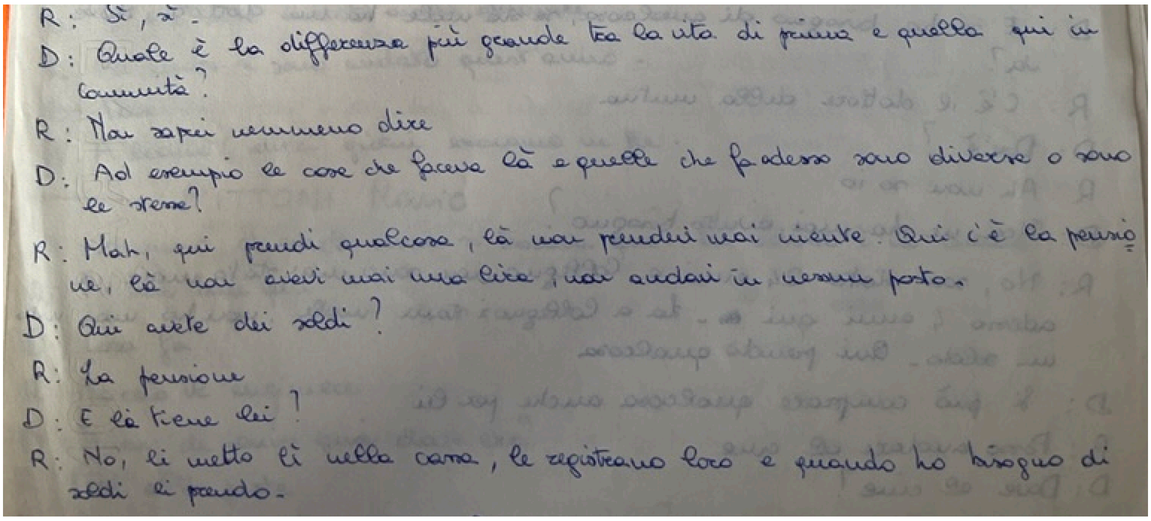
D. Dicava che é sempre uguale rispetto al reparto?

R. Per me é sempre uguale. Adesso sì, siamo aperti, ma andiamo fin lì e poi torniamo indietro

D. Comunque la vostra posizione é cambiata. Potete fare tutto quello che volete...

R. No. Pensando a prima, certe volte quasi preferivo prima. Avevamo meno paura

Fig. 4.9: Interview to Carla in a community at Grugliasco. D: did you say that is always the same in the ward? R: For me it’s the same. Now we are open, but we go until then and we come back. D: Your position is changed though. You can do whatever you can…” R: No. Thinking about before, sometimes I almost prefer before. We had less fear.   Source: ALMM Archive.



R: Sì, sì.

D: Quale è la differenza più grande tra la vita di prima e quella qui in comunità?

R: Non saprei nemmeno dire

D: Ad esempio le cose che faceva là e quelle che fa adesso sono diverse o sono le stesse?

R: Mah, qui prendi qualcosa, là non prendevi mai niente. Qui c'è la pensione, là non avevi mai una lira, non andavi in nessun posto.

D: Qui avete dei soldi?

R: La pensione

D: E la tiene lei?

R: No, li metto lì nella cassa, le registrano loro e quando ho bisogno di soldi li prendo.

Fig. **10**: Interview to Maurizio in a community at Grugliasco. D: What's the biggest difference between the life of before and the one here in the community? R: I would not even know. R: For example, what you used to do there and what you do now are different? R: Mah, here you get something (money), there you did not get anything. Here there is the pension, there you did not have any money, you did not go anywhere. D: have you got money here? R: The pension D: do you keep it? " R: No, I put it in the kitten, they register it and when I need money I take it. Source: ALMM Archive.

In the autumn of 1979, there were 15 guest communities spread across Collegno and Grugliasco (Archive, ALMM; Lasagno, 2012). Not all of them were refurbished to a standard that could make them look like residential units; the resemblance to a clinic environment, if not to a hospital, was both in architectural and functional terms. In 1981 only 71 guests (over 400) managed to leave and came back to their families, found a flat or, much more often, went to a nursing home. Otherwise, the population, and the conditions, were rather stable, with the risk of festering a situation born to be temporary and propositional. While many saw any attempt of improvement of these spaces as a dangerous act of legitimation that would have impeded their future dismantlement, members of ALMM kept making a call for getting conditions of living better, in a debate that faced a hardly reconcilable ideological view to a more pragmatic one (ALMM, 1980). With this concern, a huge project of social rehabilitation dedicated to the guests still in the asylum was set up by the municipalities of Turin, Grugliasco and Collegno. The project, called "Torino Progetto", was aimed to combine issues of housing and employment with a therapeutic support. Support provided in some meeting spaces across the city and meant to deal with all the difficulties patients would have encountered outside the asylum. Through this programme was also possible to provide around 300 bedrooms from the public housing stock, specifically bound to a socio-sanitary use.

> *"The project, funded by the CEE was aimed to locate patients from Collegno. We were looking for flats to buy. There would have been impossible for them to find something. We kept assist the ones that needed more support, going at their places. We cannot think to put them there and leave…Some of these flats were part of the public stock…that the municipality decided to specifically assign to psychiatric patients, that otherwise would have not got a place in the waiting list. The mental health service still runs some of these flats* (Interview to Dr. Caterina Corbascio, WI, 26/05/2023).

In parallel, a common destination for patients was the market represented by private inns, family-run, mainly located in dilapidated buildings in the city centre (ex: the neighbourhood of San Salvario); often off-limits for sanitary staff. In the meantime, there were associations like Primavera 85 born for helping people to self-organise material life and their free time.

> *"There was enthusiasm but also a lot of fear…the asylum was also a protective situation…from the world that put them there".* (Interview to AD - educator, WI, 28/05/2023)

Patients definitively enjoyed more freedom of movement, into a society though that did not show to be as welcoming, at least in the first place.

> *"There was a rather high tension. I remember a flat in Crocetta, at some point one of the flat of the building was occupied by patients…and they had some weird behaviours…part of the job of medical staff was to mediate with them. Make them change their preconceptions" (Interview to Dr. Caterina Corbascio, WI; 26/05/2023)*

> *"Patients used to talk with everyone. They ended up being a train d'union between the neighbours. They were a catalyst of sociality. We organised parties in order to modify the perception of madness in the mind of the others. Our role was pivotal…to put together people who distrusted each other. (Interview to AD - educator, WI, 28/05/2023)*

It is worth adding that the role and presence of cooperatives in the transition to the post-asylum has de-facto allowed the state to abdicate its role and responsibilities to the market. Using the hybrid medium of the third sector, a market of service provision has been created, often with no specific expertise and very little control from outside. It is unlikely that the rise of this market sector would have occurred in the absence of a gradual withdrawal of State involvement and the subsequent mushrooming of private bodies of all kinds. Therefore, a series of cooperatives, many of which are still operating in the city, started to provide accommodation on behalf of the public sector. According to the typology and degree of support, different categories of residential units were set up, going from the therapeutic community to the group home and, in the best scenario, to home care. A landscape of facilities that we still have in place and that the Region Piemonte has recently tried to systematise with a regional law (dgr 84) - showing to be willing to put housing at the core of its mental health care system.

As far as employment is concerned, a series of cooperatives like "la Nuova Cooperativa", started operating in the 80s by employing former patients, mainly in the cleaning sector. Employment seemed not to represent though a real priority and initiatives in that regard have always been scarce and little effective. This despite the widespread use of the so-called "occupational therapy" within psychiatric hospitals, where in the name of the beneficial effects of an active life and a sense of purpose, exploitation was normalised (Lasagno, 2012). Outside the asylum, a substantial lack of trust on the reliability of psychiatric patients has led though not to invest on their employability, limiting their market "*to cleaning, gardening, small catering or volunteering…another form of exploitation*" (Alessandro, Educator; WI; March 2023).

4.1| GEOGRAPHIES OF THE REFORM

In the vision of the reformers, with the closure of the asylum, people would have been housed by their own family or, relying on the network of extra-hospital services and the support of staff, undertaken a mostly independent life in homes, rented out or provided by the public or third sector. The reality was less generous of settings where the patients could test their autonomy; much less of families keen to accept their relatives back. For what concerns services, the process of deinstitutionalisation was characterised by steps forward and backwards that held the renewal back; renewal that was far from being linear and homogenous, in Turin as elsewhere. A blind trust in the intrinsic therapeutic virtues of both territory and community underestimated the risk of reproducing asylum-like dynamics and forms of exclusion even in the new services. In parallel, the private sector grew, becoming, with its therapeutic communities and all the nursing homes, the natural and expensive alternative to the asylum. As a former member of ALMM laments, the landscape of mental health care pulverised, making harder to monitor or assess the status and quality of services. The geography and with it, the types of problems, were fragmented and difficult to grasp. A very much important point that really speaks to the way in which the geographical landscape of care has been changing as the process of deinstitutionalisation unfolded. With the disappearance of the asylum as a building, it was taken for granted that the unequal power dynamics present there, would have gone as well. With the walls of the institution, the contours of the power to oppose started to blur, together with the defence mechanisms put in place until then and the critical mass necessary to keep the reformist spirit alive. As Lidio Maffi, ex member of ALMM, explains:

> *"After the reform the support from the civil society that worked as a stimulus and gave us a sense of direction went declining. We lost the families that used to come to our assemblies. It was like we lost a common enemy…Law 180 put the association in front of a change of prospective. To be honest residual elements of the asylum persisted for a while after the closure of the psychiatric hospitals in the guest communities. But we had to face community mental health services. Same people but in different contexts. Changing prospective was not as banal. We had model in mind that came from the 68, 69….it was difficult to change the approach, the categories of analysis…you did not have to go to an enclosed place anymore. You had to change scenario…much more fragmented. You needed to adapt your flow chart, born for assessing an asylum to a SPDC, a daily centre or home". (Interview to Lidio Maffi, WI, 28/05/2023)*

With the end of the asylum, the issue of space disappeared from any discussion on mental care. What was mainly born as a spatial concern, found its fix in the removal of the simple container of unequal relationships that, unfortunately, found a way to reproduce somewhere else, under track. It is with this concern in mind that this research aimed to explore both the topography and the topology of the landscape of community care born after the reform, briefly described in the next section.

COMMUNITY CARE

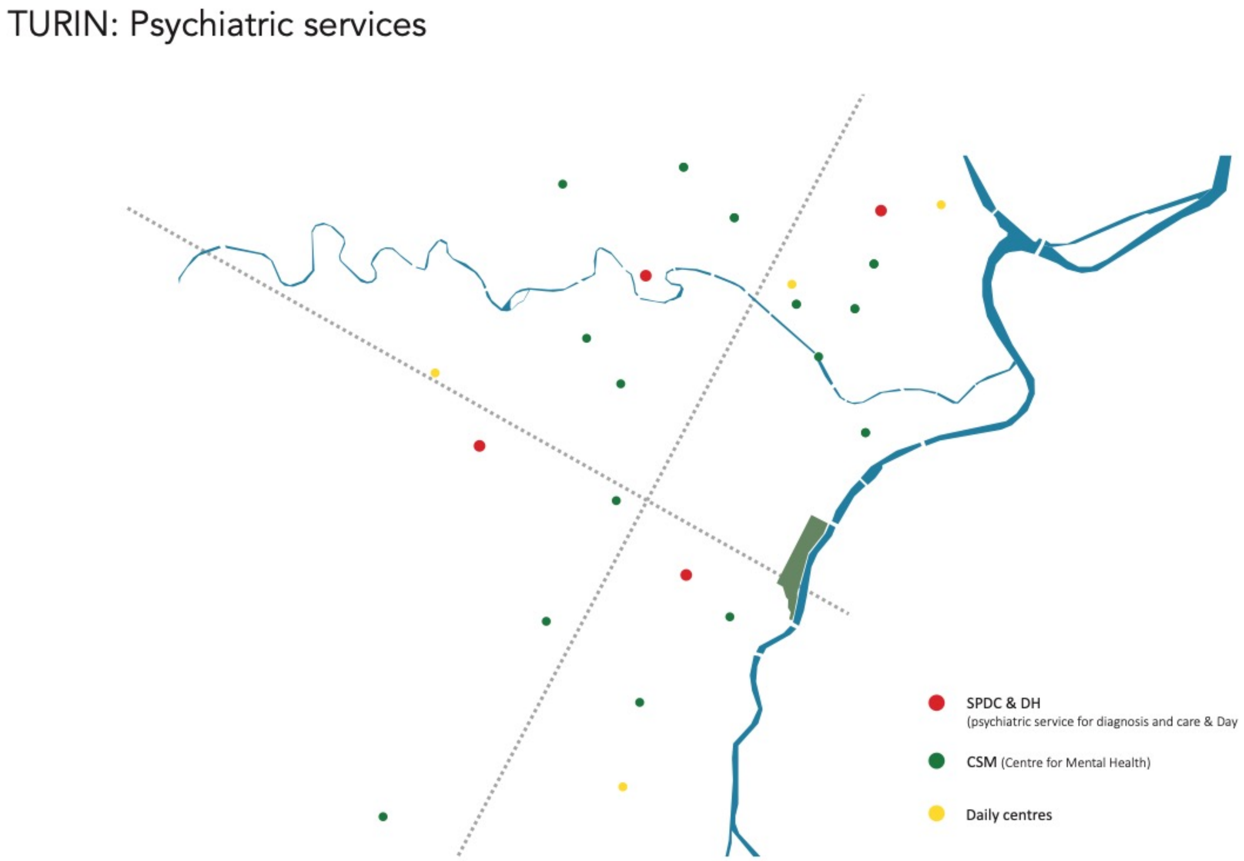


Fig. 4.11: Network of psychiatric services in Turin. Source: Azienda Sanitaria Locale "Città di Torino".

The DSM (Dipartimento di Salure Mentale - Department of Mental Health) is the set of facilities and services responsible for taking charge of the demand related to mental health treatment, care and protection within the territory defined by the Local Health Authority (ASL). The DSM is equipped with the following services:

a) Psychiatric Diagnostic and Treatment Services (SPDC) and Day Hospitals (DH) (Inpatient services)
b) Mental Health Centers (MHCs)
c) Day Care Centers (CD) (semiresidential services)
d) Residential facilities (RDs) divided into therapeutic-rehabilitation and socio-rehabilitation residences.

SPDC (Servizio Psichiatrico di Diagnosi e Cura - Psychiatric Diagnostic and Treatment Services) is the hospital site where the acute phase of psychiatric pathology is managed under voluntary or mandatory hospitalization. The service functions as a psychiatric emergency room for care in emergency-emergency situations, after which patients are referred to the basic territorial services.

CSM (Centro di Salute Mentale - Mental Health Centre): as places for the prevention of mental distress and the promotion of mental health, CSMs today offer first and foremost outpatient-specialized care. CSM plans and coordinates the operation of a territory's network of outpatient and intermediate psychiatric facilities. Usually placed in normal urban residential settings to foster socialization and the use of existing leisure spaces and activities in the community.

CD (Centro diurno - Day Centre) is a semi-residential facility with therapeutic-rehabilitative functions, located in the tneighbourhood. It has its own team, possibly supplemented by workers from social cooperatives and voluntary organizations. As part of personalized therapeutic-rehabilitative projects, it allows for the implementation of therapeutic pathways and the testing and learning of skills in self-care, activities of daily living and individual and group interpersonal relationships, including for the purpose of job placement.

Residential facilities are "places of assisted living" with medium or long stay, where personalized rehabilitation programs of a therapeutic or social nature are carried out, aimed at people who face or may face acute or emergency situations, for which hospitalization is inappropriate. As a rule, these facilities are placed in urban residential settings to foster, through the direction of the CSMs, the socialization of the guests also with the involvement of families, associations and the community in general. Residential Facilities are divided into:

- Therapeutic communities, in which social and health care is of a rehabilitative type with a high therapeutic intentionality;
  - Sheltered and Family (or semi-sheltered) Homes, where rehabilitative care is primarily social in nature, as well as therapeutic;
  - Group Homes, where small cohabitation groups reside of people who may face conditions of mental distress but nevertheless do not require continuous assistance, because they are able to manage their private and social lives independently or together with social workers.

CD, CSM, Residential Facilities can be operated by the DSM or by private social and business entities. In compliance with national standards for accreditation.

Source: Ministero della Salute and Azienda Sanitaria Locale "Città di Torino"

In Turin, the re-structuring of psychiatric services, contextually to the dismantling of the asylum, took over 20 years and passed through intermediate phrases like "guest communities"; facilities that, all similar to therapeutic communities, accommodated some discharged patients (ALMM, 1973). One of the first steps was to decentralise psychiatric care across departments of the general hospital and to set up a unit in the emergency room; this with significant resistance from the "traditional" medical staff, that frowned upon the association between traditional medicine and psychiatry (Lasagno, 2012). The link between the hospital and the territory was guaranteed by an intricated network of complementary services, the structure of which is still with us. As much as in the rest of the country, mental health care in Turin is organized through the Departments of Mental Health (DMH), the umbrella under which the net of services operates. Psychiatric wards in general hospitals, community mental health centres, residential facilities, and day centres, all constitute the complementary body of facilities that, within a defined geographic area, manage diagnosis, hospitalization, therapies and, ideally, rehabilitation. The DSM has a central role in terms of planning and management of resources and holds the reins of all the activities run by other services; at the core of the community-based system though, there is the Community mental health centre (CMHC), where therapeutic and rehabilitation activities for outpatients are delivered on a daily basis. Psychiatric units, where a maximum of 15 inpatients can be hosted, and residential facilities, represent the residual attitude towards a provision of mental care based on custody and hospitalization. On top of that, the private sector, out of the radar of public authorities, provide up to 54% of all psychiatric beds (IRES, 2020). Differently, day centres, where rehabilitation therapies and entertainment activities are provided, constitute the closest facility available to citizens, spread across all neighbourhoods (Figure 4.11).

The distribution of these services across Piemonte is higher than at the national level, to the detriment though of opening time. None of these facilities stay open for more that 12 hours per day and they are all closed over weekends and holidays, moments when the number of involuntary commitments and emergency calls raises (Public Psychiatrist, May, 2023, TI). Beyond issues related to this, a scarce collaboration and coordination between services compromises the functioning of the system; this despite the complexity of needs would require a strong and constant synergy. Moreover, a bureaucratic and risk assessment focused model, together with an approach mainly based on emergency, appears to characterise the entire system (Lasagno, 2012). The process of deinstitutionalization in Turin appears to be an unfinished project but what is highly problematic is the lack of debate around issues related to its spatialisations. People need to be treated somewhere; therefore, how spatial settings might contribute to their recovery must be a matter of continuous discussion. “From secluded asylums to the psychoanalytic couch” (Högström, 2018, p. 316) the search for the ideal therapeutic space and the best arrangement has often characterised mental health care provision, but nowadays a debate on how the asylum has been replaced in terms of physical space and its implications on individuals is not on the political agenda and is even less a matter of public concern. A model based on confinement was rigid and static and more than that represented the single answer provided by the public to issues of mental health. The renewal offered a series of options and possible paths but also a degree of uncertainty and confusion that created a rather heterogenous landscape of care, made of services that worked more as alternatives than as a complementary system.

So far, this analysis has explored the shift that, in relation to political, economic and social drivers has led to the current set of settings and practices; but it cannot be stopped here. A proper evaluation of the post-asylum landscape of mental care cannot be limited to a mere list of its services but needs to acknowledge and assess users' experience. The substantial lack of first-person narratives around the provision of mental care leaves us with a limited understanding of the status of services and impedes to envision their future development. The relational nature of these spaces is therefore dismissed, despite its potential role in the process of recovery. This makes then become necessary to start observing new geographies of care through the eyes of their users, the embodied experience of which has so far been overlooked or openly ignored. As I already said, where and how mental illness was treated was an issue of public and political concern that, starting from the 80s has gradually blurred. The concern around the rights of patients and the interests towards first-person experiences has dropped away. This while practices made after the reform have become always more difficult to track and represent.

While this research is grounded in the context of Turin, it is important to acknowledge that Piedmont has been a particularly fertile region for ethnographic studies on psychiatry, especially regarding coercive practices in acute psychiatric wards (SPDC). Over the last two decades, scholars such as Cardano, Gariglio, and Ferrero Camoletto have conducted extensive ethnographic work in Piedmontese wards, highlighting the contradictions of psychiatric reform and the persistence of constraint and surveillance within rebranded institutional spaces (Cardano & Gariglio, 2020). These contributions are particularly relevant in relation to this project's attention to embodied and spatialised forms of power, and the affective atmospheres that govern post-asylum geographies. Beyond traditional ethnography, Piemonte has also been central to autoethnographic and collaborative research, especially studies conducted with or by people with psychiatric experience. An important example is the work by Gariglio and Luvera (2023), a collaborative autoethnography born from an encounter in an SPDC and carried out through interviews in a therapeutic community. This kind of situated, co-produced knowledge resonates closely with the ethos of this thesis and its attempt to engage with madness not only as an object of study but also as a source of epistemic agency and resistance. Moreover, the recent work of Eleonora Rossero (2023) on coercive practices in Friulian psychiatry offers a crucial lens on the tensions within so-called "Basaglian" territories. Her ethnography of care during crisis, and the co-authored article on gendered dynamics in coercive contexts (Rossero & Ferrero Camoletto, 2025), provide comparative insights that further support a reading of psychiatric geographies as deeply marked by ambiguity, porous boundaries, and situated resistances. In placing myself within this landscape, I am aware of the implicit autoethnographic dimension of many of these works—something that Gariglio (2025) has recently named "implicit autoethnographies" a concept that also describes the porous boundary between fieldwork, embodiment, and lived knowledge explored in this research. Collectively, these references shape the genealogy of my work and reaffirm the importance of building on the Italian trajectories of critical, situated, and collaborative psychiatric research.

5| CONCLUSION

Nowadays, the community-based system planned by the reform has not found its full application everywhere and the reality of Trieste, Basaglia's legacy, often taken as an example and a model, represents an anomaly, hardly replicable. Contextually, neoliberal policies have led to a rationalization of public expenditure over psychiatric care; this has jeopardised the implementation of the reform and, consequently, the delivery of services, which have defaulted due to a lack of resources. Moreover, the reorganization of services has been run by regions and the landscape of care across Italy is anything but homogenous (Jones, 2000). If this dispersal has been achieved at the regional level, it can easily be denied at the local scale, where, as an example, a series of group homes, for convenience, can be grouped together in a secluded location. Mental health care is scattered across different places and takes a variety of forms that embed new relationships and power dynamics, still to be explored, from the macro- to the micro-scale (Scotti, 2009). The process of deinstitutionalization across Italy appears to be unfinished, but what is highly problematic is the lack of debate around issues related to its spatial and relational nature and, more importantly, a substantial lack of direct representation. Here we can observe the urgent need to look back, while questioning what comes next, basing our judgments and propositions on the capacity of moving forwards, in line with the political and critical endeavours of the 70s.

In this chapter I have traced the developments made by mental health geography within the wider context of the radical movements of the 60s and 70s, which led to the process of deinstitutionalization in Italy. I have adopted a geographical lens with a particular focus on the under-studied experience of Turin. The focus on Turin has allowed me to access an experience that took place far from the direct influence of Basaglia and his team and, given the lack of research outside Italy, fill a knowledge gap. This gap is further filled by the concern over space, given that geographic studies of mental health are mainly confined to British academia (Crooks et al., 2018). The specificity of how the reform unfolded in Turin was less centred around a persona, and more on a collective endeavour, grounded on a very active collectivity placed outside the asylum. The "deinstitutionalisation of the asylum" has meant the transfiguration of a spatial organisation from a centralised place to a number of interconnected geographies where forms of institutionalisation may still take place. The real change has been in providing patients with more humane conditions, and non-physically violent places to live in; at the same time though many limitations have emerged, including the lack of attention to what such a complicated cartography of services brings to the fore; to the timings of its functioning, and to the lack of debate around the institutionalising nature of this system.

In the wake of Basaglia's approach, my research constitutes a call for a practiced and situated knowledge about mental health care as it is experienced by patients and workers. The case of Turin has shown how users' active role in the anti-institutional movements made them feel part of a collective struggle for social justice, gave them visibility and created a political dimension that needs to be reactivated and adapted to the new circumstances. Since the closure of the asylum, the history of madness and psychiatry has been merely told by psychiatrists, while patients have been silenced again and their current needs, both material and immaterial, spatial and relational, openly ignored due to the assumption that they have been stabilized over time (Cipriano, 2018). People need to be treated somewhere. Therefore, how different typologies of settings impact their daily life must be a matter of continuous discussion. As the Italian case shows, those that need to be consulted are not only doctors, social workers and relatives, but the patients themselves, those for whom others should stop assuming to know what is best for. In light of the above, this research must be considered an initial contribution to better understanding how a reversal of perspectives was instrumental for planning different geographies of mental health care in the past. By exploring the largely neglected case of Turin, I have provided a wider picture of the Italian reform, through an experience that, in line with Basaglia's lesson, followed a parallel but distinct course and from which we still have a lot to learn.

AUTOETHNOGRAPHIC VIGNETTE N.2

At the beginning I had assumed that the historical research that preceded the reform would have less of an impact on me, than the properly ethnographic study that would follow. I had presumed that having been mad, in a country and a period where asylums are gone, would make me less emotionally involved with the terrifying images, descriptions and spaces of the asylum. Although the crossing of old asylums was actually less painful than one might have expected, all the accounts on Basaglia and the reform, often narrated with heroic overtones, evoked a certain discomfort. I must admit, not without embarrassment, that I felt a little annoyed whenever that period was celebrated without acknowledging the current issues or the suffering that being labelled insane can still generate. I felt that in this epic, the mad was often a mere background figure; a secondary character you do not really need to know much about. Psychiatrists are always at the centre of the plot, while patients, when characterised, serve a largely instrumental role, mainly there to set up the hero doctors' gestures. My scepticism and annoyance towards that narrative was the incounscious result of a feeling of resentment towards a rhetoric that, even unintentionally, led one to believe that the mad was now in good hands. I also noticed, the lack of ethics with which archive material is often used to create what could be described as "mad pornography". Has anyone ever considered whether, in the position of the mad, they would have wanted a photo or video, taken without consent, to be used for a publication or a documentary? Would they have liked to be referred to by their first name and remembered for eccentric behaviours alone? It seemed to me that the madman, even if freed, continued to see his suffering as an object of exploitation, sometimes even as an object of mockery and derision. This research has to some extent made my peace with part of this rhetoric. The work of the ALMM in the 1960s and 1970s was the result of an ongoing dialogue with patients, relatives and medical staff, and although it played the role of mediator and advocate, it never really took the place of one or *the other. It is no coincidence that at the trial against Coda, which was reached through evidence gathered by ALMM, it was the patients who provided testimony, rather than the members of the association.*

The archive, with letters and transcripts of interviews, collects traces of lives that someone decided were not worth living; it brings to life different stories and similar sufferings, about which we would otherwise know nothing about. Leafing through it made everyday life in the asylum vivid, in all its banality and cruelty. Moreover, while seeing and touching the innumerable drafts and corrections made by the members of ALMM on every report, manuscript, simple telegram or letter, I was struck by the remarkable political and social commitment. I was impressed by the extreme patience with which they tried to build up relationships with patients and their relatives. I was pleased by the attention to details in describing the places they visited and the people they met. In their work there was a clear desire to have one foot inside the institution to stay there and observe without ever misrepresenting the facts.The sensitivity and attention with which they responded to the, sometimes bizarre, demands of the patients; the energy with which they refused to compromise with the institutions; the intelligence with which they forged alliances with trade unions, students, associations and enlightened administrators; the extreme care with which the material of their work has been catalogued and preserved. That small archive in via Vanchiglia 3 (formerly in via Avogadro), "smells" of profound political commitment, a robust sense of civic duty, and an unwavering feeling of justice that moved me deeply. The association offered support to the marginalised without seeking any form of recognition in return. Only those with direct knowledge of the work of the association cannot help but recognise its contribution and recall the names of its first two presidents, Piera Piatti and Silvana Cottino. In recounting their experiences, the three "Basaglias" in Turin, Pascal, Crosignani, Luciano, acknowledged the pivotal role of Piera Piatti and the members of the ALMM in the process, featuring them as protagonists. They are described as cultured, clever and impertinent women, but also as rich "wives of". However, ALMM members belong to a minor history made of non-illustrious individuals, without which the History would have taken a different route and not have been told in this way.

CHAPTER 5

RULING THE MAD HOUSE

1|INTRODUCTION

Although this fact is not widely known, residential facilities[50] remain a key resource at the disposal of the *Dipartimento di Salute mentale* (DSM, Mental Health Department). What is perceived by most as a marginal phenomenon, affects though almost 28,000 people nationwide, with an average length of stay of 3 years per person (Ministero della Salute, 2021). In this picture, Piemonte is one of the Italian regions that makes most use of these facilities, with a total reach of almost 3000 beds. However, the narrative surrounding the psychiatric reform and the implementation of Law 180 has unintentionally led to the belief that the closure of the asylum and the establishment of community-based services have made the need for supported accommodation obsolete, except for emergency phases requiring hospitalization. Phases whose procedures and implications are little known to the public anyway. The hope patients could be treated at their place, if they have one, unfortunately clashes with reality, made in some cases of toxic environments, from which would be best to keep patients away, absent, or uncapable family members, dire economic circumstances. Therefore, since the closure of the asylum and the creation of guest communities, designed for patients who could not be discharged from the psychiatric hospital, a variety of facilities, both private and public, has seen the light. Except for those "protected communities" dedicated to the most severe cases, which are still a clinic context and often preserve a custodial vocation, over the years, a huge effort has been made in making these services as close to home as possible, in terms of typology, size, and location. This has led to prioritise small sized communities and the so-called "group home", typology in which Piemonte has heavily invested, subsidising both the third and the private sector.

In the previous chapter, we looked at how the asylum was broken down into a number of services, each with its own function. Among all residential services, the choice to focus my study on group homes, was primarily due to

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[50] Protected accommodation for people with psychiatric issues supported on their daily activities by socio-healthcare staff.

three reasons. Firstly, the substantial lack of knowledge or simple awareness of this residential facility, despite its widespread presence in our cities (DGR 2021, n.84 -4451); secondly, the desire to meet patients in what is presumably the final phase of their therapeutic journey, with a more conscious understanding of their life-history as psychiatric users, in and out of services. Finally, my personal curiosity about a model that despite being so widespread and potentially virtuous, remains almost invisible, because of its molecular and ordinary nature and whose invisibility could either reintegrate the mental ill or, vice versa, conceal them in a more subtle way.

In this chapter I will present both the legislative, conceptual and urban context within which the group home is situated, and then, through my ethnography within Zenith's residential facilities, show how they function on an everyday basis. This was done by combining what I was able to observe there as a shadow operator and conversations with workers, while patients' perspectives will be explored in the third and last empirical chapter (Chapter 6). As I have already mentioned in the methodological session, I started my ethnographic study in January 2023 after a preliminary exercise of mapping of residential service providers, some site-visits and few meetings with coordinators of services. Once I was given the chance to conduct research within 7 Zenith's group homes, I started to participate to weekly team meetings and to spend three shifts a week with two of the three teams that run the service, interacting with 32 patients, 20 operators, 2 nurses and 2 coordinators.

1.2 | RESIDENTIAL CONTINUUM; UP AND DOWN THE TREATMENT LADDER.

In practical terms, residential facilities, as identified by the National Action Plan for Mental Health (Piano Nazionale di Azioni per la Salute Mentale, PANSM) and, in more details, by regional laws, differ by levels of needs, intensity, and time presence of staff[51]. Different typologies are distinguished by the degree of therapeutic - rehabilitative interventions and by the level of care intensity provided; all correlated to the level of impairment of patient's functions, abilities, treatability, and the degree of their overall autonomy. Therefore, typologies mainly differ for high or low presence of staff, types of rehabilitation programmes, level of care intensity and for the maximum number of patients they can host (Table 5.1).

TABLE 5.1

Types of residential facilities identified by law

SRP1	SRP2	SRP3.1	SRP3.2
intensive therapeutic rehabilitation treatment	therapeutic rehabilitative treatment of an extensive nature	social-rehabilitative interventions	social-rehabilitative interventions
24 hours	24 hours	24 hours	12 – 6 hours

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[51] Based on the types of programmes implemented and the level of care intensity, three types of residential facility are identified by law:

a) SRP1 Psychiatric residential facility for intensive therapeutic rehabilitation treatment (Protected community)
b) SRP2 Psychiatric residential facility for therapeutic rehabilitative treatment of an extensive nature
(The above-mentioned facilities, SRP1 and SRP2, may be articulated on different levels of care intensity, which configure different sub-types) (housing community)
c) SRP3 Psychiatric residential facility for social-rehabilitative interventions, with different levels of care intensity, divided into three sub-types, with sociomedical staff present for 24 hours, 12 hours, or by time slots. (group homes)

Over the past decade, the Region of Piemonte has approved two decree-laws aimed at restructuring and reforming its psychiatric residential system. The last one, the Dgr 84 (22 December 2021)[52], attracted both criticism and praise; on the one hand because of the excessive requirement for staff presence within the service, which, according to some of the workers "*risks turning care into mere custody*" (Alessandro, June 2023, WI) and, on the other hand, because of the increased number of options and the greater freedom of choice regarding the facility and the treatment plan for the patient. Freedom that, as we will see, is rather limited by the still meagre array of options made available. The DGR requires the observance of more rigid parameters in terms of location, size, number of guests, types of expertise required from staff; plus, it guarantees the rights for relatives and members of some associations to visit these spaces under request. Another element introduced by the regional law that many workers appreciated was a clearer division of tasks among different professions and the differentiated allocation of hours based on these[53]. The law represents the last effort made by the Region to find some sorts of common guidelines between different providers, while trying to safeguard patients' rights. In that respect, as an attempt to put the patients at the centre of the policy, two local patient and family associations were involved in the last draft (ALMM and Diapsi), although the direct involvement of patients living in institutions was not considered at all; evidence that the patient voice remains undervalued.

The decree is always built around the idea of a residential continuum, and foreshadows, or rather hopes for, a gradual progression of patients towards less and less intensive care settings, until full or partial "autonomy" is achieved. It envisages the involvement of patient's family and local community, and the selection of a facility that enables them to maintain their social network. As an alternative, when possible, it is always incentivised the activation of therapeutic projects in one's own home where individuals are supported on their daily activities by educators, nurses, and cleaners. However, the lack of one's own home or employment make this option not always applicable, regardless of one's state of health; often extending the stay in residential facilities more than

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[52] http://www.regione.piemonte.it/governo/bollettino/abbonati/2022/03/attach/dgr_04451_1050_22122021.pd

[53] The figures of the educator or the psychiatric rehabilitation technician can no longer be replaced by the socio-healthcare worker or the nurse, but they must be equally distributed throughout the teams and the flats, and they are the ones in charge of planning. They also interface with doctors, the CSM, support assistants and social workers, whether they have been assigned, and, ultimately, with family members.

necessary. This constitutes an obvious discriminating factor that makes a “mad career” more likely if you lack support, whether economic or social. Moreover, as one of the coordinators of Zenith, previously employed as a home social worker, highlights: “*…one imagines that the quality of life at home is better; but for many, independent living, after years of hospitalisation or staying within psychiatric services, is synonymous with loneliness*” (Igor, September 2023, TI). Reflection also made by my psychiatrist at CSM who speaking of the much coveted “autonomy” warns of *“the risk of leaving patients alone”* (Public Psychiatrist, May, 2023, TI). All operators are aware of the poor results in helping to maintain, or build, social networks. “*One tries to cultivate relationships with the few family members and friends who have not disappeared, but it is not easy”* (Anna, July 2023, WI) although “*in anticipation of afterwards, a lot of work should be done with the family. But this work is completely lacking”* (Luisa, June 2023, WI). Not to mention friends, who, if they exist, are mainly part of the institutionalised circle and *"may not always be desirable companions... In addition to the disease, recreative activities such as drug or alcohol use bring them together"* (Anna, July 2023, WI). Moving from one service and sheltered environment to another makes it almost impossible to build relationships outside the world of psychiatry.

It is not rare patients end up trapped in what is called the “revolving door syndrome” of cyclical admissions and discharges. Following these wanderings or after years in the bubble of residential facilities, they are the first to doubt their ability to live on their own. An educator from Zenith admits that *“it is rather common to see patients entering a crisis once they have to leave a residential facility*. *Several patients from this service have relinquished their entitlement to social housing…and it gets more and more difficult to help them obtain another one*” (Alessandro, May 2023, TI). He mentions a couple of patients, for whom the possibility of leaving now seems remote. Speaking specifically about one of them, he adds that he sees that fact of giving up social housing as his ultimate failure, from which he is unlikely to ever recover. “*…and if your job is to get them out of here…you feel defeated at the start”* (Livia, August 2023,WI).

1.3 | RESIDENTIAL PROJECT

The residential pathway of a patient derives from an official “intake” by the *Centro di Salute Mentale* (Mental Health Centre, CSM), often, but not always, as a result of a compulsory or voluntary health treatment and hospitalization[54]. The CSM creates an Individual Treatment Plan (ITP)[55] which serves as an agreement with the patient, and ideally, their relatives. In theory, this ensures the patient's voluntary participation and adherence to the treatment plan, particularly with regards to medication. In addition, there is the Personalised Therapeutic Rehabilitation Project (PTRP)[56], which is agreed with the psychiatrist, but it is mainly designed and implemented by educators and social workers. It involves a set of tools and interventions aimed at addressing patients' most urgent needs and it represents a transition from a task-based model to an objective-based organization of work. It also works as a communication tool among all team members responsible for patient's care, as well in the transition between different services.

The spirit in which 'the project' is approached differs. One of the senior educators I worked with sees it as "*a fundamental part of their job*" but lament "*the lack of time and space dedicated to it*" (Anna, July 2023, WI). Others admit that in most cases becomes a formality, a mere box-ticking exercise embellished with good, but simplistic, intentions. As Luisa, another senior educator of Zenith claims: "*You only have to put a cross on the various areas on which you intent to work with the patient, which are more or less always the same. The aim is always to make them autonomous…that means, the patient arrives here and learns all the skills considered necessary to live alone. In reality, in the midst of this, there is the illness, the difficulty of building up or keeping relationships, the patients' unwillingness to be alone…the inability to achieve certain goals, the lack of employment, the lack of economic resources….*" (Luisa, June 2023, WI). All aspects that, even when acknowledged, seem to be no one's direct competence or responsibility, and therefore delegated to others, at a later stage.

Every actions is aimed at modifying certain behaviours or acquiring lost skills: "*the objective may be to achieve, for instance, autonomy in mobility…in moving around the territory, so what strategies do we put in place? We accompany you, we show you the route, then we help you download an app on your phone, we look at the routes together, then you start moving around on your own...* (Anna, July 2023, WI). When changes occur, they may be

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[54] TSO, trattamento sanitario obbligatorio, TSV trattamento sanitario volontario, ASO accertamento sanitario obbligatorio modulo. https://www.diritto.it/lintervento-sanitario-obbligatorio-il-punto-su-tso-e-aso/

[55] Piano di Trattamento Individuale

[56] Progetto terapeutico riabilitativo personalizzato

minimal and so integrated into everyday activities to go unnoticed (Minelli, 2011). Said that, compared to other types of users (intellectually disabled, drug addicted, elderly), or to protected communities, between workers there is a consensus on the real possibility of change "*here, changes are more visible…there is a little less frustration…I consider this job more rewarding than my previous experience in communities and with people with cognitive impairment. In some cases, the change happens a little more quickly...in other cases it takes a lot of patience. I believe that one of the qualities that educators must have is patience, both on a daily basis than in the long term*" (Anna, July 2023, WI). Of course, you end up feeling rewarded for things that without knowing the person's path might look insignificant to an outsider. Alessandro, a sociologist working as an educator, suggests to consider the case of patient "*who until last month spent all day in bed in his pyjamas; now he agrees to take an evening walk with us to the park every day, under the pretext of lowering blood pressure… might look like a small achievement…but for us is a great success, we have found the key…Let's take Ivana, she has been living in a residential facilities for almost 20 years… been treated as a spoilt child, now she is happy to contribute to household management…we just stopped replacing her and now she feels to have a role. The paternalistic model adopted before has compromised most of her abilities. It was easier to believe she was not capable…Unfortunately, the world of educators is full of mother hens and master fathers whose work is based on the stick and carrot method. We are not parents and regardless of this, alternating rewards and punishments, it is not an educational model that works with anyone"* (Alessandro, June 2023, TI).

The metaphor of the parent fits well with two processes that my observations and interviews have highlighted: the infantilisation of patients and the gradual domestication of madness (Scull, 1983). There is the sense that madness needs to be tamed or educated and that the home is one of the ideal sites to teach new habits and behaviours to patients to adapt to the outside world, in exchange for security and an partial sense of belonging. To achieve so, this domestic space becomes a site of imposed rules and routines that often become unquestioned rituals.

2| GROUP HOME: GETTING IN

Within this framework, the so-called Group homes - in technical jargon SRP3[57] - ideally represent one of the last steps of this therapeutic rehabilitation pathway and one of the possible residential facilities provided by our health system to patients with psychiatric disorders who require rehabilitation or socio-sanitary support. Support that was deemed necessary to provide in a residential environment other than one's own home. Group homes are conventional flats located in both towns and villages, accommodating a maximum of 5 guests, all with a psychiatric diagnosis and where socio-healthcare staff (see Table 1) are present 6 to 24 hours a day, depending on the severity of the cases. These psychiatric residential facilities are aimed at patients with mild psychiatric problems who cannot be cared for in their family environment and who require a low level of care intensity, or patients in chronically ill conditions, on whom therapeutic rehabilitative interventions have no effect. The interventions provided by this type of facility are social-rehabilitative in nature and are aimed at users who are in relatively stable psychopathological conditions, with some impairment of functions and abilities in daily activities, as well as relational problems in the family and the social sphere. On the side, psychiatric clinical activities involve periodic monitoring of psychopathological conditions to allow the maintenance of users' clinical stability and pharmacological therapy[58]. In addition to this, staff are also required to encourage recreational group activities, on or off site. The residential project should last between six months and two to three years and is specifically designed to enable a person to live on their own. One of the tasks of educators is to check the conditions for obtaining social housing, renting or returning to one's own home. Along with the ideal goal of helping them find work and build (or maintain) a social network.

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[57] SRP, “Strutture residenziali psichiatriche”: Psychiatric residential facilities.

[58] The relationship with the CSM and the DSM is maintained in order to allow the public sector to evaluate with certain regularity the work performed by the providers to whom it has subcontracted rehabilitation.

TABLE 5.2:

Medical staff present in SRP3; typology and tasks.

JOB TITLE	FIELD STUDIES	DUTIES AND RESPONSIBILITY
Educator	Bachelor or master's dregree in Education Bachelor's degree in Psychiatric rehabilitation technician Bachelor's degree in social work Master's degree in psychology (but framed and hired as educators)	Liaison with psychiatrists, other health service's staff and the patient network; drafting the individual project; take care of all educational aspects; money management; socialising;
OSS (social and health workers)	6 months course (post-secondary education). The duration of the courses is 1,000 hours, including 440 hours of internship; without specific training on psychiatric illness.	Support with personal care (hygiene, eating, clothing, etc.), housekeeping, socialising, money management. Support with pharmacological treatment.
Psychiatrists nurse	Bachelor's degree in nursing.	Support with pharmacological treatment. Liaison with the GP and pharmacy.

From what I could observe, they were mostly patients compromised by the transition from one institution to another and by decades of drug use. Transition that made lose track of their desires, opinions, role. With a few exceptions, one thing that seemed to join them all, was an explicit awareness and insight of the disease, likely to be a necessary condition for gaining access to the last step of the continuum. Housing, and the ability of inhabiting it, are considered a priority and equated with independence. Employment policies are not implemented with equal commitment and rarely accompany the residential project, which thus provides a partial and temporary autonomy, compromised by economic dependence.

In the words of workers the group home, at least theoretically, is:

> *"a residential service where people are **placed** by the CSM, in our case, to make a way to autonomy, especially housing. But then they acquire other autonomies that they have either lost because of the*

> *illness, because of the treatment, or that they have never had…it is a path that **in theory** has a predetermined time, with a beginning and an end. And then you would have to go out and make progress... **outwards**. It is not always the case". (Anna, July 2023, WI).*

> *"I see it as a home in which people, some can experiment and then go and live on their own and others can continue to live a semi-autonomous life and live a normal life as much as possible, without being locked up in facilities that restrict autonomy and freedom. It is not really a shared home, because you do not choose the people you live with, you do not choose furniture, you do not choose rhythms… **it is an imposed situation**"*. (Luisa, June 2023, WI)

The cooperative where I had the opportunity to conduct my ethnography runs 11 flats in Turin, with the accreditation of the Public Sector and in close collaboration with the local CSMs. This means that all patients have their own assigned public psychiatrist. While the cooperative's task is also to ensure that the relationship with the doctor is maintained over time and the drug therapy taken correctly, the doctor's task is to verify whether the residential project brings benefits. Less frequent is the opportunity to attend psychotherapy sessions which "*due to lack of funds and staff, never seem to be a priority for these patients*" (Luisa, June 2023, WI). In this respect, Livia, a socio-health worker that has been working in the cooperative for more than a decade, complains that "*They tell us there is no money. The fact they live in the group home for the CSM reassures them, … they don't understand that they should have psychotherapy simply because they live inside these places...regardless of the illness… they have no idea" (Livia, August 2023, WI).*

In addition to the assigned psychiatrist, the social worker (if necessary), the CSM educator and all the "operators" of the various services available to the patient (usually educators, OSS and nurses), as well as the patient's family, if there is one, there is another person who is often consulted to give an opinion on the patient's future: the support person. This role is often filled by a relative, a private lawyer or, if one cannot afford it, an employee of the *Ufficio Tutele* (guardianship office) (L.6/2004). The support administrator is responsible for managing the income of patients deemed unable to provide for their own interests and plays a rather controversial and invasive role, having to approve all extraordinary expenses and a monthly budget. It is therefore necessary to consider the extent to which so many individuals are required to make decisions about a patient, and the manner in which these dynamics are intensified within a psychiatric facility. The operators keep the money of the administered patients in a safe; they provide them with the agreed amount on a daily or weekly basis, performing a rather violent gesture: an adult acting as a parent that grants "pocket money" to another adult, acting the role of a spendthrift kid. The worker is also required to request receipts and it is not uncommon they express a judgment on what is bought. Occasionally, with not a few qualms, spending money to go and see a prostitute (for men) is allowed but it is not so common to be asked. Especially if the support administrator is a relative or a woman. When this happens, the request is made only to the male members of staff. Otherwise, embarrassment and shame prevail; "*as with other forms of disability, the psychiatric patient, being infantilised, is also desexualised" (Livia, May 2024, WI).* The use of the internet and dating apps have fortunately made things easier, despite staff concerns about possible frauds.

Although the intention is to simulate a family vibe, it must be remembered that the group home consists of 4/5 adults who have not chosen themselves and that in most cases share a double room. In the ones I visited, for most of the day there is at least one member of the staff, that regardless of the profession, is there to help, but also to monitor how one behaves. Beyond the workers, other 3 or 4 patients, with more or less similar issues, with which one is asked to co-live peacefully, cooperate, in some cases even take care of them. The observation is not though a neutral act but is inevitably spoiled by the lens of everyone's diagnosis. Everything becomes then a symptom of mental illness, even if in another context would have been read as a reasonable reaction or a mere character trait, in a gradual dehumanizing process that may lead to the identification of the person with their illness and their symptoms. This despite the intimacy of such small settings fortunately limits the dehumanising effects observed in total institutions. In the following sections, to better understand how new power relations unfold, I will have a look at the relational and material features of these settings, with a particular focus on the everyday practices, put in place to make this "other" form of inhabiting domestic space as functional as possible.

2.1| TEAMS: MEETINGS AND SHIFTS

My actual participant observation inside Zenith's group homes was preceded by two preliminary meetings with one of the three teams that run the service - namely the so-called Team Regina (from the name of the street of one of the flat they manage). All the three teams, (Regina, Orta, Tunisi), meet with the coordinator once a week.

This to discuss, update and compare with each other about current or potential issues, progresses, steps backwards, things to do, fix or change. With very few exceptions, I followed all the weekly meetings of one or two teams, depending on the shifts I was assigned to. Every team runs between 3 and 4 flats, and it is generally composed of 3 educators[59] and 3 to 4 socio-health workers (OSS)[60] (see Table 5.3).

TABLE 5.3:

Type of workers per team

	TEAM	FLATS	WORKERS	HOURS
1/2 COORDINATORS	TEAM R	4 (1 with 12 hours, 3 with 6 hours)	2 EDUCATORS	1 part-time
			1 PSYCHIATRIC REHABILITATION TECHNICIAN	part-time
			3 SOCIAL- HEALTH WORKERS (OSS)	1 part-time
			1 NURSE	1/week
	TEAM O	3 (3 with 12 hours, 1 with 6 hours)	3 EDUCATORS	Full time
			3 SOCIAL-HEALTH WORKER (OSS)	Full time
			1 NURSE	1/week

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[59] Educators or TRP (Psychiatric rehabilitation technician), psychologists, social workers equated and hired as educators.

[60] OSS (Operatore Socio-sanitario)

In addition to them, across all teams, 3 self-employed nurses, who visit each flat once a week, and a cleaner who usually goes once every fortnight[61]. One coordinator manages all three teams, sets the shifts and mediates each request between patients, relatives and the SSN. In addition to dealing with any conflicts between patients, patients and workers and between workers themselves. Over the course of my fieldwork, in only 8 months, I met 2 coordinators (the first one went on maternity leave starting from March), I witnessed a series of transfers from one team to another, two non-renewals of contracts, three dismissals, two recruitments, two maternity leaves. For what concerns the patients, I saw three dismissals, three hospitalizations (two were voluntary), one escape attempt.

All psychiatric services, as much as the services dedicated to the elderly, abound of the so-called OSS, a relatively new profession that precedes the nurse in the hierarchy of health care figures, in terms of tasks, specialisation and salary. While the roles and duties are in theory spitted, the management of the flats, due to a lack of staff and inadequate spaces, sees a reduced use of co-presence, and the individual worker on duty, whether OSS, nurse or educator, has to manage whatever emergency regardless of their job description. "*The fact of being alone in the shift and being trained to deal with every situation, if on the one hand it makes the team less hierarchical and aware of almost every issue"* (Noa, August 2023, T), on the other "*may create a certain frustration"* (Anna, July 2023, WI). It is not uncommon for the educator to be asked to help a patient have a shower, whereas the OSS is not allowed to make planning or educational "interventions", although it is neither possible nor desirable to limit their role to the management of primary care, hygiene and nutrition, without establishing a relationship involving some sort of emotional support.

"*all educators, whenever they work, need to base their work on building relationships…you have to be brought up to a minimum, OSSs do not necessarily have this skill… an OSS working in a nursing home certainly has a different way of doing things from an OSS working in a group home…I'm sorry to say that but not all of them have the relational competence to put in place with our guests…in our team we have been lucky"* (Anna, July 2023, WI). The subdivision of roles between professions, although clearer with the new law, loses its meaning in

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[61] Patients are often reminded that routine cleaning is their responsibility, but this varies from service to service, from cooperative to cooperative. I know other cooperatives where cleaners go more often.

practice, at least for educators: "*they say that educators are in charge of liaising with doctors, with the CSM…but at 5pm or over the weekend everything is closed... the only thing you can do is to support the person in their daily activities…you help them with cooking, cleaning, etc.. You sit at the table with them.... but then they tell you that this is more "OSS's work". You find yourself doing everything, despite the official subdivision"* (Luisa, June, 2023, WI).

TABLE 5.4 [62]

List of workers I have interacted with, during staff meetings (ME), during their shifts (PO) and that shared their views, through formal interviews (x) and informal chats (inf)

TEAM REGINA	ME	PO	INT	TEAM ORTA	ME	PO	INT	TEAM TUNISI	PO
Ed Imma	x	x		Ed Alessandro (left)	X	x	x	Ed Laura	x
Ed Anna	x	x	x	Ed Luisa (moved)	X	x	x	Oss Anita	x
Trp Nadia (moved)	x	x	inf	Ed Ilenia	X	x		……	
Oss Livia	x	x	x	Oss Elia	X	x	inf	……	
Oss Antonio	x	x	inf	Oss Luis	X			……	
Oss Iago	x	x		Oss Noa	X	x	x	……	
Ed Adriano (temp)	x			Oss Alberto (left)	X	x	inf	……	
Oss Olivia (left)	x	x		Oss Tania (left)	X				

Every meeting lasted 2 hours and took place, according with the needs of the participants and the weather, in a space run by the volunteering spin-off of the cooperative called Self-help in Sal Salvario, in one of the flats where there was the possibility of having some privacy (in the kitchen or in the living room[63]), or in the park of the Tesoriera. The latter option, preferred by the teams Regina and Orta, as it was closer to their flats and it

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[62] The coordinator decided to let me start my observations with one team (Team Regina) and then gradually join a second one (Team Orta). I then decided to focus my study on 7 out of the 11 flats. After a single shift, I avoided working within the third team (Team Tunisi) due to the considerable distance of their flats from the others and the challenging circumstances they were facing at the time, with one group home in the process of being closed and one of being opened.

[63] During the meeting, patients were of course prevented from entering the room.

could guarantee more privacy than the flats, gave rise to an amusing back-and-forth in which staff members found themselves having to negotiate the use of benches and chairs with a group of elderly people, used to gather and play cards there after lunch. Under a pagoda, padlocked or simply stacked, there were about fifty chairs and few tables. The first team, whose meeting started at 1 p.m., would take three to four unattended chairs and choose a bench around which to gather. At 3 p.m., the second team would arrive, which, in the handover, would regularly have the chairs claimed by some card players. It happened that the coordinator would have to negotiate one or more chairs to keep the others until the end of the meeting, at 5 o'clock. When we did not find any chair, we ended up wandering around the park, looking for steps or other types of seating. Towards the end, some of the members of the staff started to bring folding chairs from some flats. That skit re-named "the drama of the chairs", became a ritual, and it well represented the unintended consequences of having "the territory" as a "workplace". The fact that the cooperative found it efficient to have two teams travel to the other side of the city, losing at least 40 minutes in travel time, was equally bizarre. Other inconveniences involved the pruning of trees, the noise from maintenance work, excessive heat or cold, mosquitos. Guaranteed bathroom access for the cost of a drink at the bar. An interesting aspect to note is also that the cooperative has a head office not far from the park, where, however, community workers cannot go to hold meetings. This, according to some of the workers, exemplified the fact that they are the "*last wheel of the cart and they are little respected by the top management*" (Livia, May 2023, WI). The official reason is that there is inadequate space there and the operators' comings and goings would disrupt the office staff. In addition to leaving operators without a base and a sense of belonging, as a result, communication from the grassroots to the top tends to go through the coordinator and is not always that efficient.

The meetings tended to follow the same structure. The agenda is set, with the first session devoted to administrative matters and the second, usually longer, devoted to patients. Patients, or flats, to focus on, are identified while drafting the agenda and are reported from time to time by members of the staff. During the first meeting I was asked to introduce myself and my project; everyone was very friendly and, apparently, they carried out the meeting without being too much influenced by the fact I was there. Over time, as I got to know better some of them and the individual relationship that had with patients, I learned to pick up on some of the performative elements adopted, to justify certain comments or decisions to me, the potentially judgemental outsider. For some, my presence became less and less of a problem, for others, it continued to be at least meddlesome, if not intrusive. To avoid any potential annoyance and ensure the validity of my observations, I often chose to take on shifts with members of the staff that viewed me as a resource. This approach allowed a more positive relationship with patients and less biased observations.

After my first meetings I wrote this note "*I feel a little bit of discomfort in hearing so many intimate stories about people that I have never met…especially the way they laugh at some".* With time, I understood the need for workers to be ironic, as one of the few coping mechanisms at their disposal for maintaining the right distance between too much empathy and complete detachment. With a few exceptions, they were never disrespectful. When someone did, the team always found a way to make it clear that the limit had been crossed. My role was a hybrid, I felt to be at the border: while it was easy for me to empathise with some of the patients, I also often understood workers' position, or at least what led them to behave in a particular way. When I perceived certain decisions or comments as wrong or potentially harmful, I have always tried to imagine what I would have done in their place; finding alternative ways, in their circumstances, was not always as straightforward. Some of their questionable behaviours or comments were also fruit of years of disappointments or simple tiredness. At the same time, I was aware that as a patient, I would have found some of the workers difficult to deal with and very far from being helpful. The variety of gender, age and backgrounds within the team, allowed though different approaches and this is for sure a plus for patients that might not benefit from an attitude but appreciate another instead. Having said that, major decisions are taken in a collegial manner during the meetings, and it is often the veterans who dictate the line making each team appear compact; being this a work made of relations, the balance is regularly challenged by new entries, both in the staff and among patients. This makes also difficult to univocally assess pros and cons of every approach. Team Regina looked more flexible while Team Orta was definitively more executive, but their patients also varied widely. It was unclear though whether this discrepancy was due to the team's methodology or whether the team had adapted their approach to align with the specific needs of the majority of their patients.

Team Orta has two flats at 12 hours, their patients are worse off, and the majority of its members works full time. Team Regina has only one flat at 12 hours, but it is a flat where patients spend a lot of time outside and having longer shifts allows to check on everyone. The fact that a couple of its workers is part-time and therefore more rested is noticeable. "*It's clear that as fatigue increases, patience drops….and this threshold is important* *because our work presupposes engagement...even if you're not apparently doing much. But you must listen, you have to respond in a certain way, you have to pay attention to what they're saying, how they move, if they're sick at that moment and so on. Deal with potential conflicts between them....Over the weekend, we have shifts of 11 hours. And once per month you work on both Saturday and Sunday. It is a lot, two days at 11 hours is really too much"* (Luisa, June 2023, WI).

Both due to the lack of space in the flats and the shortage of staff, it is quite rare to work in co-presence, spending between 6 and 9 hours alone in the shift. Beyond the meetings, daily confrontation, sharing - and why not complaints - are limited to the change of the shift, phone calls and written reports. The geographical distribution of Team Orta's flats, which are close to each other, combined with the fact that all its members work full time, facilitate more informal meetings and exchange. As well as making the team more up-to-date and cohesive, the act of sharing represent a release valve that the other team laments to be missing. A role that I often found myself playing, and which made me understand difficulties and fragilities of otherwise imperturbable workers. Said that, co-presence, if it is of some help for workers, can become a proper invasion for patients. Coffees, lunches and short walks between members of staff between shifts, are rarely a proper break. In my presence, they justified the break with an apology even though they talked about work all the time. The simple fact of not being with patients during their shift made them feel guilty.

To bring the staff together was the fact of being underpaid, overworked and with limited new training and support. Often alone in their shifts and therefore without the possibility of a direct confrontation. They are accustomed to working extended shifts during which boredom is only broken by the occurrence of an emergency. Beyond the salary and the unregular shifts that do not allow to have a right work-life balance[64], something that almost all workers complained about was the lack of supervision and the poor and often irrelevant training provided to them. After a long time without any supervision, they have recently started one with all the three teams together; but it will last only for a couple of months whereas each team would prefer to have a dedicated and ongoing supervision since "*not everyone would feel at ease in a larger group*" (Luisa, June 2023, WI) and "*one-off supervision is pointless"* (Anna, July 2023, WI). Alessandro, an educator from Team Orta,

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[64] They know their weekly shift on Friday for Monday.

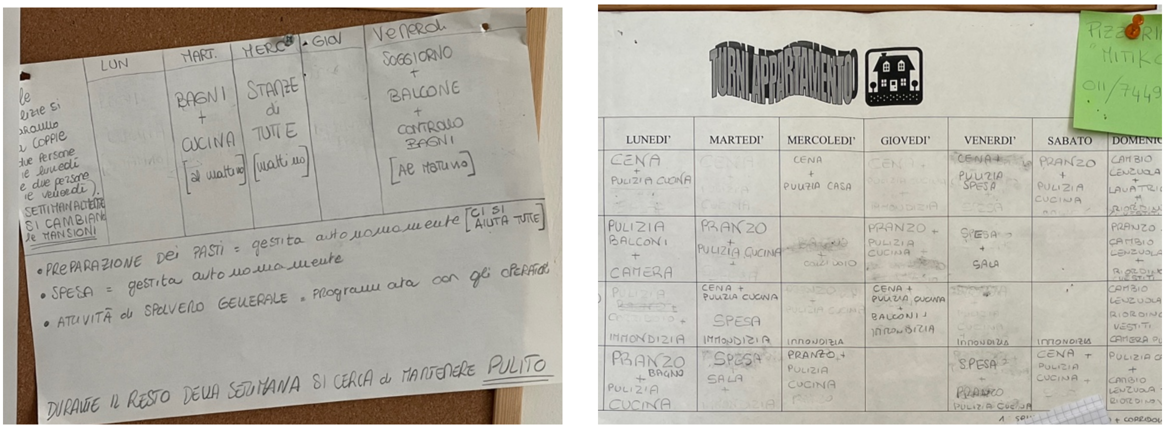
mainly talking about one of their patient that "*lives in another space-time dimension*", once stressed the need to "*find someone that teaches us how to enter in relation with her. With our knowledge we can only strive to provide material support, nothing more"* (Alessandro, April 2023, TI). While in Team Regina, during several meetings, some members of the staff expressed the need and urgency to attend some courses or to receive supervision on eating disorders and drug or alcohol addictions, from which some of their patients suffer. Requests that demonstrate a level of awareness, way beyond a simple concern, about the lack of ongoing support and inadequate preparation in handling certain situations.

Another aspect that often came out was the unbalanced relationship between community-based workers and psychiatrists. After a meeting or a conversation with doctors, it was not uncommon to hear that some of their concerns were not taken into serious accounts. "*You report a problem, and it is never taken into consideration. You are pointing out that there is a problem, but no one takes charge of it, and you can't take charge of it because it's not your responsibility, you're not even able"* (Luisa, June 2023, WI). This feeling that they are never taken seriously or that decisions are mainly made on the basis of monthly meetings, ignoring considerations resulting from daily and long-term observations, is another source of frustration. When I reported that to my private psychiatrist who, as a self-employed, works in a couple of these facilities, he said "*I was hired by the cooperative mainly to mediate the relationship with the CSM on an equal footing. But I just repeat what the workers tell me* (Dr. Private, September 2023, TI). All these things together, appear to justify Livia's point (August 2023, TI): *"it's a shitty job that you cannot do for long, you live with a constant feeling of frustration, helplessness, little value… loneliness".* Having established the general conditions under which the staff feel they work, I will describe the nature and functioning of this residential facility, while leaving the details about of the individual flats and their residents in the next chapter.

2.2|FLATS: THE RULES

Following acceptance, patients are invited to visit the accommodation and meet the other guests for coffee or a meal in the presence of one or more educators. Subsequently, the patients are afforded a few days to either accept or decline the offer. Upon acceptance, the patient is required to sign the so-called "service charter", which is a legally binding contract between the patient and the cooperative. This document lists rights and obligations of both parties. Patients are expected to behave responsibly towards their flatmates and staff, and to take care of the flat; staff are required to work towards a set of objectives aimed at patient autonomy. Upon entering the facility, the patient is placed under observation for a period of at least 15 days, during which, the they are not permitted to leave the premises unaccompanied, to sleep outside, or to receive visitors. Following approval from the educators and the coordinator, requests for leave may be submitted, for instance to remain with a family member or to receive visitors, provided that the staff are present. Visits are infrequent, whereas spending the weekend with relatives is relatively common.

The group home offers a service aims to strike a balance between educational and care aspects; therefore, the objective is to some extent to reintroduce elements of daily life, including activities, behaviours and responsibilities, that are as close as possible to the characteristics of an autonomous adult life. This encompasses self-care, housekeeping, awareness of domestic risks, respect for the rules of coexistence, and acceptance of others as equals. Besides of course respect for the staff members, who are there to help but not to fully replace patients in their daily tasks. The objectives of the group home are therefore pursued through a mix of regulatory and educational interventions that shape the work of the staff into the "management of daily life", understood as the development or strengthening of individual autonomy. The simple activities of dressing, cleaning, washing and setting the table are therefore planned, according to schedules and shifts established by the staff (Figure 5.1 & 5.2).



	LUN	MART.	MERC.	GIOV	VENERDì
le izie si rallo coppie due persone le lunedì e due persone le venerdì). SETTIMANALMENTE SI CAMBIANO le MANSIONI		BAGNI + CUCINA [al mattino]	STANZE di TUTTE [mattino]		SOGGIORNO + BALCONE + CONTROLLO BAGNI [AL MATTINO]

- PREPARAZIONE DEI PASTI = gestita autonomamente [CI SI AIUTA TUTTE]
- SPESA = gestita autonomamente
- ATTIVITÀ di SPOLVERO GENERALE = programmata con gli operatori

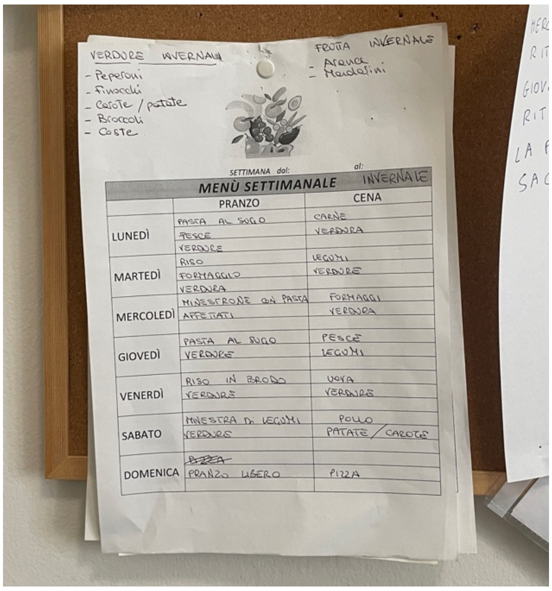
DURANTE IL RESTO DELLA SETTIMANA SI CERCA di MANTENERE PULITO

TURNI APPARTAMENTO

LUNEDI'	MARTEDI'	MERCOLEDI'	GIOVEDI'	VENERDI'	SABATO	DOMENIC
CENA + PULIZIA CUCINA		CENA + PULIZIA CASA		CENA + PULIZIA SPESA	PRANZO + PULIZIA CUCINA	CAMBIO LENZUOLA + LAVATRI + RIORDINO VESTITI
PULIZIA BALCONI + CAMERA	PRANZO + PULIZIA CUCINA +	+ CORRIDOIO	PRANZO + PULIZIA CUCINA +	SPESA + SALA		PRANZO CAMBIO LENZUOLA + RIORDINO VESTITI
IMMONDIZIA	CENA + PULIZIA CUCINA SPESA IMMONDIZIA	IMMONDIZIA	CENA + PULIZIA CUCINA + BALCONI + IMMONDIZIA	IMMONDIZIA	IMMONDIZIA	CAMBIO LENZUOLA RIORDINO VESTITI CAMERA PU
PRANZO + BAGNO PULIZIA CUCINA	SPESA SALA +	PRANZO + PULIZIA CUCINA		SPESA + PRANZO PULIZIA CUCINA	CENA + PULIZIA CUCINA +	PULIZIA C + CAMBIO LENZUOLA RIORDINO V

Fig. 5.1 & 5.2: Examples of shifts hanging on the wall

The preparation of meals marks time and becomes then a central aspect of daily life within this context This may extend from the decision-making process regarding the weekly menu (Figure 5.3), which can be a rare occasion for the members of the group to engage in collective decision-making, to the division of tasks related to shopping, cooking, washing up. Furthermore, maintaining a balanced diet and having regular meals are often primary educational goals. Objectives that staff complain they are unable to achieve as they lack the necessary skills to effectively manage eating disorders and their impact (Figure 5.4). The same can be said for drug and alcohol consumption, "that would require approaches other than mere prohibitionism, or pretending nothing is happening" (Livia, August 2023, WI). These rules tend to be observed in the presence of the workers, often broken in their absence. It is rare for patients to snitch if someone slept outside, a guest came without permission, someone smoked or drunk too much. With an *"omertà"* that all in all creates complicity and shows solidarity and a sense of belonging. Lying or omitting seem to be the only defence systems against rules that sometimes seem to be excessive even to the workers themselves.



VERDURE INVERNALI
- Peperoni
- Finocchi
- Carote / patate
- Broccoli
- Coste

FRUTTA INVERNALE
- Arance
- Mandarini

SETTIMANA dal: al:

MENÙ SETTIMANALE INVERNALE

	PRANZO	CENA
LUNEDÌ	PASTA AL SUGO PESCE VERDURE	CARNE VERDURA
MARTEDÌ	RISO FORMAGGIO VERDURA	LEGUMI VERDURE
MERCOLEDÌ	MINESTRONE CON PASTA AFFETTATI	FORMAGGI VERDURA
GIOVEDÌ	PASTA AL SUGO VERDURE	PESCE LEGUMI
VENERDÌ	RISO IN BRODO VERDURE	UOVA VERDURE
SABATO	MINESTRA DI LEGUMI VERDURE	POLLO PATATE / CAROTE
DOMENICA	~~PIZZA~~ PRANZO LIBERO	PIZZA

Fig. 5.3 & 5.4: Sample of a weekly menu & the diagram of the food pyramid hanging on the wall of a flat where a patient suffers from binge eating.

2.3| FLATS: THE MATERIAL

With a few exceptions, all flats look like a cheap student flat for rent. The cooperative owns just a couple of them, otherwise it prefers to rent. Many of the group homes are on the ground or first floor of residential buildings, maximum to the third. To prevent and reduce the risk of suicide, but also to benefit from lower market values; at the cost, however, of having less light. The rules require to raise the parapet of 10 cm regardless of the actual risk, or height; therefore, an iron bar is added to balconies and windows by default (pictures). Thanks to this hint I have been able to spot many group homes in my neighbourhood (San Donato), discovering that within a radius of 100 metres there are at least 4 fall-proof flats. The closest to my place is at the ground floor and I could easily look inside. It is run by a different cooperative the one I worked with, but beyond the bar, completely unnecessary since it is on the ground floor, I recognised the anonymity of some furnishings and prints that Zenith's group home share.

Although group homes are not clinical settings, they are highly medicalised environments. Not everyone is able to handle therapy by their own, so they are helped. Once a week, the nurse assists them in the preparation of daily and weekly blisters, that, kept in the safe, are given to them when needed by members of staff. This to prevent drug abuse and to check if patients respect the dosage. Living some patients free to manage the therapy is a sign of trust, not accorded to all, and at all times.

While representing a minority, some of the patients go daily to CSM to receive therapy. I think this happens when they refuse to be controlled in that respect by Zenith's staff, or when the CSM believes necessary to check on them on a daily basis. A substantial lack of trust is also found in the monthly or quarterly administration of the "depot", an antipsychotic drug, given with an injection at the CSM, aimed at improving adherence to therapy in patients that showed not to take it correctly in the past. The depot has several side effects after the injection and reduces its effectiveness as time passes. As one of the patients told me "*Doing the depot it's one of the things that makes me feel sicker. I guess it's for being asked to physically go to the CSM when I could take a pill at home, for the implicit lack of trust, for reminding me that in the past I did not want to take the therapy* (Rojita, May 2023).

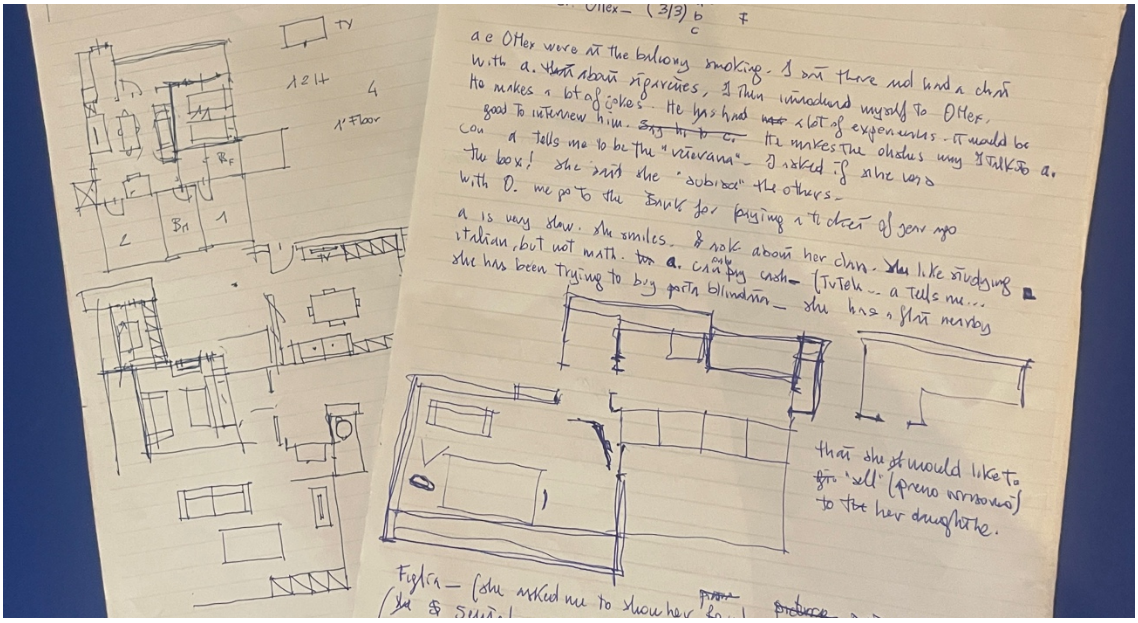


Fig. 5.5: fieldnotes with sketches of the plans of some flats.

The flat groups are mostly three- or four-room flats and, with few exceptions, patients share a double room. As there is no room specifically dedicated to staff, the staff spend time between the kitchen (or kitchenette) and the living room, rarely entering the patients' room. When the kitchen and living room are separate, the staff members mainly sit in the living room, while patients prefer to stay in their bedrooms or in the kitchen. When the living room is the only common space, there are only two options for the patient: hiding in their room or socialising with the worker. In many flats it is impossible to go to the bathroom without being seen. In the group home there are so very little interstitial spaces that it is difficult to escape the eye of the operator, unless one of the other flatmates keep them busy. In every flat there are at least two patients that, thanks to higher sociality or need for attention of others, manage to elude, to hide. Workers tend to avoid entering bedrooms, but it is not uncommon for them to ask to use them as an office in order to make a phone call or have a confidential conversation with some of the patients. As already said, patients often share the bedroom, so there are rarely alone anyway. The majority of conversations happens during the meals and while smoking cigarettes, therefore the balcony and the kitchen represents the main therapeutic spaces of the flat. As it is easy to imagine dynamics change a lot, according to the member of the staff that is there and if the flatmates get along. Some workers are more liked than others, and some patients show their preference quite openly. If they do not like them, people tend to hide in their rooms or leave the flat with random excuses. Excuses, that even if generic or fake, have to be provided anyway.

In the common spaces, there are three types of things hanging on the walls of Zenith's group homes: prints that depict cities, landscapes, flowers, animals, drawings or painting made by former patients for some classes at the Day Centre, or, if a patient has been there for a long time and feels at home, some personal pictures. It is more common to find pictures in their rooms, close to their beds. However, it is rare for them to personalise their bedroom too much, as they often have to share it. Moreover, excessive customisation is likely to make the setting feel as permanent, whereas it is meant to be temporary. Not taking too much care of the space, in terms of furnishing, tidiness and cleanliness, thus becomes a way of refusing to feel too much at home. The fact that there are so many flatmates and that they are officially transient, contributes to not taking too much responsibility in that respect. This is where the role of workers comes into play most clearly. A daily rota on the wall reminds the distribution of tasks. Workers help the less independent, while reminding others when they shirk their duties.

The communal areas are full of random objects whose origin is unknown. A broccoli-shaped soft toy, a giraffe-shaped vase, an elephant piggy bank and a crocodile figurine were just few of the most eccentric objects I noticed, which none of the patients claimed but at the same time did not dare to throw away or move. Furniture is cheap and neutral, sometimes its arrangement is causal and not particularly well thought-out. The position of some shelves is sometimes equally random. Some workers confided to me that many paintings have been put there mainly for covering damp stains or similar. Perhaps before a monitoring or before a new patient's visit. One of the flats has stickers on the doors. They cover a couple of holes, that a patient, in a fit of anger, made (Informal chats in Via Crevacuore & Sansovino). Empty shelves or bare bookcases give an impression of neglect and little life.

There are many elements that suggest we are still in a clinical setting. The most obvious is the presence of 4/5 adults who have not really chosen each other, often hastily matched according to the mere parameter of diagnosis, age, gender. Parameters that become less and less important when the discriminating factor is whether and where there is space available. When planning a new "placement", the patient and their network (e.g. relatives, psychiatrist, support administrator, social worker, etc.) meet with the coordinator, who gets an idea of the support needed and individual requirements. Once one or two suitable flats have been identified, especially depending on availability, the patient first meets one or two educators, and a coffee meeting is arranged in the flat with potential future flatmates and the educator they have already met. When I was there, there was only one case in which the visit did not result in an entry. The substantial lack of options kindly pushed patients to accept the place. Moving from one flat to another within the cooperative, although sometimes requested, is only granted in special circumstances, and so it is the request to change the psychiatrist, considered highly problematic. If you want to change psychiatrist the easiest route is to change address and therefore CSM. Many workers, while describing the need to adapt and overcome difficulties, define the "group homes" as a "gym" where, in order to test for life outside, it seems you are called to accept conditions that few outside would accept. More similar to an obstacle course, the perception that patients are constantly tested and put under constant scrutiny stands at the core of the management of both the flat and psychiatric care in general.

This constant examination finds its materiality in the worker that, on the kitchen table or in the living room, writes down the report ("*consegne*", literally "deliveries") on what happened during the shift. The embodiment of the gesture of writing down observations together with all the folders within which these reports are kept, filed under key in a safe, taken out and put back in at every shift change, represent both a material and relational practice that objectify the patients; patients who, although protagonists of this practice, are excluded from it. The workers often point out that patients may read the parts that concern them, but they also admit that it is rare they ask for it. In addition to the reportss, the safe also stores meds, individual documents, administered patients' money and the weekly budget for the flat[65]. In addition to the safe, a first-aid box, a fire extinguisher, a lot of guidelines on the wall reminds us we are still in a clinical setting. Rota, shift sheets, the weekly menu on the wall, offer an idea of how time is marked in the flat.

2.3| GROUP HOME: THE ROUTINE

On an ordinary day when there are no appointments (or dramas), a member of staff rings the doorbell at 9 a.m. The staff does not take the key with them, as a symbolic sign that they are to be let in and that they do not have free access to the flat. Given the value that having the keys to one's own home must have had for former asylum patients, the fact that they do not have the right not to open the door to staff makes patients wonder how much of this practice is just form, slowly emptied itself of substance. The same can be said for the absence of a proper office within the flat. "*It's their flat, we should not have a dedicated space*" (Igor, September 2023, TI)," but *this makes our presence even more intrusive and cumbersome. in some flats while we take out the folders and write down the reports, they don't know where to put their heads anymore*" (Livia, August 2023, WI)

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[65] Every week, a worker withdraws 50 euros per patient that must be used for regular expenses (mainly food and resocialising activities. Extraordinary expenses require a formal authorisation by the cooperative and are mainly used for household stuff, pieces of furniture or, always as part of resocialising activities, for trips or meals out. Requests for furniture follow a more complex process and the necessary waiting time seems to aim to discourage or render the request obsolete.

A patient opens the door but does not necessarily wait for the operator; they often go back to bed, or simply holes up in their room. This really chances flat by flat and day by day. As a first task at the beginning of the shift the workers must read the already mentioned "*consegne*" (Assignments). In these notes there might be also a list of things to do, like calling a doctor, buying a drug, helping a patient in carrying out certain activities. After the update, they try and wake up who is still sleeping, ask how people feel and engage in a series of activities, mainly aimed at housekeeping and preparing meals (menu, shopping list, grocery shopping). All aimed at creating an individual and group routine, both for patients and the worker. In some flats, where the waking dream-rhythm is disrupted and where the team has found that an imposed schedule could be counterproductive, a degree of flexibility is granted; this can be seen though as an exception, not widely shared among the staff. If patients become active at 11, and the worker has been there since 9, the 2 hours of inactivity are obviously considered as lost and often used to replace patients in housekeeping. As Livia highlights (August 2023), "*getting up at 11am instead of 9am if you have no commitments should not be seen a sign of illness, quite the opposite*". However, following the opening time of the CSM, from 9 to 5, is understood as a willingness to lead a healthy lifestyle. Anna, in describing the setting up of a predetermined routine in an undisciplined flat says: *"Sometimes I feel like I'm doing violence....so I am always a bit flexible....you think the patient has to leave the apartment as a person whose daily routine is predetermined by someone else. I wonder how right it is to break certain habits... not for their own sake, but because of parameters dictated by society, which says it's better to wake up at .9" (Anna, July 2023, WI).*

If there is someone that needs to clean or tidy up is called to order, they make sure what is planned for lunch, considering whether or not to go shopping, and who to go with or who to send among the more independent ones. Preparing the menu and making the shopping list is perhaps the most democratic practice. All residents are called upon to participate and express themselves, despite hearing many "for me it's the same". As much as cooking, going shopping is among the abilities that patients need to regain, therefore the support of the worker is supposed to decrease more and more. Some would go over budget by buying too many things or things off the list, others would struggle to make decisions and choose products. Compared to other public places, such as the tube, the supermarket does not seem to be a source of social anxiety for the patients I have been with. Coffee is often offered to those going for a walk and is another way to pass the time and get to know the neighbourhood. During the meals, some workers spend time with the group facilitating the conversation, others prefer to leaving them alone. The meal still represents one of the few moments when patients gather in the same room, however, in some flats is consumed without a word or see only a couple chatting. A nap, another coffee and it is soon dinner time. After 8 o'clock the worker leaves and some activity, forbidden in their presence, is likely to take place: a couple of beers or a bottle of wine, a joint, an unauthorised guest, someone going to spend the night elsewhere. Breaking the routine from time to time are visits to the doctor. Otherwise, life seems to pass, day after day, also thanks to the distraction of the operators. Few are the patients that have a job and just as many are actively seeking one. Sport activities, despite being incentivised, are off limit for economic reasons; when organised by the Day Centre, reproduce an environment not very different from the one of the group homes that patients tend not to be willing to attend. All the activities offered by the Day Centre are defined as "*mere entertainment*" (Luisa, June 2023, WI) and seems to address the most compromised patient. Painting, theatre, jewellery making, crochet are among the most common activities but both workers and patients are not always as enthusiastic about them. "*Some of the patients, in attending the day centre, would risk becoming even more institutionalised*" (Coordinator 1, November 2022, TI). Over the summers activities tend to increase, to include the swimming pool and the picnic in the park. I witnessed a failed attempt to go to the cinema and a failed daily trip to a national park outside the city because the majority did not want to go and there were not enough workers for both going to the trip and staying in the flats with the remaining residents. The attempts of organising something different, unless it does not involve food, often fail; with them the willingness and enthusiasm of operators in organising them.

As I have highlighted, all the rules that concern the management of the flat appears to be mainly linked to the need to make patients follow a routine, made of small tasks and habits. To these are those that prevent the consumption of drugs and alcohol inside or prohibit the entry of outsiders, unless authorised. Every night not spent in the flat has also to be authorised. Few patients have the right to spend the weekend with their relatives, but outside that window, they need to ask for permission. Apart from these more rigid and fixed rules to which every worker adheres, a degree of discretionality appears to characterise the model: discretion which, while allowing a certain flexibility to adapt to individual circumstances, more often than not, takes the shape of non-specific and arbitrary decisions, becoming a form of power hard to predict, question and therefore resist. Decisions are taken based on observations and perceptions, that passing from one mouth to another, become a solid truth, regardless of their validity. In addition, once the whole team has been made aware of something, it is common for them to look for and then see it, even if it is not there.

Sharing activities and space between flatmates within the group homes is considered therapeutic itself. However, it should not be taken for granted patients socialise among themselves, even less that the socialisation that takes place is necessarily therapeutic. While "individualism prevails" (Luisa, June 2023), the mere sharing of a history of suffering and of a space cannot be considered sufficient. One of the OSS who is attending a master's in music therapy hopes "*to offer classes to the patients in the future…outside of here. Gather them around a guitar with the aim of learning to play an instrument might help develop a sense of belonging. We should admit that spontaneously very little is born here in the flat"* (Elia, February, 2023). I approached this community-based service with the hope that the group home, at least partially, could play as a support group and help empower individuals. I soon realise that when it happens, it happens by chance. The same can be said for the community life that was hoped for.

2.4| GROUP HOME: THE NEIGHBOURHOOD

All the flats are in neighbourhoods well served with shops and transports. It is likely that they have been used for social purposes for decades; they are often placed within social housing complexes or close to them. Over the years, the value of properties and the prestige of the areas in which they are located have increased considerably, as has the quality and variety of shops. Given the limited amount of money at the disposal of the group, shopping is always done though in the closest discount supermarket, first polarity for all. The second one is represented by one or two cafeterias nearby, the tobacco shop, the closest park, the CSM and the pharmacy. The relationship with other residents and shop keepers are very limited. Life within the group home goes mostly unnoticed and the benefit of anonymity and invisibility that the city provides with is enjoyed by patients. They feel safe at home, and they do not feel any needs to make themselves recognisable outside. The comings and goings of ever-changing workers is perhaps suspicious and make some of the residents of the buildings wonder. However, as far as I know, suspicion rarely translates into prejudice or intolerance. The public characters that are aware and that play a key role in a potential re-socialising process, are the bartenders. Few are the patients that autonomously explore the neighbourhood. Even less the ones that had already had a relationship with the surroundings.

> *"The relationship with the neighbourhood is very much limited to basic needs... the shop, the bar…the flat seems almost like a happy island with very little relationships with the neighbourhood. In many cases they have been uprooted from their neighbourhood... perhaps the motivation for some may also be that…in the sense that the area in which they live now is not their home neighbourhood. In any case, there is this tendency to shut yourself off. The fact that the flat is a little island of happiness, which is only considered happy because you feel protected." (Anna, July 2023)*

3| CONCLUSIONS

The infrastructure underpinning the family home is therefore based on a clear distinction between the roles of staff and patients, with the former assuming the role of guide and ruler, and the latter the role of the guided subjects. The staff are internally categorized according to skills and professionalism, which in a sense anticipate patients' needs according to generic minimum objectives. However, these objectives are often inadequate for specific cases. In addition to the set of rules imposed to ensure quiet living, manage the flat and achieve the aforementioned goals, which contribute to the production of coercive forms of control, there is a combined lack of privacy, trust and autonomy. Due to the nature of the illness paying attention to each behaviour and putting into question whatever is said, appears to be at the core of the workers' task. A general mistrust and extreme caution towards patients contribute to demotivating those already lacking motivation and purpose. All the rules they have to abide by, a very little negotiating power and the lack of alternatives make the degree of autonomy limited and insufficient. Patients are free to refuse the activities, to go and do what they want, but within a predetermined framework and with all the limitations that come with being a guest and a user of a service. Moreover, without money, dependence on the service turns into a constraint. A dependency that is also relational: the help and support they receive from the staff is unlikely to be matched elsewhere. What I am describing is not far from what we all have experienced up to adolescence. This is nothing more than the effect of an infantilising approach on which psychiatry is based on and that I had the opportunity to observe in many of the practices and gestures performed every day, more or less consciously. To this must be added the discretionary nature of some of the decisions taken, whose arbitrariness makes them more difficult to question.

The group home is undoubtedly a more humane model, but with time it has become a rule and an organisation that does not allow individual needs to change, needs that often boil down to the basic ones: food, a roof, control, pharmacological compensation. Some of today's practices and habits come as such from the 80s and 90s, when patients who had been in the asylum for decades were helped to readjust to life outside. Teaching former asylum patients to walk to the café, shop at the supermarket and make lunch had a different meaning than today. The routines and schedules established by the staff have lost their original purpose and consequently their effectiveness. Some of these old practices and routines are repeated today as if they were rituals, but without really understanding why they started. What I saw, experienced and was told was a bureaucratic organisation that gives unspecific answers to problems that are, by their very nature complex, diverse constantly changing. Consequently, standardising the fates of patients. We celebrate the reform without realising that we have crystallised models which, while representing a preferable alternative to the asylum, are not necessarily virtuous. What I saw was a machine that operates out of inertia somehow due to a lack of imagination, not in the territory as was hoped but simply in the territory. They, in a less striking way, sometimes reproduce similar dynamics. If we do not want to be satisfied with having improved the living conditions of the mad, while continuing to marginalise them, perhaps we should start practising a listening exercise again and carry out a systematic “disciplinary unlearning”. The liberation process as outlined by Basaglia was supposed to be a model in continuous evolution, capable of moving the horizon further and further. Now it seems we have moved from the optimism of the practice to the pessimism and frustration of a routine that is uncritically reproduced, a routine through which the madman is once again silenced. In the next chapter I will elaborate on how such standardisation is experienced, felt and narrated by those who suffer it the most, patients themselves.

CHAPTER 6

EMBODYING THE MAD HOUSE

1|INTRODUCTION

I built up the geography of Zenith slowly, flat by flat, patient by patient, and only towards the end of my ethnography I eventually got a partial picture of how it works. Although the group home can be seen as a format, its standard is continuously challenged by who inhabits it, whose individualities - and their interrelationship - shape its dynamics in different ways, almost on a daily basis. It can be surmised that relationships between patients, as well as between patients and staff, develop in ways and at times that are difficult to predict, resting on a rather unstable balance. Balance that is easily broken by its inherent fragility and by the frequency with which staff members and patients themselves change or move – or better, are moved. To this must be added the "interference" produced by my presence, rather cumbersome in such small spaces. Spatial constraints that made me always bear in mind the "volume" of my gaze on someone else's everyday life. In spite of this, life in the flat appears to flow in the same way all the time.

The aim of this chapter was that of unveiling renewed power dynamics in their daily manifestation and it was achieved through a combination of participant observation, informal conversations and more in-depth life-history interviews with some patients (n. 5). Although the eight-month observation period was insufficient to provide a comprehensive, stable and univocal picture of the group home, it was nevertheless a useful foray to gain insight into a world that remains largely inaccessible to outsiders. As well as unheard or undervalued are the opinions and points of views of those who live and suffer in these spaces. There are aspects that characterise these spaces that are rather difficult to imagine from outside, yet they constitute their defining elements once you are there. I am referring, for example, to the impact of both protective and restrictive nature of psychiatric care, made up of inertia, boredom, extreme caution, concern, bureaucracy, that like a ubiquitous dense cloak covers all. To understand what it means to embody and feel this cloak, I questioned those directly concerned, the patients. Each of the them interpreted the nature of this “atmosphere” with slightly different nuances, identifying distinct repercussions on them.

The patients that have been involved in the research have been considered as users of a service and therefore experts whose direct knowledge cannot be fully replaced by no other expertise. In order to avoid any exploitation of their suffering, with the associated potential risk of making “pornography of illness and sadness”, I consciously decided not to explore deep and painful experiences of madness, unless they were the ones talking about it. As well as ethical issues, for not having the necessary skills. All the patients within the flat, except for a few and for short periods, can be considered relatively balanced, or as used in psychiatric jargon, “compensated”. This has not allowed to adopt lived madness as a proper epistemological lens for looking at the reality they were living, as Mad Studies suggest.

To begin with, in the next paragraph I will describe all the flats where I conducted my ethnography, following the order in which I visited them and focusing on my initial impressions. I will then introduce the patients living there and illustrate some relational aspects I was able to observe. Subsequently, I will elaborate on five individual experiences fruit of in-depth interviews with patients who decided to participate in the research with their stories and insights.

2|GROUP HOME: GETTING IN

2.1| TEAM REGINA

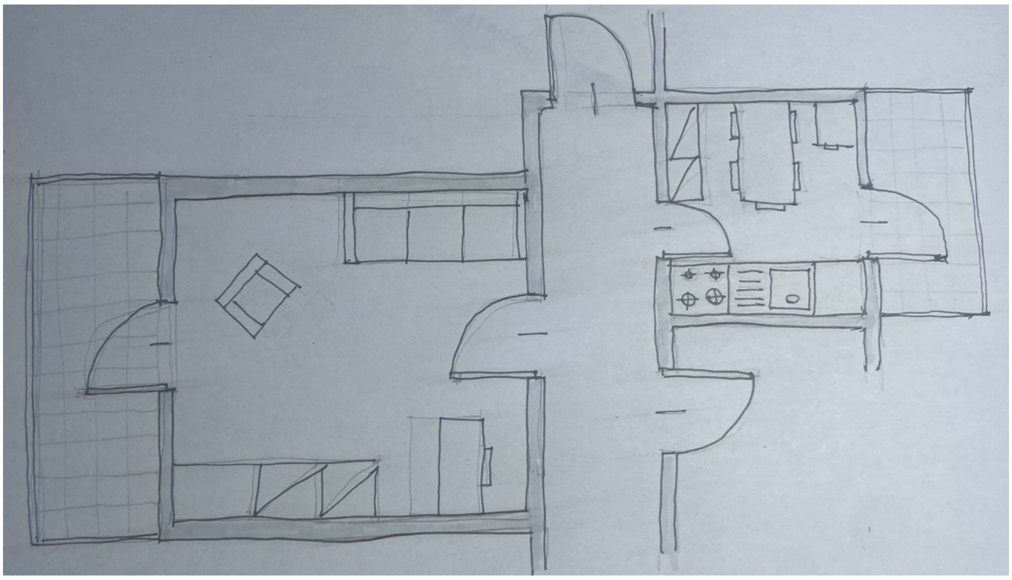


Fig. 6.1: Flat R1: common areas.

My first shift was on a Monday morning, in Flat R1. The flat is located within a rather pleasant complex of public housing built in 1926 and later extended in 1946 by the Autonomous Institute for Social Housing (IACP). The dwellings are distributed, among gardens and treed courtyards, in well-designed but decadent four storey-buildings. The quality of the settlement, legacy of a different approach to social housing that we have slowly lost, can be seen in the relatively low density, in the rich decorations on the façades, in the attention given to open space, in the presence of wide balconies. The complex is surrounded by a fence and a gate, beyond which one enters an almost village-like dimension. The relatively poor maintenance of the buildings might suggest that this is a working-class neighbourhood. The neighbourhood appears to lack diversity, in terms of class, ethnicity, age; the residents seem to be predominantly elderly and white. The presence of a CSM within the complex suggests that the area has historically hosted psychiatric patients.

Imma, an educator in her late twenties, was waiting outside to describe the "situation" to me in advance. The "guests" as she calls the patients, are four. She anticipates that "*the group gets along very well, probably too much*" (Imma, January 2023, Inf.), so much so that they now depend on each other to an extent that is now difficult to break. The flat is composed, in order of age, by Adriano (70s) the "father" of the group, long-standing and well-liked patient of both the cooperative and many other territorial services in the city, Ubaldo (60s), a former support teacher, Ugo, (50s) the only worker of the group - he works at the public transport company - but currently, and as I later discovered quite often, on a sick leave and, finally, Oliviero (50s), father of a 16 year old girl. We had just come out of Covid-19, and the staff was asked to wear the mask in presence of patients. That mask, we soon stopped wearing, filled somehow the role of the uniform; it was a way to maintain distance and to claim roles, also in presence of neighbours and shopkeepers. We therefore found it liberating to get rid of it. The other distinctive element was related to clothing; given that patients spend a significant amount of time at home, they tend to wear tracksuits. Few are those who, even when they do not have to go out, do not wear home clothes.

Imma treated me like a proper intern, showing me the full range of tasks a worker is expected to complete during a given shift. To begin with, the reading of the already mentioned "deliveries" (shift reports) - a couple of handwritten lines on the shift. As an introduction to the patients, she made me read their reports and medical records. I kept doing this for other two flats and I then decided to stop, having realised that I was inexorably influenced by this information in a way that was in no way useful, but rather potentially detrimental to the purpose of the research. Their diagnosis and medical history would inexorably influence the way I would relate to them and look at their behaviours: having a fresh and unprejudiced perspective would have been much preferable, which operators could not have. My view was though somewhat compromised by whatever was said during the staff meetings.

My first impression of the quality of the space was always worse than the one I later gained. Habits and relational dynamics somehow made the space a secondary element overall. Over time, I stopped paying attention to the mess and the poor cleanliness; while at start my attention was more on the material elements of the flats. As I said the group gets along well so the living room, the kitchen and the balcony are very much used by everyone; only Oliviero prefers to spend most of the day on his bed. Ugo is sitting on the couch complaining about the slowness and incompetence of the Ufficio Tutele (Guardianship office) that does not allow him to buy a new pair of glasses. Adriano e Ugo describe me the trap of being administered; Adriano hired a lawyer, so the process is generally faster, even though, having a gambling past, his budget is rather low. He claims he has stopped gambling thanks of this, beyond reducing the number of cigarettes as well. He points to the electronic cigarette and tells me: "I have switched to this and then I get 3 real cigarettes per day". Ugo rolls his eyes and adds, *"plus all the ones he scrounges*". I will later discover Adriano receives cigarettes in exchange for all kinds of favours to others (cooking, shopping, etc.). They all smoke, which is quite common among patients. The same can be said for workers: they are a minority who do not smoke and somehow this prevents them from engaging in informal chats and therefore establishing a deeper connection with patients who smoke. "*I always thought I would start smoking doing this job*" put Nadia (May 2023, WI), an educator.

After lunch, it was planned "an accompaniment", namely we went with Adriano to his CSM, in Barriera di Milano so I had the opportunity to attend a routine visit, a monthly duty for both patients and educators. Adriano is probably one of the most knowledgeable about the city and navigates public transport very well. Many tend to keep their previous residence in order to keep the same CSM, which is therefore sometimes very far from the group home. At the CSM, he knows everyone, and he feels at his ease. He does not mind if I assist to his visit. The doctor is nice, but she clearly underestimates Adriano's concerns. "*Take it easy*" is the best she can advise. On the way back, he started telling me stories from his childhood and youth, and when we got home, he showed me a picture of himself in the mountains. "*I haven't been climbing for 30 years*" he said with resignation. He likes to talk about his past and has no shortage of anecdotes, often told in the same way. He talks about his move from homeless shelters to group homes via communities as something quite common and not particularly traumatic, which happened to him as an alternative to other, not necessarily more desirable, possible fates.

When we are back, sitting at the kitchen table, watching videos on Youtube, there was Ubaldo. He seems to be the most independent of the group. However, Imma tells me he may get very anxious for very trivial things, especially outside of the flat. His speciality is to make up jokes and tell them non-stop. It is not uncommon for others to intervene with old jokes, by creating a sketch hard to interrupt. When Oliviero is around, he demands everyone's attention. He repeats things over and over again, hogging the conversation and leaving very little room to anyone else. The others treat him like a child, they care about him but are visibly relieved when he is not there. He mainly talks about his daughter and about his father who committed suicide when he was 16 years old. I realise he complains about the past because not much happens to him nowadays and this is something I also found in the accounts of other patients. The dramas of the past are still vivid and still seen as responsible for the suffering of today. Overall, it is clear that everyone appreciates the presence and support of the operators, whom they believe they perhaps need more than they really get. An aspect that, even at first sight, makes difficult to imagine them outside of this context.

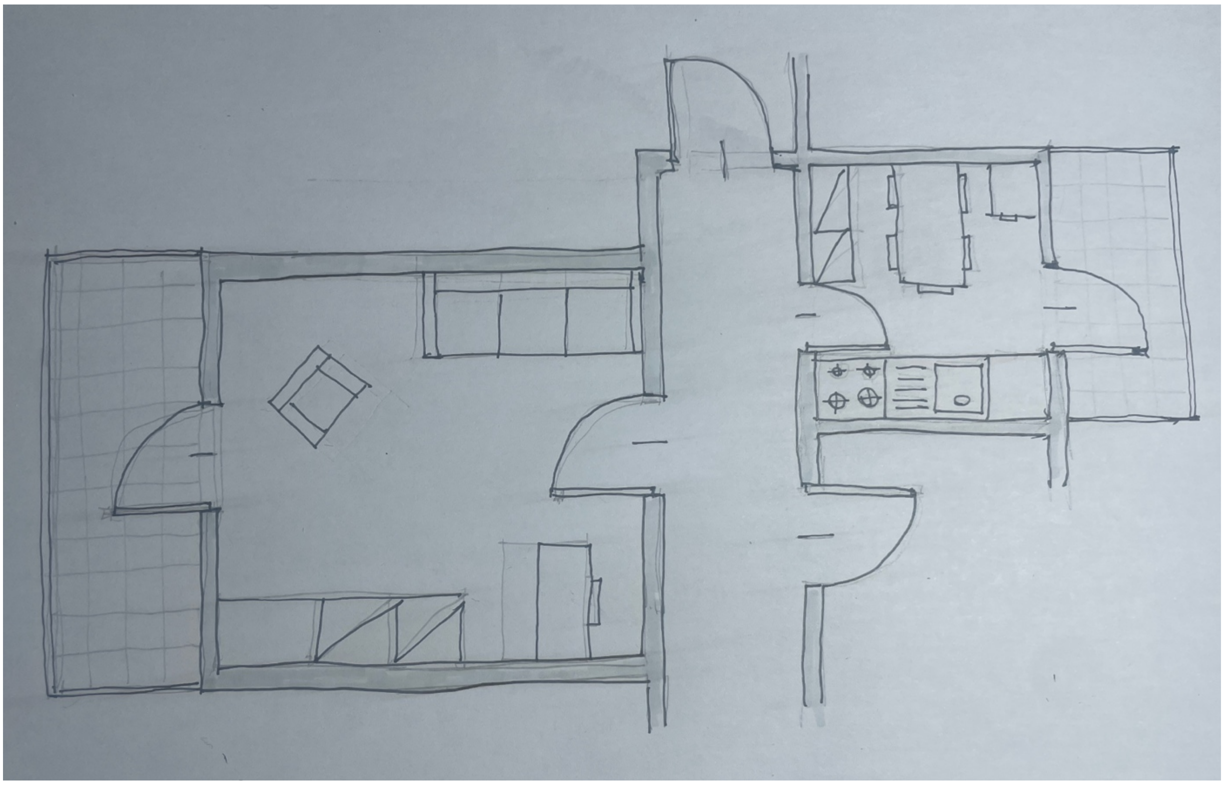
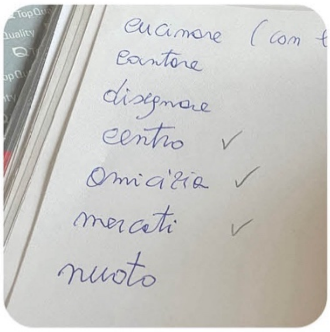


Fig. 6.2: Flat R2: common areas.

My second shift was in the flat in Flat R2. Corso Regina bisects San Donato district; the flat, in an elegant building, is on the side considered slightly more prestigious and faces a rather busy street. San Donato was traditionally a working-class neighbourhood, especially the northern side of it. However, in the last couple of years, has been partially gentrified. The flat in Regina was one the of first to open, so it has seen the district change, in terms of both social fabric and facilities. Among the door name plates I recognise another social cooperative that run group homes, allowing the building to reach the maximum number of permitted psychiatric residential facilities in the same establishment. The flat is rather dark; you get in through an entrance without windows, from which all other rooms can be accessed. The entrance has some furniture and a cloth hanger, but being so cramped is merely used as a deposit. I never visited the two bedrooms, but only the common rooms: the kitchen and a living room that, as often happens when there is a second room, is used as an office by workers and mainly deserted by patients in their presence. The flat is rather clean, to make it slightly untidy the jumble of furniture and objects - as usual. But it is pretty obvious that the ladies relatively care about it. With the exception of Romola, that works all day, the other three ladies spend a lot of time at home. I got there at 9 and I could already smell tomato sauce. Ursula, the oldest lady (in her late 60s), gets up very early, goes shopping and starts cooking for everyone. “*She has found her raison d'être by taking care of all the others, on her own terms. Being useful makes her feel good, but it’s not educational for the others*” (Livia, August 2023, TI). By doing so, she has asserted the right to decide what, when and how much to eat. The others, in order not to take care of the food, accepted the deal. Towards the end of my fieldwork, a new entry, unwilling to make this compromise, wreaked some havoc and called Ursula's role into question, not without daily dramas.

The first time I went they offered me a coffee in the kitchen and wanted to know more about my project. While Ursula, was sitting in silence with folded hands, Alma, a primary school teacher in her late 50s, showed an interest in my research, not without displaying some scepticism about the fact the service could somehow improve. At times hostile, or more simply reserved; when I asked her how long she had been living in a residential facility she replied with a resigned “*way too long*”. Sara is the one that gives you more confidence and requires more attention. She tells you many personal stuffs, then suddenly stops and tells you she does not want to talk



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about it anymore, shifting the conversation to quarrels at home. Ursula that counts the number of apples to eat, Alma that does not want the tv on in the morning; more generally the fact that everyone treats her like a child. At times she indeed behaves like a child, but you never know if it is a sort of performance to get some attention or what else. Even the tasks assigned to her by the psychiatrist evoke childhood activities. She is the only one that spends time in the living room when the workers are there. She often talks about wanting to make friends by excluding a priori that she could establish a relationship with the housemates. Alma and Ursula, on the other hand, seem very close and protective of each other.

During a staff meeting I discovered that Alma got a supported accommodation, another facility to share with other two ladies but with much less staff presence. She is worried about Ursula’s reaction so much so that she was not convinced to accept, despite being for sure an improvement for her. The staff luckily managed to convince her but the following week when I met her and I enthusiastically congratulated, she shut me up. She still needed to talk to her flatmates about the move, that was going to happen in less then two weeks. I realised then how sensitive the issue of housing can be and how difficult it is to leave the group home and some of the flatmates. The passage from a flat to another is not always as straightforward, leaving the task of moving to the person, often devoid of support and resources. Therefore, it is not uncommon that some workers help on a voluntary basis, by providing time and cars. Since Alma moved out, I have heard that Ursula visits her from time to time and that Sara occasionally comes for a coffee at the flat. The last comment I read on the reports about her was a laconic “*She is fine where she is*”. The lady that replaced Alma brought some turmoil, with regular threats of voluntary hospitalization and continuous disputes, with factions reconstituting themselves on an almost daily basis. At some point the situation became so problematic that it was suggested that I stop going. I kept being regularly updated about Reginas’ dramas, as well as at meetings, every Sunday when I joined Livia in her shift change. There she could not help but vent her frustration about these dynamics with me, treating me more like a colleague than ever.

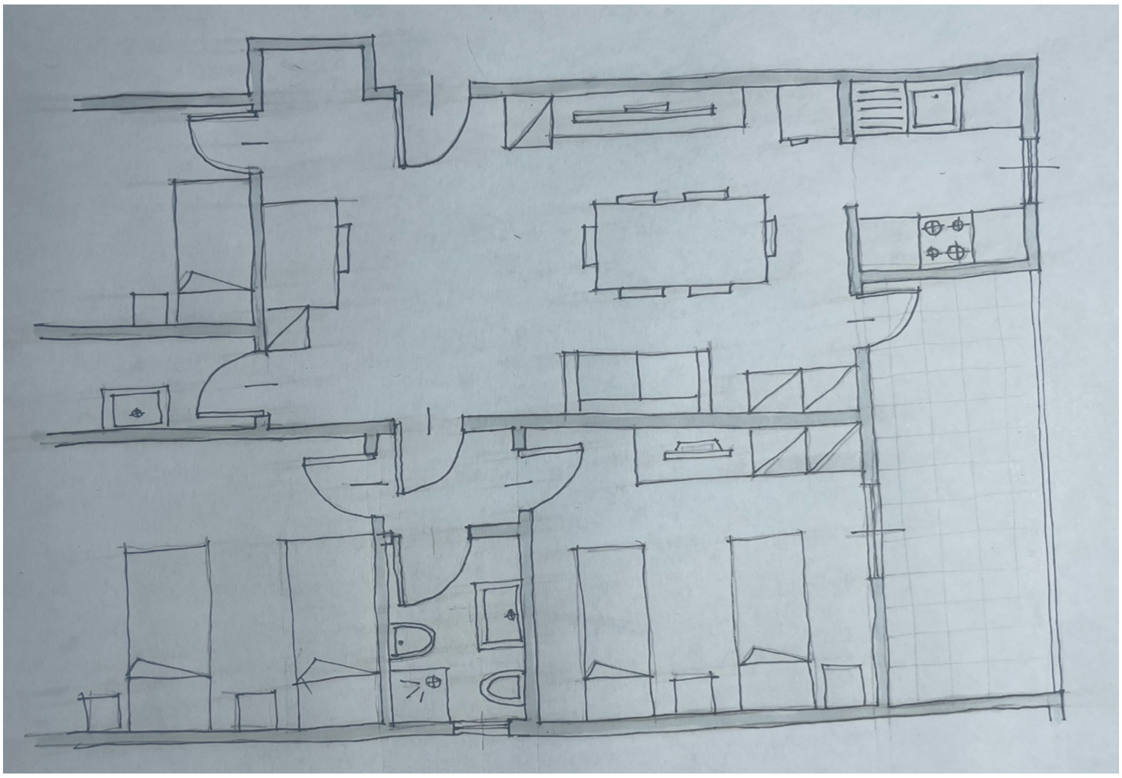

Fig. 6.3: Flat R3: common areas.

Flat R3 remains somewhat isolated from the other three flats run by the team. The 10-storey building stands out in a mostly low-density area, right behind the Juventus Stadium. On the edge of the Vallette neighbourhood, most famous for the presence of a prison and an early 1960s housing estate. Estate of value, although negatively affected by the stigma due to its proximity to the prison. The new football stadium has contributed to regenerate the area and beyond the shopping mall linked to it, many other supermarkets recently opened (Carrefour, Lidle, BancoFresco). Local shops and a couple of neighbourhood bars complete the offer, as well as parking areas and small and middle size parks. It still looks like an area in the making, without a clear identity. The flat is owned by the cooperative and, as it often the case, is at the first floor. Access is through a small living room with a kitchenette and a spacious balcony. While one bedroom and one toilet overlook the living room, other two bedrooms and one toilet are separated by a small hallway. The space would appear less sombre if it were not for the antiquated and dark furniture. The bedrooms are quite small but rather bright. This group home is mixed, both in terms of sex and age and is composed by Alberto, a 68 year old men, former drug addict, Lorenzo, a guy in his 50s, Roberto, the youngest of the group (33), and Rojita, an early 40 year old girl, that welcomed me warmly and expressed a lot of interest in my research since the start. While Lorenzo and Roberto spend the majority of their time in their bedroom, Alberto, enjoy his pension at the bar downstairs, where he spends almost 5 hours per day, since lunch time. He comes back home, always quite drunk, for a nap and the dinner. With very few exceptions, he always maintains a cordial but detached relationship with the staff. Always ironic and in its own way wise he performs the role of the father with all. Rojita usually spends the weekend at her mother's house, where she meets with one of her children, whereas she can see the other child, a 10 year old girl, in a "neutral place", in other words at the presence of a social worker. Without any doubt, she is the one that interacts more with workers and that seems to believe in the project. She is also the only one that puts an effort in building a relationship with all the others. Roberto only seems to have bonded with Alberto, his roommate, even though the main reason is their complicity in pot consumption. Lorenzo, in spite of his size he is like a ghost. You see him at mealtimes or when he goes to the toilet and to smoke. He does not say a word to anyone and rarely leaves the house. He follows the pace set by the presence of the staff, but his life appears to have lost meaning to him. Once we convinced him to have a coffee with Rojita and he said few things about his disease. "*We have never talked about it*", said Rojita, making me realise that is not that common for people to share their stories and feelings with roommates; sharing space and time does not per se encourage sharing. Towards the end of my fieldwork a new lady got in. A lady that after a couple of weeks the workers defined "*unsuitable for the service*" as being too un-independent. Despite the unanimous opinion of the staff, she was not moved and kept staying there, changing the nature of the support required (workers had to help her showering) and the general atmosphere of the flat.

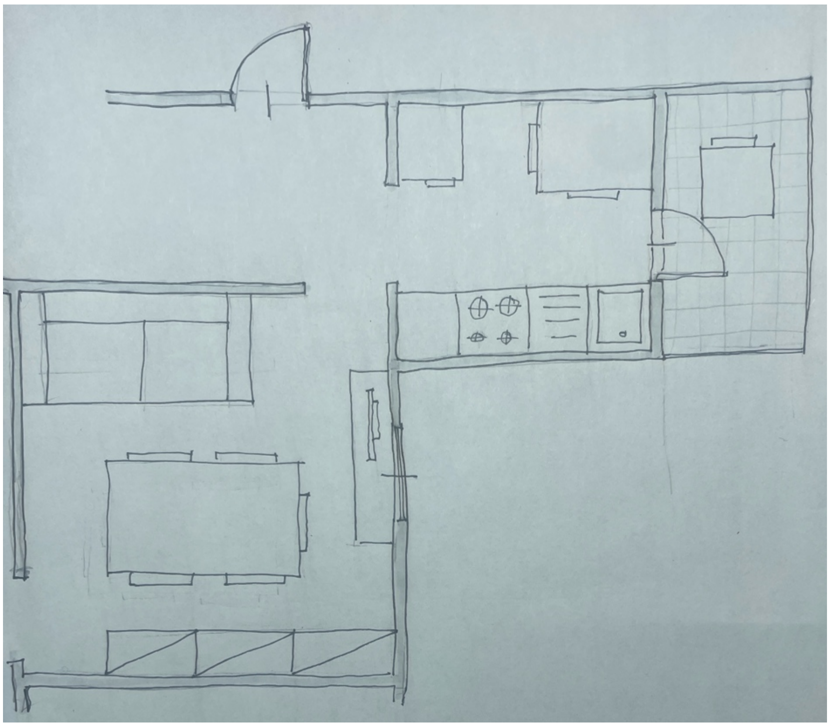

Fig. 6.4: Flat R4: common areas.

In the residential district of Parella, in close proximity to the well-frequented Tesoriera park, in a relatively anonymous apartment building, one of the cooperative's oldest flats. The group home R4 is the one for which I gained different and contrasting impressions as I kept going. Undoubtedly the untidiest and with the tenants least respectful of a regular routine; on paper, it is the group home that performs the worst. A labyrinthine and dark hallway, packed with old furniture and stacked boxes, acts as a dividing and interstitial space between the two bedrooms and the common areas, a living room, an eat-in kitchen and a balcony. The three ladies who live there are active in the late morning. It is therefore more likely that the house looks better in the afternoon and that they are engaged in some activities. The standard of cleanliness is anyway rather low, with cigarette butts and teacups lying around the house regardless. Compared to other patients though, the lounge is used not only for eating: Alcin, studies math and chemistry everyday (a printer, books, handwritten notebooks as a support) while Matilde writes poems cutting newspaper letters and drawing on them, with a method called "Caviardage". Therefore, the table is often full of cards, glue, markers and newspapers. It is the flat where they watch tv more often, taking turns on the couch. They all smoke and, although it is theoretically prohibited, they all smoke inside. Ekene is from Nigeria, and she is one of the few migrants among the patients. I wonder in which circuit all migrants with a psychiatric diagnosis end up. Ekene does not speak Italian, despite attending the school every day. While Alcin and Matilde have a good relationship, she tends to isolate herself, even preferring to eat her food on her own.

2.2| TEAM ORTA

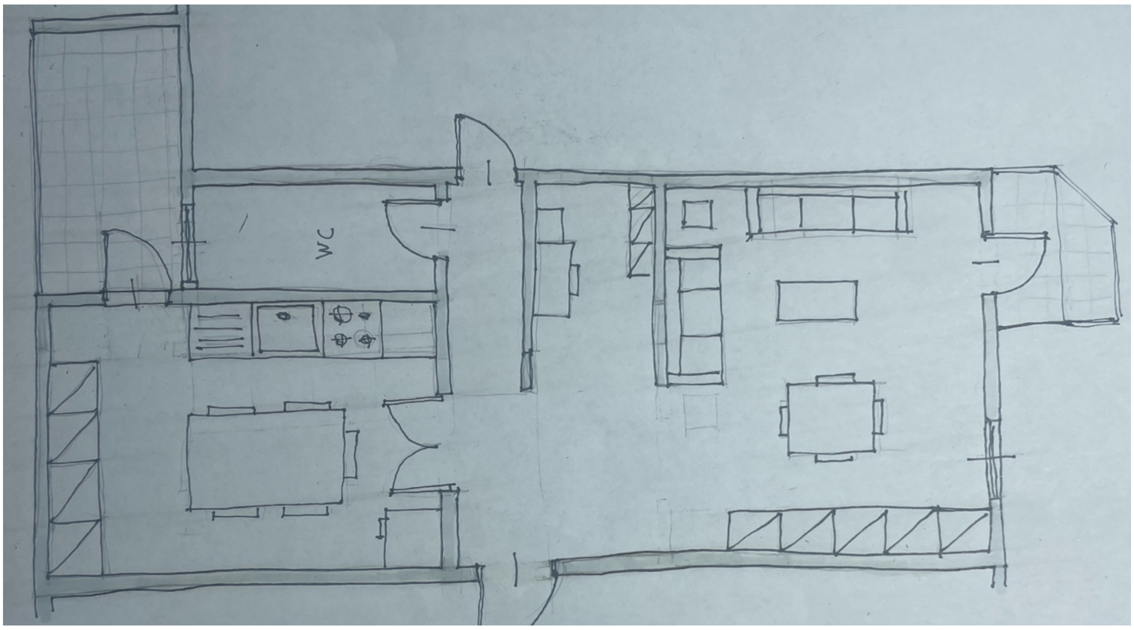

Fig. 6.5: Flat 01: common areas

I started working with the second team at a later stage, with a house that is both the most beautiful and the most problematic. Located opposite R1, Flat O1 is on the third floor of an elegant building on the corner, with a concierge at the entrance. Very bright and spacious, it has 3 bedrooms, 2 toilets, one big kitchen, a large living room and two balconies. Being at the third floor it enjoys much more light than the other flats. Although the usual paintings and furniture can be found, greater care than usual can be seen in the arrangement. The presence of house plants, owned by a patient, makes a difference too. A guitar, leaning against the sofa suggests that someone occasionally plays. Not everyone is so bad but at least two cases make the house a mini retirement home, where much of the work is reduced to material maintenance. You realise that there is something unusual because the bathroom and the kitchen are often locked: a lady sends the washing machine and dishwasher out all the time, and this was the solution found; forcing others to have part of the house locked off and having to ask permission to enter it. Anna, an elegant lady in her sixties, “got mad” once she lost her son, whom she kept at home dead for a couple of days believing him to be alive. Having a conversation with her is a bit complicated because she crosses several space-time dimensions: one thinks she is describing her morning in the neighbourhood, but soon realises that she is talking about her childhood but placing it in the village where she moved as a newly married woman. It is commendable how others show patience towards her, as a reward maybe for blaming her for more or less everything they did wrong. On the other side of the spectrum, Jon, a Peruvian men in his 50s, laid down in his assisted position and to some extent the unvoluntary results of long-term poorly directed forms of welfare. Giuliano, a Calabrian immigrant, by all account, the ideal patient, is always kind and cooperative and makes you wonder why he is there. Also given the huge support network he has got, made of family members and friends. However, he is the first to say that he cannot see himself outside the group home and when the time eventuality arrives, he has a crisis that takes him back years. Crisis that surprised everyone but that led to make all agree with him about his permanence in the group home. Ivana has been within a Zenith's facilities since 2003. She speaks, moves, dresses up and behaves like an overgrown 6-year-old child and represents the extent to which a residential project can fail. She also has a cognitive deficit which makes the flat group, intended as a steppingstone to independent living, the least ideal place for her problem; the same staff seems to be unarmed with her. The combined presence of Ivana and Anna, and the measures taken for them, inevitably have an impact on the rest of the tenants, not entirely taken into account by the staff. The undisputed queen of the flat, there for almost a decade, is Crystal: a petite lady in her 60s, with platinum blonde hair styled in a masculine cut. Belonging to an upper middle-class family of Turin, she got into heroin when she was 16, from which she came out 20 years ago, encountering the world of psychiatry during that time. She introduces herself as a Tibetan Buddhist, which then makes less surprising to hear the accounts of her delusions in which she claimed to be able to levitate and to be the 15th reincarnation of Buddha. This delirium cost her the last hospitalisation, which she later confessed to me was due to cocaine consumption not to mental illness. At first glance, Crystal seems just a little bit eccentric. She has obtained a council flat, and after two years for the work and to furnish it, she was finally able to move in the summer. This in the general scepticism of the staff, that believes she will luckily relapse into alcoholism and drugs.

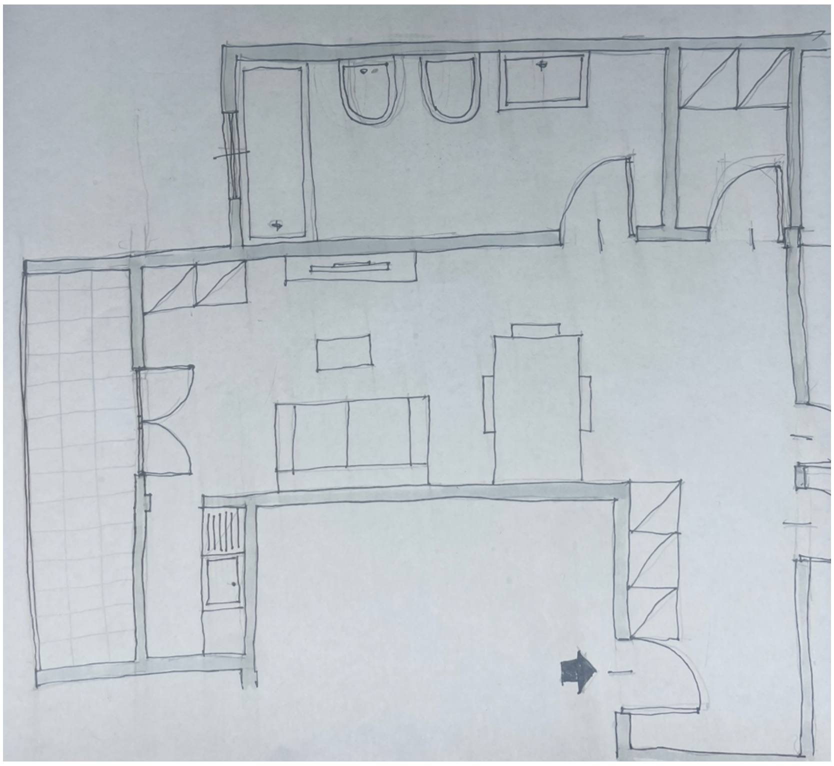

Fig. 6.6: Flat 02: common areas

Flat 02 is placed right behind my flat; so close, I can see their balcony from my window. Even though I never see anyone looking out. Just as I have never met patients in any of the shops in the neighbourhood. This flat is at the third floor, and it faces the channel Dora and the Alps. It is for sure the one with the most pleasant view. Without any doubt also the cleanest and tidiest. If the two bedrooms are rather large the common area is very small: a very small kitchenette, basically the place for the stove and the sink, and a living room with a table for three and a couch in front of the tv. It happened twice to make the shift with both the operator and the nurse. The three of us, together with all the folders, documents, pill holders piled on the table occupied most of the available space, leaving patients little scope for action. Here there are three young ladies, two of which work all day, making the third, Diletta, face the invasion by herself. You could spot her restlessness, wondering around the flat and going from her room to the kitchen for a snack or to the balcony for a cigarette. Diletta is in her late 40s, she is always very polite, but one senses that she is making a huge effort. The interaction takes places with her answering to all your questions, without ever asking you one. Being the one at home most, she does the cleaning and the tidying up. Plus having to relate with the staff to which she also needs to report how the other flatmates are doing. The limited space in the flat, Diletta's clear lack of interest in my research, the few opportunities to meet with other patients, combined with the risk of encountering them outside of the shifts in the neighbourhood, were all factors that made me decide to exclude this group home from my main ethnography. If there is anything my observations in Fagnano suggest though, it is the need for a dedicated space for workers or better thought-out common spaces. As with the group home in Regina I kept hearing stories about the flat and when now I look at their building, I find myself wonder whether Maura is still obsessed with her weight, Bianca stopped cooking kilos of beans for all week and which films got Diletta from the public library.

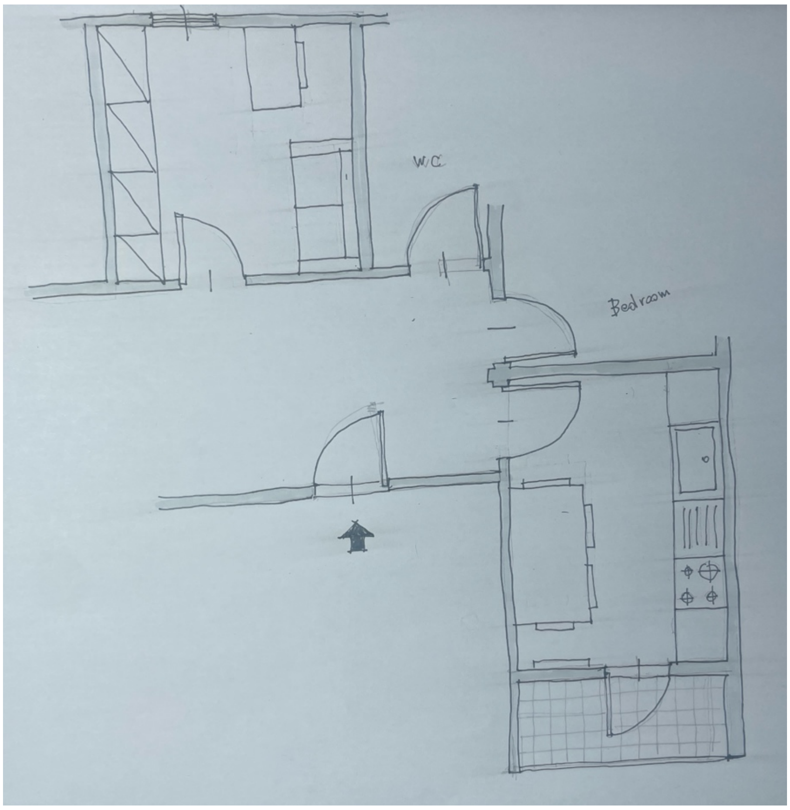

Fig. 6.7: Flat Orta: common areas

Not far from the others, there is the flat where I spent more time in the last part of my ethnography: O3. At the ground floor, right at the corner of the building, an extremely dark and old fashioned apartment, with a long corridor into which all the rooms overlook. On the extreme sides of the corridor, the toilet and the kitchen with a small balcony. On the side, the two bedroom and a living room, used mainly by the staff as an office. Although the kitchen is quite small, the patients seem to prefer spend time there: the tv is always on and the balcony allows them to smoke without being admonished. As it is often the case the bookshelves are full of random and useless objects plus a selection of rather heterogenous books, probably the result of donations, more than the legacy of past patients. Close to one of the bedrooms there is through a picture of one of the guest, dressed as a carabiniere. As I have already pointed out, it is not so common to see forms of personalisation of space and a personal photo framed and hung in the common space could signify both a desire to feel at home and to claim a kind of territoriality to others. Enzo has in fact been a guest for a while and uses that picture for talking to you about the best period of his life, before getting sick. He works for an association (Association Arcobaleno) three mornings per week, he has a clear routine, and he seems very much comfortable in the group home. He believes to feel better than the others and he is a bit like watching over them. From time to time, he gets so nervous not to speak to anyone and spends hours on his bed. Ignazio is close to 70s and comes from Sicily where he departed as a young man in search of employment. He spends most of the day on the bed, but recently, on the pretext of lowering blood pressure and losing weight, got into the good habit of taking a 30-minute walk with a staff member. He has a nice smile and a biting irony, but depression has taken all his energy away. He has a wife and a child to whom he no longer speaks. Aldo is close to 70s as well. He does not say a word unless asked and he still responds in monosyllables. He is always sitting at the kitchen table, watching tv. He has a son whom he meets regularly. Giovanni, the most recent arrival, is almost 60s. He works at the university as a doorman but since his last crisis has been on a sick leave. After previous crises he always managed to return home with his parents, but now that they are dead the psychiatrist advised against him going to live alone. In the meantime, he lost his home. He is certainly the most impatient and restless. He keeps saying he is going to rent a house as soon as possible since *“it's madness in here*”. Giovanni has explored all the neighbourhood and goes out often, as he cannot stand the presence of the workers in the house. “*They just give us orders, as if we were in the barracks*”. Nevertheless, he chats a lot with them. He provokes them, boasting plans that include getaways and parties. At one point he actually tried to escape: he was found trying to catch a train to Calabria, without a ticket. Although he often speaks badly of them, he has a couple of siblings who take care of him. When I left the field, he had just returned to work and seemed much better. “*Spending more time outside makes the time in the flat more tolerable. Still…this cannot last long*” (Giovanni, August 2023, WI).

3|GETTING TO KNOW PATIENTS

Although I had the opportunity to interact and build a relationship with most of the patients during the fieldwork, making informal chats within the flat, going shopping or walking around the neighbourhood, I decided to interview 5 patients in more details. The interviews were all conducted at the end, to make sure people trusted me as much as possible and were comfortable participating in the research. This unfortunately meant that many of the things that were said to me informally were not repeated during the interview, that someone was discharged or suddenly felt ill. The interviews have many elements in common: the themes identified were similar, but each of the interviewees focused on a particular aspect that affect them more than others and on which I decided to concentrate each account. All patients seem to share a conflicting mix of gratitude and impatience with the staff and the rules they enforce. The fact of being observed and questioned all the time Is, as one might imagine, demanding. The presence of the workers is considered both excessive and intrusive, and the space not sufficiently adequate. Each of them though went further and identified a deeper, disabling lack that afflicts and subtly oppresses them. Ubaldo talks about the lack of autonomy that binds him both to the service and to the support of the staff; Crystal mentions the lack of trust that perceives and that makes workers question everything she does and says; Alcin conveys a feeling of hopelessness, shared by workers, that does not allow her figure a different future; Rojita feels that relationships are not given the right value and has experienced a lack of affection; as for Alberto, although he does not admit it, he does not receive all the help he would need.

3.1| LACK OF AUTONOMY

Ubaldo is close to 60 and comes from Turin. He used to work as a support teacher. Watching him interact with the other housemates, it is easy to imagine him in a classroom. However, he does not seem to talk willingly about his job. When I wonder why he is here, without hesitation he answers, “problems at school”. In his final years of employment, he experienced severe anxiety, which impeded his ability to make decisions. This led him to perceive himself as unfit for work and to leave his position, despite his extensive experience. When I asked him to elaborate, he added: “*I was not good at organising myself. Maybe I had intuition and I had good skills as an educator, but I made a lot of mistakes didactically...in the method*” (Ubaldo, August 2024, TI). He goes further linking it to the illness: "*If at first the panic made me give my best, in a second phase it became paralysing*. *I had a deep sense of inadequacy...initially I hid it very well...maybe it was also due to my colleagues...but there was something inside me. Then I realised my problem was psychiatric. Of course, it also depends on the insecurity I have had since childhood…one of my parents has some issues with relationships*". Suddenly he recalls I am an architect and switches the topic to the layout of the flat and says: "*to me, space does not matter, or not that much. Relationships are the ones that make a real difference, psychiatrists do not pay enough attention to what goes on in terms of relationships here. Living in a group home means living in conflict, in a constant conflict. The idea is to try to bring people together, but sometimes the choice is random. One has to understand that everyone has a different story".* He explains that you have to work on yourself and be also able to put yourself in the other person's shoes but *"no many are actually able to do so*". When, as with everyone, I ask what a group home in practice is he keeps referring to the relational aspect. "y*ou meet with workers, they seek to address your problem..*". He highlights the fact that that relationship can be intense and that patients are perhaps too many. "*I often had the perception that someone needed more help than I did.... and I haven't always felt protected enough*".

Speaking of the ultimate goal of living in a group home he makes a really interesting point that I could see in the attitude of many others. Ubaldo specifies that the group home serves to give you autonomy but, rather sharply, he sentences "*it does not give any*". He recognises the fact you learn a lot "*but be honest, once you are out…goodbye and thank you*"[66]. What is problematic for him is the fact that in the flat they learn to have their own role and tasks while "*At home you need to do all by your own*". I find it hard not to think about my parents; my father cannot cook a fried egg and my mother has never paid a bill. I wonder why single people are expected to live alone as a happy ending in place of supported cohabitations. The most problematic issue is represented by Ubaldo by the fact that they have almost all paid now. "*We might learn how to manage 50 euros per week they give us for shopping, but we do not have an idea of what it means to pay the bills…and even these 50 euros fall from the sky*". Another interesting point result of these considerations is the dependency that a service like it unwittingly generates. Residential facilities are all considered a temporary solution but often risk, and not only

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[66] What Ubaldo says here is not exactly true. If the psychiatrist considers it appropriate you will be accompanied on your path to autonomy even at your own home. With the so-called project of "domiciliarity", support is provided through daily or weekly visits by educators and housekeepers.

for lack of alternatives, to create in its residents the idea that they are not ready to leave it and never will be. As effectively puts it Ubaldo "*we are meanwhile in and out of reality. We inhabit a fictious reality, it's like a bubble…that can easily turn into a cage. A golden cage…but still".*

3.2| LACK OF TRUST

Crystal is keen to point out she is very happy with her life, she managed to travel a lot and to meet all sorts of people before this "parenthesis". She describes her life as a wonderful mystery, regardless of the previous drug-induced adventures she stumbled into at the age of 15. The first thing she usually talks about is to be a Tibetan Buddhist, since she was 11. "*At 4 I was already able to make doing the lotus position with my father*"; the second that she was the first punk in Turin; the third that she got sober 20 years ago. If this is the case for heroin, it is not the same for alcohol, which does not admit to abuse. The early morning breath seems to disprove it though. Another element that you find out relatively quickly is that she used to run a vinyl shop in the 1990s and that she was married. Despite all, she has kept the "junkie's cunning" and with it she can easily get what she wants or get away with her daily mischief[67]. She is cultured, fascinating and she almost has the ability to hypnotise you with her partially fictional anecdotes of her family and her past. When she exaggerates, her ancestors become princes, but it is known for sure she came from a rather wealthy family. She has recently obtained a large sum of money as an inheritance, which, however, being administered since she was 17, she cannot manage independently. This has complicated in no small measure the arrangement and furnishing of the council house she obtained a couple of years ago and where she eventually went to live by the end of my fieldwork. Her house is a cosy two-room flat placed in a street right in front of the group home. She invited me there for the interview. She is so happy and proud of having her own flat; after years spent in therapeutic or detox communities and group homes of every sort.

"*The first time they sent me to Villa Cristina, at the outskirt of Turin…a place where if you're not crazy you become one. There were naked ladies, people eating with their hands, all kinds of abuse. It was like you imagine an asylum. Now they closed it*" (Crystal, September 2023, TI). The first service she encountered was though the Sert (addiction service). "*I just needed some pills for sleeping because methadone withdrawal was awful. The*

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[67] The workers believe she steals other's patients belongings (cds, cloths, etc) that then she resells on the street.

pills came before and made the diagnosis. Not the other way around. I entered psychiatry world in this way. And now I live in a group home, since 2016…before I stayed three years in a community. We were 20. it was very good… even if they stole my stuff. There was a Calabrian cook and a lot of activities. They organise regular meetings, something that you miss here".

For her the group home is "*structured as a sociality of psychologically disadvantaged people who are no longer in need of the hospital or the community…who are already a little better off and live together. They do their shopping with money from the cooperative that runs the flat. All in all, I made friends, it was a good experience. The presence of the operators was very heavy for me because I have no mental problems. I am there only there for the drugs, to boost that little bit of confidence. The fact they write everything down is annoying... one moves his left finger and they write it down. Every day they write a bibliography*". Moreover:

"*The fact that they're watching you all the time is insane...it's a bit like having your mother there all the time. I made friends with everyone, even the operators and I had no problems...but the toxic aspect is all this Big Brother. 12 hours are too many...I had my own room and that saved me. Everyone should have a single room. The community was less oppressive, the nursery was closed. Then there are more people. It seems a paradox to prefer it... but out of twenty people you find someone nice, out of four you easily can't stand three. Then you are left doing nothing all the time...I had my meditation, walks, cooking. Otherwise, you risk nullifying all your capacities, your whole body becomes invalid. I found it intolerable that we were exhorted to do stuff, to talk…that we were asked all the time - What did you do?, where did you go, etc. - ...an approach that needs to be revised all over again. There is a fundamental lack of trust. And then there should also be a little more conviviality, a little more sociability, a little more openness towards the outside world. Instead, there is still so much distrust. And then the operators are really too much. In my opinion it's already a debacle at the start... some people regress in some way*".

The lack of trust she experiences, in her case not entirely unjustified, is at the core of the relationship between patients and workers. There is indeed the idea that, as a patient, you have to gain the trust of the system by passing a certain number of tests. The lack of trust is not only due though to the fact that one thinks the person wants to cheat but to the belief that they are unable to choose the best for themselves. This mistrust, at the core of the relationship with the workers, is so obvious that it affects the patients, who at the end are the first to doubt their own choices and opinions.

3.3| LACK OF HOPE

If have to think to Alcin, I imagine her lying on the sofa in the living room watching a tear-jerking film on TV. In alternative, sitting in the kitchen, drinking tea and smoking a cigarette. Alcin is a bit overweight and is slightly slow in all her movements. She often wears a woollen cap that makes her “feel protected”. Sometimes, when you talk to her, she shakes her head. She apologises and explains me that this gesture serves to banish her voices. Another sign that she is hearing voices if when you see her studying math or chemistry, the only thing that really distracts her. When I asked her for an interview, she suggested to conduct it in her flat. “*So you can tell me if you see me there*” (Alcin, August 2023, TI). It is just one block far from the group home, but she rarely goes there. “it’s full of bad memories” and this is the main reason she would never come back and live there. When she goes there alone the voices are louder. The flat, a 2 room-apartment, is very nice and clean. Her parents regularly send a cleaner to take care of it. She would like to donate it to her daughter at some point, also because, being landowner she could not apply for a council house. Her daughter shares a flat with a friend and does not seem willing to accept the gift yet. They meet once per week. She is a nurse; Alcin believes it is mainly due to her illness: “*she chose nursing to understand me*”. She considers a fortune the fact she got sick after having her child. And after she finished her university. She has a degree in chemistry, with 110 cum laude, and she used to work as a quality air consultant. Job that she thinks she is no longer able to do: “*I am unreliable; too many ups and downs*”. Every Sunday she lunches at her parents' house. She is happy with those gatherings, but she always comes back melancholic.

She broke up twenty years ago with her husband for her infidelity, that's why the voices call her a whore. “*In that period, I made a mess. I started drinking too much and the mental illness manifested*”. The daughter was 10-year-old but she never talks about that period. “*When I was hospitalised, she was sent to live with her father and never left. I did not allow them to visit me. I did not want her to see all the strange people…and me in that state*”. She does not speak ill of her husband: “*He has been a good father and a bad partner*”. “*Around the age of thirty I started to hear voices...I didn't say it but you could see it, I would talk to myself, maybe I would lock myself in a* *room and laugh or cry*". Few years later she was hospitalised for a suicide attempt… "*I swallowed all the tablets I could find in the house. I woke up at the hospital*".

When we talk about her future, she is not really able to see herself outside the flat, but she might want to occupy better her time. "I cannot work but I need some sort of activity. Studying is one". When I suggest going to the library to have a change of scene, she says that she is scared other people would realise she hears voices. And the buses, so full of people. "*I also get asthma…the Gp thinks is psychological…*". it's not uncommon that psychiatric patients see their physical pain minimised and underestimated. It seems that if you have a mental issue, you stop having the right to prove physical pain. The group home protects her from an outside world that would reject her. In conversation with the staff, it became evident that they also had no expectation that Alcin would make progress or even a minimum change. Lack of hope that is likely to be perceived and introjected by Alcin. Furthermore, the parents themselves have been described by her as "*resigned to the situation"*.

Alcin has been living in the group home for 10 years, with sporadic summer visits to Villa Turina, mainly to lose some weight. She has changed 5 flatmates, and she seems resigned to stay there until retirement. She describes the group home as "*a tool to make you socialise with other people. It's kind of a test for a life outside. And for the autonomy, in the sense that everyone shares the tasks for running the house*". She described the purpose of group home as this did not really pertain her stay there. For her, living there is good mainly for two reasons: "*The company… the fact that they give me an alternative to voices. Moreover, if I stay in the group home my relatives think I'm taking care of myself. So, they took away some of my guilt for my daughter*". The benefits seem to stop here, at least for her. Like everyone else, she struggles with the presence of workers. "*We take a place in the house and as soon as we feel it is ours, the workers arrive.… I feel a little violated*". She adds: "*You are observed all the time. It also bothers me that they write down everything on the paper…and I can't see it, that they lock it up, you tell them something private and they write it down*".

She recognises all the improvements made by her flatmates but she does not appear in the picture. For Alcin is already a lot living in a group home, far from the "repartino", the psychiatric ward where the psychiatrist "*would slam me if I raised my voice*". When I put forward the hypothesis that she kept a diary, she laughed: "*written one day, written the whole year through*". Finding a life made up of days all the same seems acceptable to Alcin, anyway better than the one that just preceded it. Talking about one of the communities where she stayed she said "*Mamma mia, that was a trauma. They stole money and clothes from me. They wanted to have orgies. And all this coming and going from and to the psychiatric ward… I remember a sense of helplessness*". All this makes the group home a reasonably better solution. The ideal setting for someone that escaped the worst, but whom cannot really improve.

3.4| LACK OF AFFECTION

I end up Interviewing Rojita twice, the first time informally, without recording her, in a restaurant near Parco Dora. The second one, in a park close to the group home. She was the first I interviewed but after we agreed to meet the cooperative started raising doubts about the legitimacy of my "solo" activity. This created some friction with one of the workers that shared the cooperative's line. With Rojita we decided to meet anyway; we had a very nice walk and a lunch. We passed by a shopping centre, something that she later mentioned "*we went to a shopping centre like normal people*" (Rojita, June 2023, WI). She wanted to know more or less what I was going to ask so she could prepare herself. We crossed few places that made her recall some unpleasant events from her past. The only area where I still struggle to go is the area of the Balon (antiques market). She ended up there one night, in a state of confusion. After asking to sleep in the homeless shelter, without success, was joined by two policemen who accompanied her to the hospital, for her last compulsory health treatment (TSO). I was rather surprised when a couple of months later she called me to have a walk in that area of Balon, without showing particular discomfort. After this umpteenth hospitalisation, her mother refused to "take her home" and a group home in the Asti countryside was chosen for her. Far from her children, but also far from her abusive and alcoholic partner. At the beginning she was rather reluctant to accept the situation and the treatments but she slowly started being engaged with the life of the flat, even starting a sex relationship with one of his housemates. Sex is rarely something is talked about, especially by workers that pretend it does not take place within their facilities. If you infantilise patients, you cannot admit to yourself that sex is a need and a legitimate desire.

The formal interview took place some weeks later and, unfortunately, the presence of the recorder, or the fact of repeating some of the points for the second time, made Rojita slightly shier and less talkative. Rojita is a very beautiful girl, with red curly hair and green eyes, somewhat weighed down by drugs. You soon notice that despite her young age (she is nearly in her 40s), she is quite slow in her movements and she rarely looks you in the eyes. She looks up, as if searching for the words somewhere. When I ask to describe herself, she says "*first and foremost I'm a mother; a mother of two children who don't live with me*" (Rojita, July 2023, TI). A 17-year-old boy and a 10-year-old girl who have been in the care of their paternal grandmothers for years (different fathers, different grandmother). "*I see my daughter in a neutral place, at the presence of an educator. My son, on the other hand, goes to my mother's place every weekend so I see him freely there. Thanks to the workers I've eventually applied to the court for seeing my daughter freely as well*"[68]. She recognises the role that her family played out in her recovery. "*At the beginning I was very upset with my mother and jealous of my mothers-in-law but now I understand them. My children gave me the energy to react. In this flat I'm the only one with such a strong bond and you can see how much difference does. Family and relationships in general are something psychiatry does not give enough attention to. I had to fight for my family. I manged to make me move to a closer location, so I came back to Turin. Once here they wanted to make me stay far from my family for two weeks…. there is this observation period when you are basically in prison. It's a period in which you must gain their trust… as if you couldn't break it after. My mother was so angry. She argued with the staff and managed to get me to go to her. Seeing her arguing for spending a weekend with me moved me. Since then, the workers very helpful networking with my daughter's social worker*".

It is obvious the extent to which her family and the prospect of coming back to be a mother stimulates her and gives her energy. "*When I would like to leave the dirty dishes, I think about when I will have to live with my children…this thought helps. Beyond the fact that I hate receiving staff's orders…so I always try to anticipate their requests and make myself look active, as a defence mechanism.*" Coming back to her family she adds that *"It's difficult to perform the role of the mother now. Especially for my son. He recently told me that he does not see me as mother but more like a sister, that I came back home as a daughter not as a mother. My daughter is very protective of me too".* What obviously worries Rojita is not being able to regain her parental role in the eyes of her children. *"I'm not a mother anymore, I do not have a job and I live in the world of fairy tales*."

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[68] By the end of my ethnography Rojita was granted the right to see her daughter freely.

Rojita used to be an OSS, a job that is not sure she will ever be able to do again, due to the long and night shifts. She would like to work with children, but she is not sure "*there will make work with children with a psychiatric diagnosis*". She accepted to start a course (at Progetto Itaca) where she will learn to use Excel. Firstly, very optimistic about it, she started losing enthusiasm. "*it's just one hour for week, I thought it was an intense course. When the hell is it going to end? Part of this hour is spent summarising the previous one. I feel treated like a stupid. I have a schizo-affective disorder, I'm not an idiot*." I think she has a point, and this is not the first example of work placement attempts I hear about where the concept of "protected environment" is not properly calibrated for mental illness but rather for mental deficits.

For what concerns the life in the flat, Rojita is the one that for sure engages the most, with both the flatmates and the worker. She speaks positively about her experience in the flat, although she is now exhausted and sees the benefits diminishing. "*Here I have overcome some fears I previously acquired in the other group home in the countryside, like the traffic.. Or the fear of people on the street. There all knew us and we felt judged and stigmatised. It was nice to have a garden and doing long walks in the nature…but I much prefer the anonymity and freedom of the city*". As far as the organisation is concerned, she thinks there has been some kind of regression due to the extensive presence and interference of staff. An annoying aspect is the lack of privacy and a place to spend time alone. We discuss the relationship with the neighbourhood and she confirms the fact that they do not have one. "*The presence of the operator is continuous. You feel observed, controlled, judged all the time. You are in a continuous performance; you are at home, but it is as if you can never relax*".

As Rojita highlights, the lack of privacy is not only spatial. She is now dating a guy she met online. As one can imagine, the staff is concerned and never stops showing disappointment. However, online dating represents one of the few available avenues for individuals to expand their networks and interact with individuals outside of the psychiatric circle. The desire for connections, affectivity and sex are not considered though to be among the primary needs of these people, who are expected to be content with the provision of food, accommodation and the company of roommates and caregivers. Despite these criticisms, to which she adds that living in a group home brings her back daily to the fact that she is ill, she recognises that it helped in making her feel lees lonely. "*I think if I had joined the flat group earlier, maybe I would have solved it a bit sooner. The family doesn't always have the means to help you*".

3.5| LACK OF RIGHT SUPPORT

I established a relationship with Alberto going shopping with him and a member of staff, every Wednesday, to get the over-65 discount. He liked this tradition even if he would have liked it more if we had a drink with him afterwards. He is 68-year-old with an obvious alcohol problem, which he claims allows him to survive. "Having gone from one addiction to another...you are left with that kind of lack. Maybe that's why I'm depressed. I was shy as a child and with alcohol I solved it". His addiction makes him the most integrated in the neighbourhood. He often goes to the bars near the flat and talks to other customers, building a rather rich social network the others do not enjoy. At home he is friendly, ironic, entertaining. Not particularly cooperative in housework; when he does not want to do something, he uses the elderly card. No one seems to be able to make him do anything against his will and, having his own savings, he can afford to stay at the bar when he does not want to deal with the staff and housemates. "*Who is better off than me? I do what I want. I only have company and support when I want. If I lived alone, I'm afraid I would be lonely*" (Alberto, September 2023, TI). He admits having accessed the psychiatric residential services merely for practicality. He needed a roof and his doctor told him…"*you're just dysthymic; what I can offer you is a bed and warm meal for 70 nights. And I ended up in Villa Augusta. There I even enjoyed myself but after a while it's maddening. We eat well, the doctors are kind, never had any arguments. Of course you need to have character*".

I wonder if he considered it much more acceptable to enter the psychiatric channel than one for drug and alcohol addiction. Was it better to be labelled mentally ill than drugged? He comes from an educated family that might not stigmatise mental illness but would be less understandable with drug addiction. He clarifies that he is not as mad "*I'm the only one here that does not do the Depot*". Again, the depot, identified as the trademark. Alberto' s past life is made of endless jobs, fraud, bankruptcy, problems with the tax office but given the amount of money that he spends daily he must have a good sum in the bank. He came from a high-middle class family. His father was a tax lawyer and he studied law against his will. "*I don't know when I fucked it all up*". He has a daughter that meets regularly. "*The only good thing that happened to me*".

When, as usual, I ask him what a group home is for him he replies "*It's a microsociety...with four adults who have not chosen to live together. But then if things go well, relationships are established. I don't see myself outside the flat group. I mean, I'm not ashamed, I'm afraid to be alone*".

If he must find something that he does not like of the group home is that “*The operators tend to act as a parent who forbid you. You can see that for what concerns sex. They don't see it as a consequence, but the simple fact you can't take anyone home is related to that*”. In this regard, he tells me a juicy anecdote about two former patients who had started filming porn videos inside the flat. “*They were selling them online... they made a lot of money until they were discovered. Of course, the staff pretends that such things cannot happen*”.

“*I’m not bothered by the presence of the staff, but it is true that I spend a lot of time outside. When I’m there I gladly talk to everyone. I love everyone. They did the impossible for me*”. Apart from providing some company, I am not sure if Alberto's stay in the group home is of any benefit to his health. Staff members admit that they are not equipped to deal with addictions and a collaboration with the network of addiction services does not seem within their reach. “*His alcohol abuse, although less than he would do by living alone, is still alarming. He cannot drink at home, but this is the only risk reduction strategy adopted*” (Anna, June 2023, TI). Then you wonder what the rationale behind the decision is to send Alberto to this facility given the limited support that can be provided. Thanks to my psychiatrist, I discovered that many of the so-called “double diagnoses”, i.e. those who suffer from a mental health condition as well as having a substance abuse problem, may have been diagnosed after a psychosis that could be treated with a drug tested only for psychiatric problems. In short, the drug made the diagnosis. This leads me to conclude that Alberto is well represented in the psychiatric population, which in turn makes the shortcomings in terms of essential and targeted support even more unjustifiable.

4| CONCLUSIONS

My research was mainly driven by an awareness of how little psychiatric patients' opinions are taken into account. I thought, that in my own small way, I could partially remedy the lack of first-person narratives that reigns this world. However, the number of people that accepted to be interviewed was very small and the statements made by the ones that agreed were somewhat less poignant and effective than I initially thought. What is perhaps missing from the interviews is that feeling of urgency that I imagined their words would be imbued with. The same urge and will to retaliate that the letters from patients in the 70s kept at ALMM are rich.

I therefore needed to accept that once your life has been frozen and your voice silenced for so many years, is not that easy to take it back. This can be attributed to the same mechanism I have observed to occur every time they were presented with a choice. If for decades someone has always chosen for you, you first may begin to question your own preferences and desires. Consequently, your thoughts.

To all the lacks identified by the interviewees, there are other two types of absence that patients share to some extent: first of all, they all miss a real sense of purpose and the fact that the residential project is not accompanied by an equally efficient employment policy makes it difficult for many to find a job, and thus a role in society. Their competences are as if cancelled; they are anyway the first to deny their past and, as we have seen above, they even perceive to have lost their role as parents. Even when they do have a job, it is often a job obtained as a protected category that rarely gives them any rewards. When I asked Ugo, a guy who works for the city transport company, what his job consisted of, he replied: "*I have no idea. They gave me a desk, and no one has ever let me know what I am supposed to do*" (Ugo, August 2023, WI). The jobs I have heard of are limited to cleaning and small catering, and so-called jobs for protected categories are sometimes advertised to fulfil a legal requirement but without any real need. It is not then surprising that psychiatric patients' only identity seems to be that of chronic patients, an identity that life in a residential facility contributes to forge. Secondly, in all areas of their lives, at all levels, they encounter a significant dearth of options and alternatives. From the choice of the psychiatrist to the residential facilities, patients have no real decision-making power. "*Once you get mad, you're somehow ousted from any decision*" (Ubaldo, August 2023, TI).

There are certainly other ways in which unequal power dynamics and forms of control unfold and develop; some are so ingrained that they are not even recognised as problematic by patients. Even in the language they use to describe their illness and their current situation, it is possible to recognise a language they have internalised and that they always repeat the same, like a proper plot. It is a relatively meagre language consisting of scientific vocabulary and self-critical expressions which they use as a proof of being compliant with the treatment. Many describe themselves as disabled, unreliable, unpredictable, unlovable and ultimately a burden on their families and society in general. The need to minimise certain states of health or to exaggerate them, the obligation to always remain calmer than the situation would predict, the need to always be well-disposed, willing to talk or to perform the task assigned, all under the watchful eye of an operator. All this makes life in the flat resemble a performance, where the boundaries between life and work, reality and fiction are blurred, with an expenditure of energy that goes unrecognised.

If the fieldwork sometimes revealed a muted, domesticated form of madness, this should not be read simply as a disappointment, but rather as a symptom of the wider configurations of care within which these lives unfold. What emerged was not an absence of disruption, but a careful containment of its potential - a smoothing over that mirrors the stagnant machinery that structures contemporary mental health landscapes. And yet, through the cracks, other forms of madness emerged: in Crystal's moments of escapism, in Matilde's jagged poems, in Giovanni's escape attempt. These fragments - ephemeral, incomplete, but persistent - suggest that something more unruly, more dissonant, continues to inhabit these spaces, even if it rarely finds the conditions to flourish openly. Rather than seeking a fully articulated counter-narrative, this research invites attention to these minor-key resistances: gestures, affects, silences that defy easy capture. To foreground them is to acknowledge that madness, in its more transgressive and politically charged dimensions, persists not despite the system's attempts at normalisation, but precisely through the frictions and failures it generates. In this sense, this work hopes to contribute to an ongoing conversation within mental health geography and Mad Studies: one that refuses closure, that makes space for the unfinished, the messy and the disruptive life that remains possible - even, and perhaps especially, where it seems most fragile.

I approached this particular facility without prejudice and genuine optimism. What prompted the choice for the topic was curiosity about the alternative route I could have taken if my parents had made different decisions. I often ended up identifying myself with some of the patients, imagining how I would react and how I would behave. Would I have asked to return home? Home from which, when I was sick, I wanted nothing more than to leave. I recently talked about it with my father. For the first time I told him that if they had asked me at some point I would have gladly gone to a community or a group home. *"What do you think now that you've seen them?"* he then asked. Whenever I was sick, I managed to return to my normal life after up to three months of 'home isolation' and treatment. Considering the stories I heard, it would have taken at best two or three years before a psychiatrist took it upon himself to discharge me. After so long, I would have been a completely different person and reintegration into society would have been much more difficult. It probably went for the best. However, I would like to point out, that I had no say in the matter. Depending on one's social class, one is faced with a limited set of options that tend to become fewer and fewer, as one descends the social ladder. Scepticism and mistrust of public mental health services are at all-time low. When someone is having a psychosis, if we are forced to call an ambulance we would not do so as calmly as if they were bleeding. In any case, the ambulance would be called in part to protect us as well as the other person. Are all this distrust and fear justified? Working alongside operators, I have learnt to some extent to be less suspicious, but I have unfortunately internalised some of the pessimism, frustration and lack of imagination that the system unfortunately suffers from. Feelings that can only be countered by a careful and sincere return to Basaglia's theories, through which we must question what we believe to be his legacy, and which instead contribute to betray him.

CHAPTER 7

DISCUSSIONS

1| INTRODUCTION

One begins a Phd project with the expectation of achieving a certain degree of knowledge on the chosen topic; of obtaining answers to the research questions; of forming an unequivocal opinion on the subject. At least to find arguments for a purposeful critique, on which would be possible to subsequently propose alternatives to the prevailing *status quo*. This imperative is particularly salient within the domain of PhDs in Urban and Regional Planning programmes, where the study of the past and present is mainly aimed at problem-solving and design. As an architect who emigrated to geography (by way of planning), while looking for solutions, I could not help but find all practical answers I could think of somewhat unsatisfactory or superficial, when not unrealistic or utopian. My work is then limited to identifying opportunities and limitations, shortcomings and excesses, spaces to manoeuvre and spaces to change. This objective is achieved by the attempt to adopt the perspective of all involved in my narrative, without any claim to omniscience and objectivity, nor the presumption of being able to make every claim generalisable.

This has obviously made the final chapters on discussions and conclusions the most difficult to write. Beginning to systematically engage with the research questions, read through the empirical material, has facilitated a reorganisation of ideas that hopefully transcends a merely descriptive and critical work. A work that contributes to the field of mental health geographies and Mad Studies, if only because it gives space to the everyday lives and words of people, otherwise unheard, in places, unknown to many and inaccessible to most (Philo, 1997; Conradson, 2003a, 2003b; Parr & Philo, 2003; Parr, 2008). It contributes to planning and policy making, by suggesting which everyday troubles we are dealing with, and from which flaws we should start from. This is done in the sincere belief that to stay with the trouble of madness is to stay with the trouble of the institutions created to care for it; in the awareness that we still know too little about madness to be able to identify a definitive and unambiguous way to cohabit with it. Moreover, it is imperative to acknowledge that, in the pursuit of long term objectives that appear to be beyond reach nowadays, we must not lose sight of the everyday challenges faced by individuals today (Haraway, 2016; Philo & Parr, 2019; Högström & Philo, 2024).

Many will turn their noses up at seeing the term madness associated with troubles and institutions, but unfortunately, I cannot fail to notice how even the slightest hint of eccentricity often causes us to be considered at best unfit, unpredictable, ultimately a burden, to family, friends and society. The mad, marginalised by modernity, that expels everything that slows it down and hinders its functioning, risks becoming nothing but waste (Bauman, 2003). Even if mad behaviours remain in the realm of the hypothetical, the fact that there is a small chance they will occur again, influences how the mad find their place in the world or whether or not society accepts them[69] (Thorneycroft, 2020). And just as with waste, the need arises to find a place for them, turning the question of madness into a geographical inquiry. “Where do we put them?” remains a significant concern within the field of psychiatry. Consequently, although difficult to accept, the assumption that the mad never need dedicated spaces, protected employment, adequate and continuous support, is perhaps naive and may even constitute a form of discrimination as well. On the other hand, in the aftermath of a scandal, there is often a surge in criticism directed towards psychiatric services, in a generic defence of the mentally ill that rarely considers the complexity of the issue. Complexity which would require thoughtful examination before suggesting any concrete solution. In my thesis, I have tried to untangle this complexity, exploring it from different points of view, without ever claiming to provide an all-encompassing one. In the next paragraphs, by drawing on the conceptual framework, through which I interpreted the empirical material, I provided potential answers to the research questions. Answers that open up new scenarios and other questions, which in turn may become areas for further research.

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[69] I constantly live with the fear of having manic or depressive episodes, which leads me to control every thought and to withdraw from certain situations that I think might trigger them; in a form of self-restraint and censorship that besides being very tiring, deprives me of certain experiences. The same goes for those around me who often worry more than necessary and treat me differently.

2| ANSWERING THE RESEARCH QUESTIONS

I started my inquiry by wondering to what extent the spatial and relational practices that developed after the 1978 mental health reform in Italy facilitated the transition from a vertical and hierarchical form of control to a model perceived as more capillary and horizontal. My hypothesis was that despite this perception, this new model could function as an equally oppressive one, dispersing the institutional nature of the asylum into communities and families (Foucault et al., 1991). The main aim of this exploration was to understand how contemporary mental health care practices may contribute to processes of harassment and exclusion, and whether these problems were acknowledged and addressed in any way. It also examined how power is exercised in these new geographies and how individuals deal with it on a daily basis (Butler & Parr, 1999; Chouinard, 2012; Conradson, 2003b; Parr, 2000). In order to explore how mental health care has adapted to the state's withdrawal and how it has been - spatially and relationally - expressed, I placed the process of deinstitutionalization in a specific urban context, the city of Turin. To assess the implications of these novel practices on power dynamics and identity formation for individuals, I chose a particular residential facility, known as “group home” and, through formal and informal interviews with their users, I tried to understand how it is perceived, lived, and narrated; this in the attempt to fill the gap represented by first-hand experiences of psychiatric care. Furthermore, my personal experience, beyond presenting an additional perspective, served to clarify my positionality when it came to certain research choices and how I interpreted the findings. The research was structured around the objectives mentioned above and a set of key questions that will be discussed in more detail in the following paragraphs. For each answer, I wanted to stimulate new developments and debates, thus suggesting further potential research questions.

a) what can be learned from examining the deinstitutionalisation process at the urban level?

As outlined in Chapter 4, when recounting the story of the Italian reform, there is often the risk of oversimplifying the overall experience by reducing it to the work of Franco Basaglia in Gorizia and Trieste, assuming that the rest of the country, previously static, followed the same path, as a direct consequence of it (Mossa, 2023). Although true in some cases, this narrative does not give the full picture of what was happening across Italy since the 60s and it banalises an experience that has been both polycentric and polyphonic (Burns & Foot, 2020). The examination of the Turin experience, looked at the urban scale, stressed the potential specificity of each local context (Jones, 1996, 2000; McGeachan & Philo, 2017); as well as enriching the picture, it offered a closer look at the deinstitutionalisation process and at the subsequent evolution of mental health services. By analysing an urban context and doing so through the study of archival material of a grassroots association, I was able to provide a more comprehensive understanding of that movement; with a clearer idea of all the people involved and the work that preceded, or followed, the most well-known events. This allowed me to trace seemingly minor episodes and map a multiplicity of places and people, as well as the networks that held them together, that were traditionally excluded from the prevailing narrative.

Overall, examining the process of deinsitutionalization at the urban scale revealed insight into the spatial, relational and systemic dimensions of mental health care reform. First of all, it showed that the deinstitutionalization process did not occur in a social vacuum and that urban-specific political, cultural, and economic contexts significantly influenced its application (Jones, 2001). Turin's grassroots mobilizations and active involvement of civil society illustrate how local movements facilitated and shaped the transition. Civil society and local organizations played a pivotal role in advocating for patients' rights and shaping public discourse, emphasizing the importance of collective action in driving systemic change. The diversification of subsequent psychiatric services was equally dependent on the social and political environment in which they were set, as well as the emergence of the third sector as their primary provider (Lasagno, 2012). The faith-based discourses identified by Lancione (2014) in homelessness services, can also be found behind some voluntary mental health initiatives and cooperatives. The moral commitment to social work, typified by the large presence of cooperatives (Adorni & Tabor, 2024), still seems linked to the traditional idea of Turin as a city of social saints[70]. Initially translated into a model in which the social had to be “small to be beautiful”, today this same model seems to falter in the face of the logic of “industrial cooperatives” against which the small can no longer compete. At the systemic level, deinstitutionalization reflected broader economic and policy trends, such as the privatization of care and the withdrawal of state support, which has never equalled the expenditure previously

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[70] - The Social Saints refer to a group of religious and lay people that in the 19th century dedicated themselves to charitable and social activities in the city, at the time in great poverty.

invested in the asylum complex. The reliance on private, third and voluntary sector inevitably risks exacerbating inequalities and creating barriers for marginalized individuals, as this shift has often led to precariousness and unequal access to care (Caselli & Rucco, 2018).

By examining deinstitutionalization at the urban level, we learn that the transition from institutional to community-based care required attention to spatial justice, relational ethics, and systemic equity, showing the importance of integrating mental health care into urban planning (Crooks et al., 2018). These insights are not only vital for improving mental health care but also for informing broader discussions on urban inclusivity and social justice for all, extending the concept of accessibility to different ways of being and perceiving reality (Thorneycroft, 2020; Vanolo, 2024). Moreover, the findings suggest that marginalization is compounded by intersecting mental health issues with factors such as class, housing precarity, job insecurity and the ever-present stigma attached to them (Bambra, 2022). Drawing on urban geography and the concept of the “right to the city” (Harvey, 2008) the study advocates for inclusive planning that integrates mental health care into a variety of public spaces and activities, way beyond the list of psychiatric services identified by law and often of no particular interest to planners. The Turin case, by offering a more patient-centered narrative, stressed the importance of including patients’ narratives in challenging traditional power structures and shaping mental health services. It also highlights how the centrality of patient’s stories has gradually diminished over time (LeFrançois et al., 2013; Beresford & Russo, 2022).

The ethnographical analysis highlighted several lessons that reflect the complexities of deinstitutionalization, illustrating both significant progress in humanizing mental health care and ongoing challenges in achieving objectives based on equity, effectiveness and efficiency. The infrastructure of community services in Turin can be conceptualised as an intricate network of nodes, operating in a fragmented manner and with limited integration with the wider urban fabric, which merely accommodates them. I observed that life of a psychiatric patient is characterised by a movement between these nodes, with the potential for sporadic incursions into areas close to these services, like bars and shops, but without a real inclusion. This prompts a potential question to address in future research: *how might the concepts of accessibility and the right to the city be conceptualised for people with mental health issues?*

b) How has power dynamics, from above and below, been transformed through the process of deinstitutionalisation?

The process of deinstitutionalization in Turin and its broader implications at the urban level reveal significant transformations in power dynamics from both “above” (institutional power) and “below” (individual and community agency). In the shift between isolated institutional spaces to community services, the power dynamics were supposed to be dismantled, akin to the dismantling of the walls of the asylum. At least on a rhetorical level, this transition, has been mostly taken for granted. However, what could be described as a convenient simplification, does not address the forms of abuse that have not yet been eradicated. While the physical dismantling of asylums marked a progressive step, the persistence of “invisible walls” within community care settings underscores the need for systemic change and a continuous questioning of adopted spatial and relational practices (Philo & Parr, 2019). Deinstitutionalisation marked a transition from centralised asylums, where power was overtly hierarchical and concentrated, to the network of community-based care systems, where power had to be redistributed and rebalanced. The objective was not merely to relocate care, but rather to effect a transformation in the power relations that define it. However, as my ethnography shows, this decentralization did not entirely demolish control mechanisms; power was dispersed into micro-geographies where authority manifests through rules, routines, and unequal relationships. These spaces embody Foucault (1991)'s concept of governmentality, where control becomes more diffused and embedded in everyday practices. Community-based settings have shifted some aspects of power from external imposition to internalized self-regulation where individuals navigate their identities within frameworks of compliance and resistance. For instance, adherence to medication schedules and participation in structured activities reflect how individuals are socialized into self-discipline, perpetuating a subtle form of control even outside institutional walls. It is undeniable that, from “below”, deinstitutionalization has created the opportunity for spaces of resistance and empowerment where users of mental health services may engage in acts of self-advocacy and redefine their narratives, challenging stigmatization and othering (Beresford & Russo, 2021; LeFrançois et al., 2013; Thorneycroft, 2020). However, feelings of shame and stigma, make these possibilities rare. Participatory practices in group homes and support groups could allow for shared decision-making, fostering a sense of belonging and autonomy, but they are seldom put into practice. It is quite clear that the process of deinstitutionalization has not entirely eliminated asymmetries. The historical disempowerment experienced in asylum systems seems in a way to survive also in the current landscape, without any clear understanding of what prevents its reversal. While doing their best, caregivers and healthcare workers continue to wield significant authority over patients, often infantilizing them or making decisions on their behalf. The persistence of paternalistic approaches underscores the complexity of achieving genuine power redistribution, keeping the patient in a state of subordination and dependency.

The deinstitutionalization process aimed to transform power dynamics by dispersing institutional control, fostering grassroots empowerment, and redefining the spatial contexts of mental health care. However, challenges remain in addressing residual hierarchies and achieving equitable power relations within community-based care systems (Philo, 1997; Parr, 2000). My study highlights how these spaces can inadvertently replicate hierarchies of power, turning communities into fragmented micro-geographies of care, in which it is easy to get lost. Even an exercise of mapping of all services and providers is not that banal. This decentralization necessitates a nuanced understanding of how urban spaces mediate control, autonomy, and inclusion since they play a crucial role in shaping mental health outcomes (Crooks, Andrews, & Pearce, 2018a). This PhD research stresses how relational practices, as conceived by Basaglia, must once again become central to mental health care. Given that care is not just something that has to be delivered but rather co-constructed through daily interactions that must be continuously challenged (Basaglia, 2017). This requires shifting from a paternalistic model, still very much alive, to one rooted in mutual respect, continuous dialogue and shared agency. The research highlights how the life within a group home tends to reinforce either paternalistic or infantilising dynamics, whereby patients are treated as dependents or guests. Staff members frequently take charge of their finances, enforce established routines, and establish rules that can limit patients' sense of agency, despite the stated objective of promoting autonomy. This domestication, while undoubtedly well-intentioned, may potentially compromise the development of independent living skills (LeFrançois et al., 2013). A considerable number of patients encounter challenges when attempting to transition out of group homes. This is often due to a form of dependency that has been nurtured over time by the system itself. This dependency often originates from the restricted opportunities for meaningful autonomy within these facilities, such as the management of personal finances or the cultivation of external social networks. Patients themselves frequently harbour doubts regarding their capacity to live independently, a phenomenon that is exacerbated by the so-called “revolving door syndrome”, whereby repeated admissions and discharges erode both confidence and hope.

Power from above, primarily represented by policies and mental health departments, is often described as “extremely bureaucratic”. Legislation, such as regional decrees, aims to standardize care and emphasize patient rights but can inadvertently turn group homes into environments focused on compliance rather than empowerment. Workers report feeling unsupported by higher management and burdened by excessive administrative tasks, which hinders their ability to effectively address patients' unique needs. With regard to power from below, grassroots dynamics within group homes are influenced by the relationships between patients and staff, as well as among patients themselves. While small-scale settings facilitate close interactions, these relationships can become conflict-ridden due to the proximity, lack of privacy and diversity of individual needs. The enforced cohabitation of patients with different histories and conditions, combined with staff members' dual roles as caregivers and enforcers, gives rise to a complex and ambiguous web of micro-power dynamics. Group homes are designed to function as transitional living spaces to assist individuals in achieving autonomy. However, the challenges associated with prolonged stays, restricted employment prospects, and weak support networks indicate the difficulties in attaining this objective. Staff and patients alike articulate their frustration with limited progress, identifying a discrepancy between the aspirations of deinstitutionalisation and its practical implementation.

These findings underline the need for continued critical examination and policy innovation to create truly emancipatory mental health care practices, not just theoretical ones. Post-asylum geographies often fragment care into isolated islands, such as group homes or drop-in centres, which may not be adequately integrated into the broader urban fabric and only partially meet basic needs. This spatial and functional segregation, although dispersed, may reinforce marginalization and limit opportunities for social interaction and inclusion. The question I ask is therefore: “*Would it be possible to think of places and occasions for this monocular reality to ensamble, to raise awareness, gain strength and reach visibility and critical mass?”.*

c) How is power co-constructed, performed, embodied, narrated in post-asylum geographies of care?

The rationale behind this question is that space, personal narratives, and relationships are mutually constructed, making them inseparable from discussions surrounding power and identity formation. However, the importance of understanding mental health through a spatial and relational lens has not been fully embraced within mental health research (Crooks et al., 2018). Beyond centring the relational nature of space, I then wanted to address the considerable gap in accounts of personal experiences related to madness and psychiatric care. Using life-history narratives and autoethnography, I examined how geographies of psychiatric care are perceived, embodied, and narrated by people that inhabit them, as patients and workers (Chouinard, 2012; Ingram, 2016). With this in mind, the research responds to the call from mental health geographers for practiced and situated knowledge about care, aiming to further an understanding of space as both real and metaphorical, material and symbolic, embodied and discursive (Butler & Parr, 1999; Bondi & Fewell, 2003). Acknowledging that every narrative does not just reflect reality but actively shapes it, my focus was on raw and unsanitized personal stories, tied to embodied and relational experiences (Atkinson & Delamont, 2006; Atkinson, 2009; Miller, 2011). I then investigated how people, emotions, and conversations intertwine in specific environments (Butler & Parr, 1999; Duff, 2012), analysing how spatial, temporal, and relational elements may shape mad subjectivities (Conradson, 2003a; Crouch, 2003).

The research describes how group homes and community-based services create a new micro-geography of power that decentralizes control while keeping subtle forms of surveillance and authority. Power is embodied in the lived experiences of individuals navigating post-asylum spaces but it is never a static force imposed solely from above; rather a dynamic process shaped by spatial arrangements, interpersonal interactions, and individual agency. Patients embody power through their coping mechanisms, such as acts of defiance (e.g., refusing medication, breaching rules, lying), which become expressions of self-determination - albeit always within constrained environments and with a limited set of options available. Rules within group homes, such as cleaning rotas, medication schedules or curfews, are co-produced and negotiated, yet they often reflect a top-down imposition that shapes residents' autonomy. In everyday life, power is then performed through the routines and behaviours of both workers and patients. Workers, enact power through their rules, balancing authority with empathy; patients perform compliance or resistance as acts of agency, but with a very little decision-making and negotiating power. These routines serve as tools to domesticate madness and impose order, but they also act as performances of control that reinforce staff's authority. As Rojita mentioned *"we are often reminded we are guests and that we must be grateful".* A worker points out to me that it is a cost for the cooperative to have an empty bed and that the patients have a negotiating power that not everyone recognises - therefore few exercise.

The research emphasizes the role of narratives in shaping and contesting these dynamics. By examining how power is co-constructed, performed, embodied, and narrated, the study emphasises the need for care practices that prioritize inclusivity, autonomy, and empowerment while acknowledging the persistent challenges of hierarchical and paternalistic structures. The paternalistic dynamics in worker-patient relationships inevitably infantilize individuals, reducing their autonomy and self-determination. Patients' stories, if taken seriously, whether shared in support groups or therapeutic settings, would serve as tools to reclaim agency, challenge pathologizing discourses and combat stigma. The act of narrating one's experience might create a space for resistance and redefinition of identity, moving away from labels imposed by the medical or institutional gaze. However, *if patients no longer seem to have much to say, is it perhaps because no one really listens to them?*

d) Which are the spatial, rhetorical, relational elements that are likely to exacerbate dynamics of isolation, exclusion and dispossession around issues of madness?

For the most serious cases there is still need for long-term residential facilities. Among these the group home is one of the most spread and financed. My focus on those was prompted by three factors: the general lack of knowledge of these residential settings, despite their prevalence; a desire to observe patients in what could be the final phase of their therapeutic journey; a personal curiosity about a model that, despite being widespread, remains almost invisible due to its ordinary and molecular nature. I thought this invisibility has the potential to reintegrate patients into society or, on the contrary, conceal them in a more subtle way. Despite the informal environment, the group home is still a healthcare setting where power dynamics are rather evident. As already seen, the residents are under constant observation, not only by staff but also by their fellow residents. Their behaviour is read through the lens of their diagnosis, which precedes their personal traits and that that patients make their own. The daily routine involves the creation of structured activities made of rules and tasks, such as walking, shopping and preparing meals. These are often infused with subtle forms of control, which can be difficult to challenge or counteract. For each patient, there is a personalised plan drawn up with a psychiatrist to foster autonomy. However, many workers experience this process as a series of repetitive and uninspiring tasks, leading to feelings of helplessness and frustration. Staff members also face challenges such as low pay, lack of supervision and insufficient training. Many report feeling isolated and little considerated. The system also has a bureaucratic approach that standardises the diverse and complex needs of patients, treating them as cases to be managed and fixed rather than individuals to be understood. The most obvious limitation of this environment is the constant surveillance that patients undergo, which can lead them to internalise their diagnoses and feel trapped in a performative cycle of pseudo-normality. This creates an exhausting dynamic in which patients struggle to maintain a sense of security and belonging in what should be a home. The pervasive belief that they are incapable of making decisions for themselves is often internalised, exacerbating feelings of inadequacy. The socio-material elements of control, both coercive and internalised, are then mainly rooted in mistrust and lacks. Pervasive mistrust stems from the nature of mental illness, in which whatever patients say or do is questioned. The absence of a job, income or meaningful support, leaves them without autonomy and options, making it difficult for them to express their wishes or make decisions. The lack of hope, affection and adequate support contributes to a system in which patients' daily lives are governed by routines and power imbalances that persist despite the intention to create more humane models of care. Although the group home is definitively more humane than other practices, it has evolved into a rigid structure that does not adapt to the changing needs of individuals. Over time, this model has become an uncritical and self-reproducing routine that appears to work as a distracting trap rather than as an emancipatory tool.

Persistent narratives frame individuals with mental health issues as deviant or dangerous and residential facilities seem to reinforce this idea. These discourses, embedded in public and institutional rhetoric, perpetuate fear and exclusion, hindering efforts toward integration and acceptance. The medicalization and labelling of the mad create identities primarily defined by illness, reinforcing otherness and limiting patients' ability to self-define (Thorneycroft, 2020). This “ableist gaze” institutionalizes stigma and affects self-perception too. Mental health is often framed in economic terms, as a “burden” on the system, which shifts responsibility away from collective care and onto individuals, fostering dispossession and systemic neglect (Mills, 2018a). This gaze also comes from family members that often impose well-meaning but restrictive oversight, further exacerbating dynamics of dependence and marginalization. Lack of genuine social networks and meaningful activities intensifies feelings of exclusion, while community support systems are often fragmented and inadequately resourced to foster authentic inclusion.

As far as the spatial element is concerned, the inadequacy of these settings is due to overcrowding, poor maintenance, and an evident lack of personalization, that limit their efficacy in terms of therapeutic environments. Spatial constraints within group homes, such as shared bedrooms and a complete lack of privacy, inevitably reinforce feelings of dispossession and dependency. Moreover, the lack of accessible housing options often results in prolonged stays within these facilities, fostering a cycle of dependence on services. Within these flats, power imbalances persist, with patients frequently subjected to excessive oversight, judgment, and infantilizing treatment. The forced and arbitrary cohabitation with others can lead to constant conflict rather than fostering meaningful relationships. Conflict that tends to be suppressed rather than understandood. Relationships with family members, if present, are rarely supported effectively, leaving patients isolated from external support networks. Shared spaces like kitchens and living rooms become stages for a performance, where patients and staff play roles that align with their respective positions, with staff monitoring and directing activities while patients navigate these constraints. The physical layout of group homes - small, crowded flats with shared bedrooms - embodies power through spatial control, where limited privacy and the constant presence of staff physically manifest power asymmetries. Power is also embodied in how patients adapt their behaviour to fit expectations. This includes self-regulating actions like adhering to routines or conforming to group norms, which are influenced by the implicit and explicit control mechanisms imposed by staff. Patients narrate their experiences of power in ways that highlight both gratitude and frustration. They describe their lives in group homes as structured by a mix of support and surveillance, revealing how institutional control and dependency are perceived and internalized.

Rhetorically, public discourse surrounding mental health reform tends to focus on the closure of asylums and the virtues of community-based care, ignoring the lived experiences of patients, thereby reducing their agency. The continued infantilization of patients through institutional rhetoric and the emphasis on control and compliance overshadow individuals' autonomy and potential contributions. Terms like “bubble” and “golden cage”, as noted in patients and workers' accounts, reflect the perception of these systems as both isolating and disempowering. The interplay of spatial, rhetorical, and relational factors creates layered barriers to inclusion and empowerment that cannot be left to the initiative of single cooperatives, workers or family members. Addressing these elements requires not only structural reforms but also a revaluation of societal attitudes and relational practices, aiming to integrate individuals with mental illnesses more fully into the broader community. This leads to wonder "*How can we transition from feelings of dependency and dispossession to a shared sense of belonging and empowerment? If the group home does not fulfil all is asked for, what other places could fill its shortcomings?".*

e) What, vice versa, could promote a sense of belonging, self-determination and acts of resistance?

A significant focus was placed on identifying boundaries - whether real or imagined, crossed or created - that shape the geographies of care. By studying socio-material factors in post-asylum practices, I examined how embodied space contributes to both coercive and internalized forms of control, as well as acts of resistance, feelings of belonging, and positive identity formation (Foucault et al., 1991; Lefebvre, 1991; Thrift, 2006).The study explored whether contemporary mental health care practices involve harassment and exclusion, both within and outside institutional settings, and whether such practices are recognized and resisted. Essentially, I investigated how power manifests and the coping mechanisms people develop in response to it. This shed light on how individuals may contribute to their own oppression and the potential risks of subjectivation when one's identity is defined solely by external labels (Butler, 1997). By considering governmentality and socio-materiality, I explored how negative and positive mad subjectivities are constructed, questioning which embodied, relational, and discursive factors help create self-disciplined subjects and which ones might instead foster resistance and self-determination. If power is viewed as the often-unconscious attempt to influence others, it's evident that psychiatric services, even with the best intentions, can become repressive geographies, reflecting a society that continues to view the mentally ill as a potential threat.

The factors that I reckon promote a sense of belonging and self-determination are primarily relational. Patients seem to develop a sense of agency once they perceive trust, and they have been given options. Rarely involved in the definition of their care plans, patients feel little responsibility for their progress, mainly because these plans are not fully aligned with their personal goals, often considered unrealistic. As with other disabilities, the infantilisation of the mentally ill also results in the failure to recognise the full range of patients' needs, including emotional and relational needs, which are often sidelined. Sense of belonging and self-worth in these circumstances are therefore very difficult to achieve. Acts of resistance in this context, however, arise in subtle, everyday practices where patients assert their displeasure against constraints. These acts include challenging the infantilizing norms, such as rejecting or negotiating imposed rules and expressing dissatisfaction with the paternalistic roles assumed by staff. For example, patients sometimes resist the standardization of their care by questioning the purpose of long-standing but outdated routines, such as arbitrary schedules for meals or group activities, which were originally designed by or for others.

Another form of resistance lies in the narratives patients use to describe their lives. While many internalize the language of psychiatry, using self-critical terms to conform to expectations, moments of defiance emerge when patients refuse to align with these external labels or express their dissatisfaction with the lack of meaningful roles or autonomy. In some cases, patients use humour or storytelling as a form of rebellion against the rigid structures of their environment, subtly reclaiming their agency and self-worth. Moreover, resistance can manifest through collective or individual advocacy, such as patients asserting their right to make decisions about their personal lives, including relationships and financial independence. Or trough forms of solidarity, for instance covering up the misdeeds of housemates. In an infantilised environment, it should come as no surprise that forms of resistance result in lying, stealing, rule-breaking. However, these efforts are often hindered by systemic constraints, such as financial dependence on the cooperative, which obviously limit the scope of resistance. Despite these challenges, these coping mechanisms reflect a persistent effort by patients to navigate and reshape the power dynamics within their care environments.

My research begins with the belief that even in situations of unequal power dynamics, the possibility to generate counter-power exists. To recognize and nurture this, one must though engage with these geographies directly, identifying and expanding on the “cracks” in the system (Högström & Philo, 2025). By “staying with the trouble” (Haraway, 2016; Philo & Parr, 2019), these cracks must be widened so that madness can find its place in society - not as the opposite of reason, but as an independent entity in itself (Revel, 2024). Fostering belonging, self-determination, and resistance requires systemic changes in how mental health care is spatialized, narrated, and practiced. By creating inclusive spaces, adopting affirmative narratives, and fostering egalitarian relationships, individuals can reclaim agency and challenge oppressive structures. These actions would not only benefit those directly impacted but would also contribute to broader societal progress toward equity and justice. In Turin's deinstitutionalization process, open-door communities served as a transformative model, allowing free movement and collaborative decision-making between patients and staff, which now seems to have lost strength. Building egalitarian relationships between patients, workers, and the broader community promotes self-determination and provides with opportunities for patients to voice their needs. Encouraging patients to take part in grassroots movements and public advocacy initiatives can spark acts of resistance and help dismantle hierarchical structures, by empowering individuals What I think would be worth exploring in the future is: how can the "cracks" in repressive systems be widened systematically to create transformative opportunities for patients?

3| STRATEGIES AND PRECONDITIONS

In mental health geography, there is a hidden question that few have the courage to spell out: should the mental health system be abolished altogether? However, the risk of a popular consensus developing towards the reopening of traditional asylums remains high, and this is, perhaps, why criticism of the current system seems to go only to a certain point, not foreshadowing its abolition or proposing concrete alternatives. Having completed the thesis, the results of which only partially answered the research questions, and, in any case, did not show a clear and unambiguous way forward, I feel to adhere to the lead of two eminent British geographers who have previously addressed this issue: working "*in the cracks between abolition and reform*" (Högström & Philo, 2024 : 1). I do not recall asking myself whether the group home should disappear. Rather, whether it was the ideal space for all the people I was interacting with, what could be done to improve it, or which other places or services could complement it. I often blame myself of being less revolutionary than I ideally hope; perhaps too pragmatic to envision the unconditional acceptance of madness, too realistic to believe that safe places and support may be necessary. Without in any way renouncing the possibility that the mad have a say, as mad and as whatever else they are; so that we understand that there is much more to madness, also and precisely by virtue of it (Ingram, 2016; Thorneycroft, 2020).

Nowadays, although the ideal is to provide care for patients within their own homes, this vision often collides with the reality of toxic family dynamics, absent or incapable relatives, and precarious economic circumstances. To address this gap, mental health services have created home-like environments, favouring small communities and the model of the "group home". This approach envisions a residential continuum where patients gradually transition to less intensive care, ultimately aiming for partial or complete autonomy. However, systemic challenges, such as the lack of stable housing, employment opportunities, and support networks, frequently disrupt this progression. These barriers often result in prolonged stays in residential facilities, inadvertently perpetuating the "mad career" phenomenon. While the Italian mental health reform driven by Basaglia sought to establish a dynamic and transformative model of care, the current system often feels like a stagnant machine moved by inertia. In this framework, the voices and needs of psychiatric patients are frequently overlooked, silencing their agency once again. Achieving true liberation requires a closer engagement with patients' lived experiences and an active effort to dismantle the power structures that maintain their marginalization. My research highlights spatial, rhetorical, and relational strategies that can nurture a sense of belonging, self-determination, and acts of resistance for those navigating post-asylum geographies of care.

The schematic strategies outlined below aim to reimagine a mental health system that fosters agency and self-worth among patients. By involving individuals with mental health challenges in the decision-making processes - whether regarding living arrangements or care routines - patients gain greater self-determination and a sense of ownership over their environment. Transitioning from paternalistic care models toward co-created care pathways ensures individuals feel more connected to their care, enhancing both agency and belonging. Encouraging autonomy through fewer rigid rules and increased user input allows for more control over daily lives, promoting genuine independence. An inclusive mental health system must also account for diverse identities shaped by factors such as class, race, gender, and sexuality, to ensure that care practices and community initiatives were inclusive and tailored to specific needs.

An emphasis on first-person narratives of recovery and resistance challenges stigmatizing discourses while reinforcing positive identities, creating a counter-narrative that celebrates resilience and self-determination.

Mental health care should be framed as a fundamental right rather than a charitable service, focusing on equality, dignity, and justice. This approach empowers individuals to advocate for systemic change. To achieve meaningful societal change, it is essential to challenge pathologizing discourses and instead adopt frameworks that celebrate resilience, creativity, and agency. Conceptualizing madness as a legitimate mode of being, rather than a pathology requiring correction, provides a foundation for resisting oppressive norms and redefining identities on one's own terms. Finally, fostering safe spaces where individuals can share experiences, build solidarity, and challenge stigma serves as a vital platform for collective advocacy and resistance, enabling broader systemic change.

The closure of asylums, as influenced by the work of Basaglia, redefined how mental health care is spatialized, in Italy and elsewhere. The transition towards decentralized community-based services has not invariably resulted in the actual dismantling of oppressive dynamics. Instead, new geographies, where control and care intermingle, have emerged. As one of participant observed, *"Living in a group home helps me feel less isolated, but I always feel under someone's watchful eye, even in my own room."* This sentiment reflects a broader critique: while physical barriers were removed, relational and bureaucratic boundaries persist, shaping experiences of autonomy and belonging. Community-based care, particularly within group homes, reveals the dual nature of care. On one hand, supportive relationships between workers and patients can foster empowerment and a sense of inclusion: as one worker noted, *"We try to listen, not just supervise. That's where real progress happens."* On the other hand, the same relationships often reproduce hierarchical dynamics, where caregivers' authority overrules patients' autonomy, infantilizing them in subtle ways. Daily interactions in group homes show the nuanced interplay between rules, compliance and some shy act of resistance. Observations highlighted how seemingly harmless routines—such as meal schedules or medication times - become sites of negotiation. For example, one resident shared: *"Sometimes I refuse my meds, not because I don't need them, but to remind myself I have a choice".* Workers too face challenges in balancing professional responsibilities with empathetic engagement. The discretionary power they exercise, not without indecision, often becomes a tool for either enabling autonomy or reinforcing control.

The group home is undoubtedly a more humane model, but over time it has become a rigid system that fails to accommodate the evolving needs of individuals - needs often reduced to the basics: food, shelter, control, and medication. If we are not content with merely improving living conditions, while perpetuating marginalization, perhaps it is time to reengage in a collective exercise of listening and disciplinary unlearning. While the reform is often celebrated, we fail to see how it has crystallized into static practices that, although preferable to the asylum, are not inherently virtuous. These models, in subtler ways, can reproduce dynamics reminiscent of the very institutions they were meant to replace. Basaglia's vision of liberation was intended to be an ever-evolving process, pushing boundaries and extending its goals. However, we seem to have shifted from the optimism of transformative practices to the pessimism and frustration of uncritically reproduced routines - routines that once again silence the voices of the mad. What I observed was a system, mainly limited by a lack of imagination, and operating not within the community as envisioned, but merely close to it. The concept of space, both physical and relational, emerges as a crucial factor in shaping these outcomes. While group homes provide physical safety, they often function as "soft prisons," curtailing freedom and self-expression. In contrast, drop-in centers and day centers offer more fluid and dynamic environments that may foster empowerment and connections, but they remain temporary and peripheral spaces of care. These findings align with Foucault's concept of governmentality, illustrating how spatial arrangements mediate power and identity formation. What was obvious to me is that none of the spaces I could visit, were residences, outpatient clinics, day care centres, can suffice, especially if not put into a system. To these should then be added places not specifically dedicated to the mad, not for medical treatment, rather for social and labour inclusion.

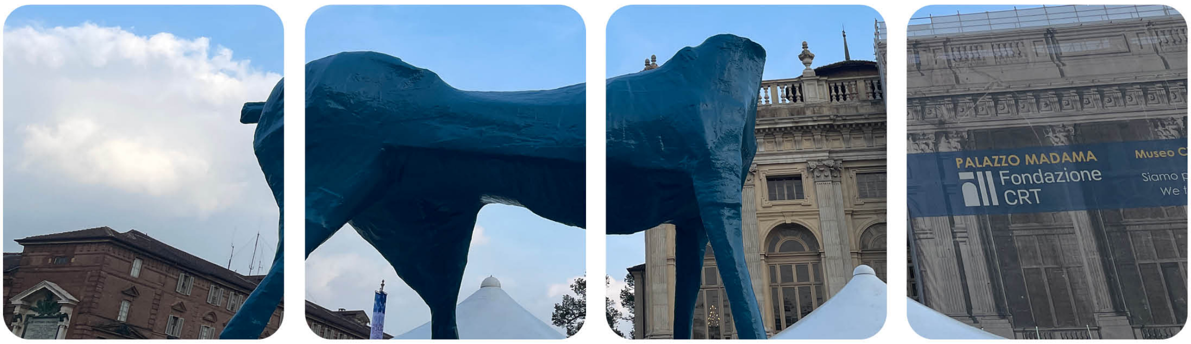
This research contributes to the spatial turn in mental health geography by situating madness within lived geographies and it challenges ableist and sanist narratives, emphasizing the role of space and relationality in producing both coercive and emancipatory dynamics. This research holds both theoretical and methodological importance. It seeks to contribute to the "spatial and ontological turn" in mental health geography and Mad Studies, and aims to modernize theories of power, space, and grassroots resistance in a post-asylum context. As Foucault and Goffman suggest, power operates not only through institutions but also through the everyday, embodied practices of individuals. By combining ethnographic insights with theoretical frameworks, the research sheds light on the multi-layered realities of post-asylum geographies at the micro scale. It underscores the need for mental health care models that prioritize autonomy, inclusivity, and relational engagement;

moreover, it foreshadows future research willing to explore the intersection of space, identities, and care, to envision transformative practices that uphold the dignity and rights of all individuals, care workers included.

CHAPTER 8

CONCLUSIONS

1| INTRODUCTION



My research examined the intimate and micro-geographies of psychiatric care in Turin, situating them within the broader context of the deinstitutionalisation process that has been underway in Italy since the 1970s. Through a geographically and historically situated perspective I looked at a variety of mental health care practices that go from drop-in centres to residential facilities, with the aim to assess the implications of post-asylum geographies of mental care for patients and workers. The idea was to explore the impact on individuals of the network of mental health services, born in the wake of the "asylum" undergoing closure. The thesis asked to what extent the spatial and relational practices that have emerged since the Italian reform of 1978 have contributed to the shift from a hierarchical form of control to an atomised model that, by dispersing the "total" character of the institution into the community and the family, has the capacity to manifest itself in less evident ways. With the risk of taking increasingly pervasive and insidious forms, therefore more difficult to recognise and counter. This together with an examination of the conditions under which a sense of belonging and self-determination can develop. The primary aim was therefore to examine whether and how processes of harassment and exclusion still occur in contemporary mental health care practice, and to what extent they are acknowledged and resisted. In other words, how power has adapted to current cultural and spatial environments and which coping mechanisms, if any, are put in place on a daily basis.

Drawing on an extensive ethnographic analysis, mainly built on participant observation and life-story narratives, my study highlighted how spatial arrangements and narratives intertwine to create dynamics of power, often highly unbalanced. By providing an analysis of pros and cons of today's psychiatric services, as they are experienced and narrated from within, I sought to look at both the spatial and relational nature of mental health care. Moreover, acknowledging the lack of first-person accounts within the existing discourses on madness and psychiatric care, this study aimed to raise the voice to those who deal with this condition. In response to the growing interest in geographical disciplines for mental health and for the role played by different spatial arrangements in the daily lives of people with mental disabilities, the central premise of this work was that space, self-narratives and relationships are co-constructed and cannot be detached from any discussions of power and identity production. The objective of the research was then to provide a situated understanding of mental health care, with a focus on how material and immaterial boundaries affect mental distress and forms of subjectification.

It should be added that the point of view through which the study was structured and the empirical material interpreted, was that of a person who has experienced mental illness at first-hand. This places this work within the strand of autoethnographic research, which makes the objective and the interpretative lens more personal and subjective than one would expect from traditional academic work. The methodology also included a combination of archival research and ethnographic fieldwork, made of long-term participant observation and interviews. All read through my personal experience, occasionally brought to the fore by few autoethnographic vignettes included only when I felt my story could add a layer of understanding to my choices, position and interpretation of the empirical material. Overall, the aim was to map the micro-geographies of care and how mad identities are there produced, lived, narrated, and potentially contested. In practical terms, the fieldwork involved participant observation in residential facilities and mental health centres, with long-term interaction with patients and staff.

The main ethnographic study was carried out in the city of Turin, chosen on the basis of its distinctive history of deinstitutionalisation and the current challenges faced by its mental health system, which are common and widespread throughout the rest of the country. While placing the experience of Turin within the wider movement traditionally linked to the work of Basaglia, I wanted to highlight the specificity of a local case and controllprovide with a place-specific examination of the evolution and diversification of post-asylum geographies. Having placed the micro-scale, the everyday and the individual at the centre of the investigation, the urban is considered not in its entirety, but rather through the partial sum of some of its fragments, seen as an integral and founding part of a larger and detailed mosaic. While recognising that a more conventional thesis in urban studies would have given much more weight to other elements, favouring a bigger scale, a larger and diversified sample, less intimate and personal experiences, I preferred to look at this mosaic by zooming in, identifying in its smaller pieces an ideal ground for studying the whole; leaving to others - and further research - the task to zoom out.

2| MAIN CONTRIBUTIONS

One of the most significant contributions of the project is the examination of the history of deinstitutionalisation undertaken from a less explored perspective and from a point of view that has been traditionally excluded from the prevailing narrative, which usually places the work of Franco Basaglia and those who worked with him at the centre of the discourse. Although examined within the broader context of the movement led by Basaglia, the Turin case was analysed by highlighting its distinctive elements, which served to characterise it as a significant, albeit not very well known, case. The study contextualises the de-institutionalisation process in Turin, emphasising the role of a grassroots association called the Associazione per la Lotta Contro le Malattie Mentali (ALMM) and the patients who, thanks to the association, were able to make their voices heard. The efforts of ALMM have been instrumental in increasing the visibility of people who have been institutionalised, while facilitating the documentation and exposure of abuses perpetrated within asylums. The emphasis on the role played by members of civil society, whose names few remember, served to enrich and complicate the picture of the period leading up to the reform and to show that every context deserves its own historical reconstruction. Consulting the archive of an association involved in the process certainly provided a novel perspective. Through the readings of letters of patients and their relatives, I have come to the conclusion that in wanting to write the history of deinstitutionalisation, one must preferably start with these minor, otherwise forgotten narratives. If only to give them back the dignity their owners were deprived of by locking up their lives and their story. Lives that were not considered worthy of being lived, let alone told, because they apparently do not make history. In addition to the archival research, which was extremely useful in delineating the specificity of the local context, I carried out a broader historical analysis that, through literature review and viewing of documentaries and reports, served to delineate the influence of the radical psychiatric movement in Italy and elsewhere, and to briefly compare it with contemporary experiences in the United Kingdom and France. In studying that period, the focus was put on the ideological shift that not only allowed a more humane approach and a move away from coercive practices but also led to a questioning of psychiatry as a discipline, and a more balanced relationship between doctor and patient.

Moreover, my research provides critical insights into the complex interplay of power, identity, and resistance within some of the post-asylum geographies of mental health care. By examining the lived experiences of patients and workers in a particular residential facility spread across the city, called “group home”, the study highlights both the advancements and ongoing challenges in the deinstitutionalization process of the country, still considered avant-garde. Through the study of this practice, I partially evaluated the concrete implementation of the reform, in its smallest scale and its daily functioning. Doing that, I opened the door to spaces that in the minds of those who subsidise and promote them, remain ideal and abstract concepts. The contribution here sits in showing the material and relational nature of life spent within these walls, in all its banality and ordinariness and through the voices of people that currently inhabit them; filling a further gap that addresses the current alarming lack of first-person accounts on experiences of psychiatric care. This work also advances theoretical and methodological conversations on mental health studies: through autoethnography and life-history narratives, the thesis foregrounds the voices of those traditionally marginalised in academic and policy discourse, presenting madness not only as a condition to be understood but also as a radical and privileged epistemological lens to interpret itself. This intersection offers novel insights and encourages further research into the spatial and relational dynamics of mental health care, starting from the perspective of their users. The findings emphasise the importance of addressing systemic socio-economic factors and co-produced care spaces that prioritise agency and belonging; stressing that, preliminarily, we must learn to listen to the people concerned, in their own terms; trying to get them used to being taken into serious consideration.

To sum up, the thesis contributes to the broader discourse on mental health by bridging the fields of mental health geography and Mad Studies. It underscores the need for a multi-faceted understanding of mental health that encompasses spatial, relational, and socio-economic dimensions. By acknowledging the complexity of these experiences and the power dynamics at play, the study advocates for transformative changes in mental health care practices that honour the dignity and agency of individuals navigating the system. As a contribution to the broader discourse, the thesis highlights how mad identities and practices, if positively embraced, can act as a site of resistance. It also wants to make a call to reimagine more inclusive and equitable frameworks for mental health care. These insights hold significant implications for policymakers, practitioners, and scholars alike, urging a shift toward transformative approaches that move beyond individualised and medicalised understandings of mental distress.

3| STEPS FORWARDS

The analysis revealed that while deinstitutionalisation has dismantled traditional asylum structures, the dynamics of control of these institutions have dispersed into everyday spaces and embodied in seemingly innocuous gestures. This challenges the perception of progress and emphasizes the need to address how these spaces continue to shape identities and relationships among mental health patients. The use of first-person narratives and autoethnographic accounts has been essential in understanding the subjective experiences of individuals within the mental health system. Discussing with workers, I was able to get a first-hand view of the effort to maintain a balance between care and control, autonomy and infantilisation, hope and lack of confidence. By observing and listening to the patients, I got evidence that this balance is rather precarious and, even when maintained, is not necessarily sufficient to achieve independence and self-determination. The study of group homes revealed a complex landscape in which four or five patients live together, without having chosen each other, under the watchful eye of a member of the staff, there for helping and observing them. It is not difficult to imagine how the “normality” of this environment is reduced to a mere quiet living in which normal equates to problem-free, both in the flat and in the society.

Although one appreciates the good intentions behind this model, my research has identified significant challenges, from a structural lack of resources to insufficient attention to the social and emotional needs of patients, to the real and recurring risk of turning the home into a mini-institution, with patients and workers trapped in the boring routine of home management. The study emphasizes the importance of acknowledging patients' experiences and perspectives in shaping future mental health policies and in envisioning new approaches. The findings suggest that mental health care should prioritize user narratives and foster environments that promote real autonomy and self-advocacy. Patients' narratives revealed the nuances and ambiguity of their feelings about autonomy, trust and their relationships with staff, underlining the importance of including their voices in discussions about mental health care. It also highlighted the critical role of systemic socio-economic factors in shaping the individual experiences: the lack of an adequate support network often exacerbates feelings of isolation, inadequacy, and hopelessness among patients, indicating a need for more comprehensive approaches to mental health that address these underlying issues.

The emphasis put on the significance of space, considered as co-produced by the material and the relational, led to advocate for environments that prioritize agency and belonging. By fostering collaboration between patients, caregivers, and communities, such spaces could facilitate a more inclusive and supportive approach to mental health care. This should have significant implications for policy makers, mental health professionals and scholars in urging a paradigm shift towards more inclusive structures that recognise the agency of mental health patients and the importance of their lived experiences in shaping care practices that offer more than a shelter. My study calls for the development of mental health care services that prioritise the voices and needs of patients and workers as essential starting point, rather than relying solely on the perspectives of psychiatrists, who have slowly lost touch with patients and their daily needs. This shift could lead to more effective and compassionate care strategies, potentially able to address systemic barriers and facilitate integration and empowerment. Concern about space must follow concern for the person and what they think. Building or maintaining a social network and a serious employment policy must go hand in hand with identifying the ideal housing solution. Concerning how to create a sense of purpose rather than worrying about the bare materiality of life, or a pharmacological compensation, should be at the core of psychiatric care.

The services we have now are not working as expected, but once we have identified the cracks, we can fill and see them as an opportunity to stay with the trouble, to find more effective and adequate solutions - without deluding ourselves that they are definitive. The research also pushes for a more relational and situated understanding of mental health geographies to emphasise lived experiences and intimate everyday spaces. The work challenges the uncritical celebration of deinstitutionalisation, highlighting the persistence of exclusionary dynamics; thus, recognising the need for a continuous questioning of the solutions found. The study has also highlighted the importance of considering the embodied experiences of individuals with mental health conditions, moving beyond the traditional focus on the built environment to examine the ways in which the body is implicated in the production of space. By prioritizing the voices and experiences of individuals with mental health conditions and their carers, this study provides some perspective on the ways in which policy and practice can be reformed to better support the needs of all. In terms of the potential for further research, it may be useful to explore the generalisability of the results by applying this approach to other urban and cultural contexts. In Turin itself, I will welcome similar studies to investigate alternative facilities, like therapeutic communities or SPDC. I also hope that mad activism and user-led organisations will receive the support they need to co-produce knowledge and challenge sanist narratives. Also, that madness is recognised as a possible lens to critique and resist injustices in society, aligning with other anti-oppressive movements (e.g., disability, queer, feminist studies). Maintaining the question of what constitutes "sanity" and "normality", the thesis aims to help deconstruct normative frameworks and to legitimate different ways of being and knowing - ideally by imagining alternative and more inclusive social structures. This is achieved by answering the five questions:

a) what can be learned from examining the deinstitutionalisation process at the urban level?
b) How has power dynamics, from above and below, been transformed through the process of deinstitutionalisation?
c) How is power co-constructed, performed, embodied, narrated in post-asylum geographies of care?
d) Which are the spatial, rhetorical, relational elements that are likely to exacerbate dynamics of isolation, exclusion and dispossession around issues of madness?
e) What, vice versa, could promote a sense of belonging, self-determination and acts of resistance?

4| CONCLUSIVE NOTES

At the time of writing, I teach technical drawing in prison within an art high school. Many of my students suffer from severe mental disorders and those who do not suffer from them probably have some personality disorder that makes them survive seemingly unscathed. Psychological support or psychiatric help is provided only if you are troublesome, or you attempt to commit suicide. Otherwise, according to them, it is sporadic and of no use. Psychologists, educators and psychiatrists are structurally understaffed, which shows that mental health is not for sure a priority there. My students, mostly indicted or awaiting trial for crimes of a sexual nature (or within the family sphere), represent the bottom rung of the prison hierarchy. They must therefore be protected from the rest of the prison population who might want to kill them. Depicted as monsters, despised even by the most heinous murderer, behind school desks, as they fight with orthogonal projections, they look at me with a mixture of gratification and respect that deeply moves me. As a woman I experience an emotional blackout in which, on the one hand I see the person, whom I often like, and on the other, I question my own judgement when I learn what they have committed, and I kind of feel guilty to like them. In the process of humanisation that those working in prison are called upon to do, once out of prison, I often find myself recognising a gesture, a physical resemblance, a tone of voice in people I meet in the street. Ideally, everyone could become a potential monster. Moreover, the moment you laugh with the monster, do you become a monster too? Is it disrespectful to the victims to believe that no one should deserve that punishment? Would it be possible to imagine a society without prisons? Once it was impossible to imagine a society without asylums. Without doubts, I am sure prison is not the solution but rather contributes to exacerbate the problem. It is much easier to forget, or not question, what life is like for prisoners and their warders; in thinking that they do not deserve any psychological support, when just living or working there has an unimaginable impact on mental health. Paradoxically, the activity at school is often characterised by laughter and jokes that are much rarer in the group home. The sense of injustice and anger perceived in prison is also more vivid and all in all helps many to react. What slowly wears you down is the lack of affection, of contacts, the waiting, the boredom, the inactivity, the fear of the outside world, the lack of hope for the aftermath. And so, even if excessive, the comparison with psychiatric patients becomes even more relevant and worrying. And not only because some of the inmates have a diagnosis, often earned in prison, which should get them out of there; but in the absence of suitable places keeps them parked there. The real question at the end of the day appears to be the same…and it is still a geographical one: ***Where do we put those we reject?***

While we should ask: ***“What kinds of spaces, supports, or relationships would those directly affected envision for themselves?”***

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