ABSTRACT. The deinstitutionalization of psychiatric patients is a deeply cultural as well as political task. It entails the sharing of responsibility for human distress with family and community. Consequently, the locus of social control has also shifted from psychiatric and medical expertise to community and legal institutions. Diagnosis and treatment models must be more compatible with lay explanatory models. This paper explores the various meanings of "going 'mental'" and "being 'mental'" in the white, working class, ethnic neighborhood of South Boston. The data are extracted from a study of the impact of deinstitutionalization on a cohort of middle-aged, psychiatric patients discharged from Boston State Hospital in the attempt to return them to community living. Individual, family, and community responses to, and interpretations of, the symptoms of mental distress are discussed. The study indicates that even seriously disturbed individuals are sensitive to cultural meanings and social cues regarding the perception, expression, and content of psychiatric episodes. While madness invariably disenfranchises, it does not necessarily deculturate the individual.

INTRODUCTION: WHY COMMUNITY PSYCHIATRY NEEDS THE ANTHROPOLOGIST*

There are several compelling reasons for psychiatrists to entertain more than an academic curiosity about cultural influences on behavior, affect and cognitive style. For one, the process of psychiatric labeling and diagnosis begins not in the psychiatrist's office but in the community. Each patient initially presenting for psychiatric consultation, either voluntarily or involuntarily, has usually had a long and complex history of negotiations with family, co-workers, and neighbors about the possible meanings of his or her erratic behaviors. Second, attendant to the policy of psychiatric deinstitutionalization (see Scull 1984), more and more serious psychiatric disorder will be managed in the community setting and, often, within the family context. Hence, the locus of social control has shifted from psychiatric and medical expertise to community and legal institutions. Increasingly, diagnosis and treatment plans involve the psychiatrist in delicate negotiations with family members, police, clergy, social workers, disability counsellors, teachers, and other concerned community members.

While the benefits of the so-called deinstitutionalization "movement" are many (not least of which is the sharing of responsibility for psychiatric
suffering), one unintended side-effect has been a calling into question of psychiatric expertise, including the scientific validity of diagnosis categories (Scheff 1975; Lovell and Scheper-Hughes 1986). A growing realization of the importance of lay perspectives on madness has eventuated in the wake of community-based, deprofessionalized, and demedicalized programs for the so-called chronically mentally ill. Public psychiatrists working in these new community settings have become aware of the need to make diagnosis and treatment more compatible with lay explanatory models. Finally, it is incumbent upon hospital-based psychiatrists to make culturally informed and appropriate decisions about the timing of psychiatric discharges and the community placements of the ex-patients of psychiatric facilities.

This paper explores various cultural influences on individual, family, and community interpretations of the meanings of going and being crazy in the tough, economically deteriorating, white, working class, “ethnic” inner-city neighborhood of South Boston (“Southie” to its residents). The data are extracted from a larger community study of the impact of deinstitutionalization on a cohort of fifty-five chronic “revolving door” psychiatric patients, discharged, again and again, from Boston State Hospital in a largely futile attempt to return these hapless souls to some semblance of “community living” (see Scheper-Hughes 1981, 1983). During the time of the study (1979—1980, with brief return visits for several weeks in 1981 and 1982) the individuals in the sample were all out-patients attending a day hospital program in South Boston. In addition to participant-observation in the daily events of the day hospital program, I visited the clients in their homes and in various ex-patient “hang-outs” (the Jolly Donut Shop, for one) after hours. In addition, I contacted family members of the clients and interviewed them in person when possible, and by phone and letter correspondence when face-to-face interviewing was impossible or unwanted. Finally, I interviewed residents of the South Boston community at large about their thoughts and feelings on the subjects of madness, deviance, alcoholism, family and community norms and values. And, with the help of several community key informants, I was able to complete a telephone survey on community responses to psychiatric symptoms and to deinstitutionalized mental patients among seventy-six South Boston residents randomly selected from the Boston telephone directory.

‘SOUTHIE’: COMMUNITY UNDER SIEGE

The original Irish immigrants who settled on the marshy peninsula south