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"Mental" in "Southie"

Individual, Family, and Community Responses to Psychosis in South Boston

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

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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 of Boston proper during the early decades of the 19th century left an indelible cultural stamp on the community of South Boston. Despite subsequent waves of Italian, Polish, Russian, Lithuanian, and Albanian immigrants in the early decades of the 20th century, and despite the fact that the Irish, today, constitute less than the majority, this community is stereotyped by both residents and outsiders in Boston as one of that city's archetypic "Irish-Catholic" neighborhoods. Irish cultural dominance is staunchly maintained and defended. The Irish of Southie live scattered throughout every section of the South Boston community, from the shrinking upper middle class (i.e., "Waterford crystal" Irish) section known as the Upper End, to the middle class (i.e., "lace curtain" Irish) waterfront section known as the "Irish Riviera", to the lower-class (i.e. "Shanty" Irish) housing projects of the "Lower End." By contrast, the other ethnic groups are geographically and politically contained in their own small two or three block square enclaves. Local civil, political, religious, and educational institutions in "Southie" are conspicuously Irish, and Saint Patrick's day is a community-wide "open-house" that celebrates the ethnic origins and solidarity of the South Boston community. The community boasts its own green and white flag with its symbols of the shamrock and a local fortress. A mimeographed flier, distributed by hand, describes the fort as ". . . symbolic of our need to guard our community against outside elements." The outsiders menacingly alluded to here are the Blacks and Puerto Ricans who have tried, with varying degrees of success, to integrate public housing projects and public schools in "Southie" under the Boston school desegregation order (*see* Sheehan 1984; Lupo 1977; Lukas 1985).

In the face of perceived threats to community survival, both *legal-political* (i.e., forced school desegregation and busing) and *economic* (i.e., the flight of industry from South Boston, waterfront decay, and the gentrification plans of Boston "Back Bay Brahmins" for Southie's largely run-down, residential beachfront property), the residents of Southie have recently banded together against their common enemies. The Irish, Poles, Lithuanians, Italians and Russians of South Boston have put aside long-standing ethnic antagonisms and regrouped around a new, common ethos—a white ethnic, working-class, Catholic social identity, which residents refer to as "Southie Pride." One observer (Novak, n.d.) has used the term "ethclass" to describe the fusion of the dominant Irish cultural ethos with the more general working class interests of South Boston residents. The people of Southie see themselves today as cast in bold and dramatic roles, the courageous victims of sham W.A.S.P. (White Anglo Saxon Protestant) liberalism on the one hand, as Protestant liberals from affluent suburbs are seen as forcing integration on a community least able "to defend" itself, and of Jewish "radicalism" on the other (as psychiatrists and mental health professionals are seen as forcing unwanted mental health programs and mental patients form Boston state Hospital on the community (*see* Scheper-Hughes 1981:96–97). Meanwhile, the most common jobs in South Boston—dockworker, policeman, fireman, utilities worker, and civil service worker (City of Boston 1975)—have become scarce and increasingly difficult to pass on from father-to-son in the traditional manner. The result is that common class interests now compete with older ethnic loyalties as the main source of social self identity in contemporary South Boston.

Within this current political-cultural climate one proceeds with an analysis of cultural influences on behavior with great caution and bearing in mind that much is shared among the residents of Southie regardless of ethnic background. I must also add another disclaimer before proceeding with the analysis. I do not wish to suggest that the deviant patterns of behavior, communication, or family interaction that I am about to describe for this small sample of chronically mentally afflicted individuals and their families are in any way generalizable to the Irish, Lithuanian, and Italian populations at large in South Boston or elsewhere. It must be absolutely clear that my sample is a skewed one, comprising people in acute pain and in deep predicament. Madness affects not only the individual, but the entire family and larger social network, its symptoms producing and reproducing distortions in human relations so that after many years of dealing with psychosis both the individual and their significant others are radically changed. The illness experience intrudes upon and transforms ordinary cultural patterns and relationships. We are not dealing, then, with norms, but rather with cultural patterns and beliefs as they are refracted through

and changed by one of the most devastating assaults on personhood: psychosis. Nevertheless, there is no doubt that cultures do provide some guidelines and social scripts for how to behave when crazy and how to respond to madness in others. It is this small aspect of culture that I am examining here.

THE PSYCHIATRIC SAMPLE

Boston State (Psychiatric) Hospital, originally located in South Boston, opened its wards in the later 19th century just in time to help manage the mental problems of poor Irish immigrants who came to Boston during the waves of immigration following the series of potato famines beginning in the 1820s and culminating in the Great Hunger of 1845–1849. Boston State was a typical custodial institution with a characteristically bad reputation in the community, even after the hospital was relocated to the neighboring section of Dorchester in Boston. Local residents still tell apocryphal stories about their immigrant ancestors who were locked up without just cause, and of Protestant "bounty hunters" who reportedly received a sack of potatoes for every "mad" Irishman rounded up on the streets of Boston and delivered to psychiatrist-jailers at Boston State. The psychiatric hospital remains to this day a feared institution, and psychiatrists remain an alien and mistrusted profession among a people still more comfortable with traditional and Irish forms of social control: i.e., the Catholic clergy, the police and criminal justice system. To this day the residents of South Boston avoid psychiatric care, and almost all referrals to Boston State Hospital from the community are involuntary ones. The stigma of having been hospitalized at "Mattapan" (as residents refer to Boston State) is very great, and attaches to the family and extended kin of a mental patient, which in part accounts for the length of stays of many of the older patients in my now "deinstitutionalized" sample. As will be discussed at greater length below, once institutionalized, many ex-patients were subsequently abandoned and cut off by their mortified relatives.

Under the mandate to initiate deinstitutionalization, the superintendents of Boston State Hospital, beginning with Barton in the 1950s and most vigorously pursued by superintendent Nelson in the 1970s, reduced the hospital census from an average of 3,000 inmates to an average of 300 inmates today (Scheper-Hughes 1981:93). In order to facilitate this process wards were reorganized so that neighborhood affiliation (rather than acuteness or chronicity of the illness) became the main criteria for ward assignment. In this way it was hoped that long-term inmates could begin the process of "resocialization" to "community living" prior to actual discharge. Hence, most of the fifty-five ex-patients in my sample had been inmates of "Foggy Bottom," the nickname given to the South Boston-Dorchester ward of South Boston Hospital, and most had been discharged with the same follow-up treatment plan: 8 A.M.–3 P.M. day care at the South Boston Day Hospital.

The ethnic, class, and religious affiliations of the deinstitutionalized cohort reflect the general demography of the South Boston community. Like most residents of Southie, the vast majority of the ex-patients (81%) are Roman Catholic; the minority were divided among Russian, Albanian, and Greek Orthodox churches, and a few Protestants. All the day hospital clients were white, and 33 of the 55 clients described themselves as Boston Irish Catholics. Eleven of the clients were Eastern Europeans (mainly first generation Lithuanians), four were Italian-Americans, three were French-Canadians, and three were self-defined "WASP's." One day hospital client claimed "inter-planetary" ethnicity only, and nothing about his family heritage was known by the staff. The Irish were somewhat over-represented, in this sample, and the Italians were under-represented, reflecting differences in mental health utilization patterns. Likewise, the sample was skewed in terms of sex ratio: 41 of the clients were women at the time of the study. The majority came from second or third generation immigrant backgrounds, and with two exceptions all came from working or lower class families. Less than half the clients had a high school diploma. The day hospital served a very chronically mentally ill population—the average age of the clients was 50.2 years, and most had experienced multiple hospitalizations at Boston State. Six of the clients had more than fifteen separate commitments ranging in length of time from a few days to several years. Most clients had spent three or more years in hospital, although not continuously. Eighty percent of the clients had been diagnosed as schizophrenic (chronic, undifferentiated, or schizo-affective). There were no significant diagnostic differences by ethnicity (see Table I).

The life histories of the day hospital clients were uniformly wretched, characterized by sometimes extreme poverty and deprivation, family violence, alcoholism, abandonment, and abuse. Yet the lives of these patients seem to be no more wretched than those of the average poorer residents of Southie living in the D-Street projects, judging from a Felt Need Survey conducted there in 1974 (Sigal n.d.), and from the autobiographical essays that I assigned to South Boston high school students during fieldwork in 1980. The life histories of these ex-patients almost justified a community psychiatrist's wry profile of the "typical" Irish-American family in Southie as: "An alcoholic father, a depressed masochistic mother, a good dose of violence and a dash of incest." I would add the proviso, however, that much the same could be said of other poor white ethnic families living in the Lower End of South Boston today. One Italian-American day hospital client who was reared with her eleven siblings in a four-room apartment in the Italian section of Southie, described her early life to me as follows:

> Living in want. Dealing with difficulty. My story is here. Where? Somewhere on the jagged journey for shelter, food, clothing, and that luxury, soap. Mother kept our window panes very clean so that our lives and our disgrace were visible to everyone. Didn't she know that we needed blinds and shades, knives and forks, separate cots? In reality maybe it wasn't so bad, but the horror, the horror was real.

The majority of ex-patients came from families with histories of multiple psychiatric and social problems, including madness, child abuse, alcoholism, drug addiction, crime, suicide. Like marginalized and excluded peoples everywhere they shared a number of social psychological problems that intersected, among these: chronic un- or underemployment; broken and single parent families with a great deal of father absenteeism; truncated childhoods with early initiation into adult behavior and into a highly conflicted and (in this staunchly Irish Catholic community) guilt-ridden sexuality; depression and alcoholism related to feelings of deprivation and loss, powerlessness, and despair.

RECOGNITION AND LABELING OF PSYCHIATRIC SYMPTOMS

In formulating the propositions relating to his social reaction or "labeling theory" of mental illness, Thomas Scheff (1966) suggested at the outset that *psychiatric* labeling would most likely constitute the last resort of sympathetic but exasperated family and friends. According to Scheff most "deviant" behavior is ignored, rationalized away, or denied by those close to the individual rule-breaker. Little empirical research, however, has followed in order to test Scheff's proposition, and little is known about individual, family and community differences with respect to reactions to psychotic-like symptoms.

In this sample the Irish sub-group was distinguished by the extent to which "denial" (to borrow, for the moment, a psychiatric interpretation) was mobilized by the patient, his/her family, and the Irish-American community at large as a characteristic response to the threatening symptoms of psychiatric disorder. In this my sample conforms to previous studies of Irish-Americans in Boston and New York City which indicate that the Irish are generally stoical about physical and mental suffering, that they do not always seek out medical help even when they are quite ill, that they have a rather high tolerance for pain, and that they tend toward confusion and inaccuracy in describing their symptoms and are generally unexpressive and uncomplaining about discomfort and illness even among immediate family members (*see* Sternbach 1965; Zborowski 1964; Zola 1966).[1]

The case histories and life history profiles of the Irish patients in this study were notable for the extent to which the immediate family members of patients were able to ignore distress signals to the point of serious crisis—one usually involving the intervention of the police and consequently public scandal. I interviewed eleven family members of ten Irish-American day hospital clients in person, by telephone, or by an exchange of letters (the latter incidentally providing a very rich source of data from otherwise extremely research-shy subjects). All were asked to reconstruct the events that led up to their first suspicions that their relative might be having severe mental problems. All mentioned at least one florid symptom of psychosis, which often followed months or years of erratic or eccentric behavior that had often been studiously "over-looked." In most cases the referral to a psychiatric treatment facility came neither from the individual nor from family members, but through the intervention of police, the courts, or social workers. The most frequently mentioned disturbing behaviors that led to family members' suspicions that something might be seriously wrong with the patient were: extreme reclusiveness and social withdrawal (i.e., refusing to leave the room or the house); suicidal gestures; vagrancy and

Table I
Diagnosis by Ethnicity*

	Chronic, Undifferentiated Schizophrenia	*Schizoaffective*	*Depression*	*Bipolar*	*Borderline*
Irish	22	4	4	2	1
Italian	4	—	—	—	—
Eastern European	7	1	2	1	—
Other	4	—	2	—	1
Totals	37	5	8	3	2

*Diagnostic labels are periodically renegotiated in the day hospital program and over the years correspond to fluctuations in current styles and usage.

homelessness; violent aggressiveness involving a public disturbance; florid hallucinations.

Although the comparison group is far too small to be anything more than merely suggestive, the eight family members of Eastern European and Italian clients at the day hospital were more likely to cite the premorbid behavioral or personality characteristics of the patient that had worried them, including: school adjustment problems; nervousness; anxiety and depressions; lack of interest in personal appearance and grooming; poor social skills, especially with respect to dating and relations with the opposite sex; immaturity and over-dependence on parents, etc.

The following vignettes illustrate how long erratic behavior can go unnoticed and unlabeled in some South Boston Irish-American families.

Terry's[2] spinster aunt Mary, an Irish immigrant who worked all her adult life in downtown Boston as a chamber maid in a hotel, lived on the same street as her nephew and his family but was never very "cozy" with her kin. She was a loner who enjoyed her independence. Following retirement, however, Mary's behavior changed radically and she began to visit her nephew's household frequently, often dropping in without warning. She became "eccentric," said Terry, citing her undignified outbursts of laughter, her fits of talkativeness, her suspiciousness of banks and shopkeepers. She withdrew her money from the bank and began carrying her life savings on her person. Convinced that the grocer had poisoned her meat, she stopped eating most foods and became emaciated. Still, Terry saw no grounds for real concern until a crisis erupted:

> I could see that she was very changed. Her face had gotten old—red and weather-beaten—like maybe she was spending a lot of time walking the streets. But then she started talking about going home to Ireland. We didn't pay any attention to it. But we finally had to call the police when she climbed to the roof of her apartment where she insisted she was waiting for an Aer Lingus [Irish airlines] plane to come and take her away.

Robert's older sister, a middle aged matron living in the Boston suburbs, wrote to me of her first inkling that her younger brother might have some serious mental problems (Robert is a street person who has been in and out of Boston State Hospital for more than ten years):

> I think it began when he was about forty. He had lost his job, had no income, and was without any place to live. He couldn't handle money at all, and when I would give him some he would have it all spent in a few days and then he'd be back out on the streets again. I guess he was drinking a lot during this time as well. He had some delusions and was acting strange. Once he came out to my house with a telephone cord in his pocket and he kept going off into corners to reach his "contacts." I knew then that something was really wrong.

The mother of twenty-four year old Dennis wrote to me about the following sequence of events that led to the initial recognition of mental disorder in her son:

> I first suspected that Dennis needed some help when he stopped talking to us altogether, and he acted like he was afraid of us. It was so bad he couldn't even stay in the same room when his cousins or other relatives came to the house. Because he was so afraid of people we couldn't get him out of the house to look for a job or anything. Then he started to hear people talking to him when he and I were the only ones in the room. Then he began to talk about wanting to kill himself, and he began to cut his body because he said he didn't like it. He said people were always talking about him. He locked himself in his room and he wouldn't come out at all. Then I got so frightened I talked to some people at church and they told me about the day care program [the South Boston Day Hospital]. I believed that it saved my son's life and his Mind (sic). God bless them forever!

Eileen's mother told me during a home visit that she was "shocked beyond belief" to be told by a psychiatrist at Boston State Hospital that her daughter (who had been arrested and involuntarily committed) was "mental." She angrily protested to me: "Such a thing never entered my mind. I never even *thought* about such an existence." Eileen understood her mother's need for denial and she explained to me during a lengthy life history session: "You see, I *couldn't* be mentally ill as a child (even though she reported having hallucinations since kindergarten). Mental illness wasn't available to me. There was a fear of mental people in my family." In fact, throughout much of South Boston, there was a tendency to dichotomize more understandable and less threatening "emotional" problems from greatly feared "mental" problems. However, it appeared that emotional problems consisted of virtually anything people suffered from *outside* the mental hospital. *Mental* problems were suffered by "mental cases," those who were carted off to Boston State Hospital, almost always against their will, often with unseemly displays of force, much to the shame of their families. In short, in this community, mental hospitals made mental cases. Prior to hospitalization even very "crazy" behavior can be absorbed and rationalized by the family and the community at large.

The ability of segments of the South Boston community to tolerate or, depending on point of view, to "deny" mental problems is at least in part a function of family dynamics. In the working class Irish American households of South Boston individual family members are allowed a great deal of personal space (physically and psychologically) despite often very con-

gested living quarters. There is in many Irish-American households a high regard for the individual's privacy. Family dynamics tends to conform to Salvador Minuchin's model of "distanced" (as opposed to enmeshed) family relations (1967). While Irish-American family loyalties are strong indeed, intimacy is generally avoided, and many deeply experienced personal feelings are never articulated. A Boston family therapist, John Pearce, who specializes in the treatment of Irish-American families has the following to say on this subject based on his years of experience with these clients:

> The paradox of their general articulateness and their inability to express inner feelings can be puzzling for a therapist, who may have difficulty figuring out what is going on in the Irish family. Family members may be so out of touch with their feelings that their inexpressiveness in therapy is not a sign of resistance, as it would be for other cultural groups, but rather a reflection of their blocking off inner emotions, even from themselves. Thus, although the Irish have a marvelous ability to tell stories, when it comes to their emotions they have no words (McGoldrick and Pearce 1981:226).

Indeed, in the Irish-American families I was able to visit it was quite clear that many topics are simply not open for discussion. During a visit to one extremely disturbed client's mother, the woman painted a glowing picture of her daughter's early childhood, one seriously at odds with that the daughter had told me herself. When I broached the topic of Kathleen's breakdown at the age of twenty and her subsequent decade as a "revolving door" and extremely suicidal patient, tears sprung to the mother's eyes and she said that it was all a great mystery to her, that only God knew what had gone wrong to ruin her daughter's life. The mother denied knowing that Kathleen had been periodically mutilating herself throughout her teenage years. I asked how Kathleen had managed to hide the wounds that she inflicted on herself with razor blades, and the mother replied: "She was mature by then. I wouldn't ever see her undressed, or barge in on her in the bathroom or her bedroom. We weren't *that* kind of family." The blood-soaked rags that turned up in the wastepaper basket in the toilet were mistaken for menstrual rags, bringing up another subject that was "impossible" to discuss openly, even between mother and daughter, in this particular household.

The other side of the coin, however, was the way in which "denial" could lead to symbiotic relationships between parents and very disturbed children. There were, for example, clients at the day hospital who, prior to the attention of social workers or mental health workers, had been kept secreted away at home in a kind of limited status as disabled household servants.

One might also refer to a kind of collective, community-wide denial with respect to the perception of mental problems. There is, for example, almost a code of silence with respect to the very visible presence of newly deinstitutionalized and frequently still very disturbed ex-patients living in rooming houses and community residence programs in South Boston. This attitude has actually contributed to some ex-patients' perceptions of "Southie" as a good place to be "mental." Sally, a middle-aged chronically ill client of the day hospital described Southie as a "fine place," a place where she could wander the length of Broadway [Southie's main street] without being "picked on" or "pointed out." She said:

> They pretty much leave us alone here, and so we just blend in with the drunks and bums along Broadway.

Initially the politics of "community mental health" in South Boston during the initial stage of "deinstitutionalization" (roughly 1965–1970) was dominated by protests against plans to open various community mental health services in 'Southie' on the grounds that there were *no* mental health problems in the community that couldn't be taken care of by families and by the Church. Residents complained that mental health clinic would bring deviants and "mentals" into Southie from *other* communities. Finally, members of the South Boston Neighborhood Improvement Association protested that if the State really wanted to improve mental health in Southie, it should end forced integration and school busing which represented in their view a real cause of anxiety, depression, and nervousness in the community. When questioned in mental health felt needs surveys conducted by the Community Mental Health Catchment Area Board in the late 1960s and early 1970s (Schmitt 1972; Sigal n.d.), South Boston residents showed a remarkable lack of familiarity with the terms used to describe the more common forms of mental problems, they denied that alcoholism was a "problem" in their community, and expressed the opinion that most personal problems were best kept to oneself. Psychiatric services were neither needed nor wanted in the community.

Hence the earliest attempts to open alcohol detoxification program and a "drop in" psychiatric (crisis) clinic were violently protested in community-wide demonstrations, some individuals carrying banners that read, "Keep Mental Health Out of Southie," much to the amusement of some Massachusetts mental health professionals. Anti-liberal, anti-communist, and anti-semitic sentiments were directed at the new mental health professionals who represented to the Irish Catholics of Southie the latest assault on their autonomy, and an insult to their pride in being able "to take care of their own." As the protests died down and more than twenty community mental health programs gradually opened (often covertly attached to social centers, church programs, health centers, and with euphemistic titles that obscured the "mental" or psychiatric focus of the programs), the community

simply responded with characteristic denial. Most residents were unaware of the number and nature of these programs in Southie, as documented in the telephone survey of seventy-six residents. Meanwhile, the residents of a large public housing project located directly across from the South Boston Day Hospital, frequently replied when questioned, that the day hospital was some kind of job-training program for "deadbeats" and "down-and-outs." That these "deadbeats" often talked loudly to themselves, sat and rocked on street corners, or dressed in outlandish clothing seemed to pass unnoticed. The owner of a submarine sandwich shop frequented by day hospital clients replied to my inquiries about just who his customers were: "Well, I guess maybe some of them could maybe have had nervous breakdowns or something like that." Then he asked me, somewhat anxiously, "You don't think any of them could be '*mental,*' do you?" I replied by drawing on the local vernacular which the clients used to describe themselves: "No, I think they're just a bit *emotional.*" The shopkeeper nodded his head in obvious relief and agreement.

MADNESS, CULTURE, AND ETHNIC STEREOTYPES: SELF-PERCEPTIONS AMONG PATIENTS

Despite the fact that the experience of chronic psychiatric disorder and, in many cases, multiple hospitalizations united the day hospital clients into a grim "alliance of the damned," ethnicity (or, as the patients would say "nationality") remained a salient category among even very psychotic clients. As many ethnopsychiatrists have pointed out with respect to the non-western world, psychoses are never devoid of cultural content or meanings. In South Boston ethnicity shaped the way in which chronically mentally ill patients behaved and the way they interacted with others. Like other members of the South Boston community, the day hospital clients tended to explain peoples' behavior in terms of ethnic stereotyping. Clients were not only acutely aware of each other's ethnicity, but they tended to evaluate each other in these terms. Ethnic slurs were a common cause of dissension in the otherwise tranquillized milieu of the day room.

A Lithuanian client of the day hospital said that she needed help finding a new roommate, and that she couldn't continue to live with a very quiet, regressed, and hallucinatory Irish client of the same program: "She's haughty and stuck up like all the Irish," said the woman. And when Lucia, a young Italian client got frustrated with the landlady of her group home and angrily shattered a window, she explained in her own defense: "I didn't know that this wasn't allowed. I have to be *taught* how to behave. I came up from the bottom, from a big, loud, Italian family."

The staff of the day hospital program tolerated a certain amount of the ethnic slurs that would erupt in the daily group therapy sessions on the grounds that such attitudes were appropriate to the community to which they had been returned. Within the program, as in the community at large, Irish ethnicity was dominant, celebrated in the Irish flag hanging conspicuously in the day room. Irish cultural dominance was also expressed in the self-deprecatory comments of non-Irish clients, as when a Lithuanian client retorted to another: "What do you expect from a slob [Slav] like me?" and when an Italian patient goaded "Patrick" from across the day room: "Did you hear that they found out Saint Patrick was a Jew after all?" But the most compelling demonstration of the salience of ethnicity to this psychiatric population was to be found in a graph charting annual psychiatric hospital readmissions. These tended to cluster around the Roman Catholic and Russian Orthodox liturgical calendar with Ash Wednesday, Good Friday, Easter Sunday and ethnic holidays representing particularly troublesome times. The period around Saint Patrick's Day, March 17th, was the time of greatest risk for the day hospital clients who, one staff member quipped, "just decompensate all over the place" on that day.

Characteristic of the day hospital patients in general, but of the Irish cohort in particular, was an anxious and often ambivalent attachment to the local community, which one staff member glossed as "neighborhood psychosis." It was expressed in clients' fears of crossing the little bridge that separated "Southie" from Boston proper. Field trips into Boston generated a great deal of diffuse anxiety during the planning stages, and many clients would stay home rather than confront the short bus or subway ride downtown. On each of the few field trips I ventured with the clients a "neighborhood psychosis" would flare up in a phobic or panic-flight response. On one occasion a thirty-year old male client bolted from the subway at the first stop and had to be chased by a staff member. He said he got disoriented and just wanted to go home. On another field trip a woman client expressed her anxiety in a constant barrage of questions: "Are we *still* in South Boston?" "How far are we from Broadway?" "Can we go home soon?" The insularity of the day hospital clients was, in fact, a general neighborhood trait, particularly of women, many of whom claimed they hadn't been out of Southie for months and, in a few cases, for years. The attachment of clients to the home community and neighborhood is all the more poignant since, for most, they have been subject to frequent forced removals "all the way to Dorchester," as one woman described her frightening trip by police car to Boston State Hospital at the time of her last involuntary commitment.

A number of personality characteristics distinguished the Irish-American clients at the day hospital, among them: reserve and propriety, secretiveness, religiosity, a damning sense of guilt and 'inner badness', and a tendency to defuse anxiety-provoking situations with humor and often very clever "double-talk." The reluctance of Irish clients to share "family secrets" seemed to me

more pronounced, as I learned in trying to elicit "privileged" information. A middle-aged first generation Irish-American client reneged on her original promise to be interviewed by saying:

> I don't know exactly what it is you want from us, but my mother said to stay away from you. Look, it's all there, everything you think—the drinking, the beatings, the father in and out of jail, the mother in and out of "Mattapan." I told my story a thousand times, but it doesn't make anything different or better. It only gives us shame and makes me feel rotten.

Another client postponed my interview with the following statement:

> We all have a story to tell. But should I tell it? The things I think about are: how much do you want to just forget about it and close the door? Won't you ever let the case rest? And, am I stepping on somebody's toes? Maybe I want to say: I'm separate, I'm different, and I hate you. I hope I didn't hurt your feelings, Dr. Hughes.

The characteristic traits of reserve and respectability among the Irish clients at the day hospital meant that few presented any significant behavioral problems for the staff, with the exception of occasional suicide threats and gestures. In the history of the day hospital program most of the suicides were by young, quiet, single Irish males. The landlady who supervised a community residence where several day hospital clients were living at the time of my study, commented that she preferred single Irish males to any other residents because they were so little trouble and were so well behaved. "My only fear with them," she said, "is that one may decide to quietly climb to the roof some evening and jump off." She actually spoke from such an experience which had occurred while she was away visiting relatives for the Christmas holidays. But she said that with the Irish patients one could usually apply to their enormous sense of respectability. She told of the case of a young man who became very depressed and suicidal:

> I warned him that if he committed suicide in my house he would give me, the Irish, and mental illness a bad name in the community. He took my words very much to heart and when his situation deteriorated he checked himself into Boston State Hospital where he quietly and privately took his life.

In the milieu of the day hospital the Irish patients behaved in a generally decorous manner and tended to be rather judgmental of those who "acted out." D., a very regressed and almost continuously hallucinatory client, always arrived at the day hospital carefully groomed and neatly, if idiosyncratically, dressed. When I complimented her on her neat appearance, she replied:

> Well everyone has their own set of behaviors. Mine is alone and lonely and sad. One set I especially hate is called "dirty and crazy." Like A., over there, she uses her craziness to cover her dirt and laziness. That's something I really hate because crazy or not crazy, there is still a responsibility to be clean.

"Are there any other 'sets' you hate?" I probed, to which she replied:

> Yes, there's the jerky set. When J. does this [and she demonstrates with grotesque gestures the tremors induced by long-term use of psychotrophic medication]. He can get himself out of that when he wants. You can *be* crazy but you don't have to *look* crazy.

Even during a psychotic episode the working class Irish-American clients manifested that concern with propriety that one observer of the Irish (Corry 1977) referred to as the "... curse of the Irish since they came to America, building respectability layer on layer." Public comportment was particularly problematic for ex-patients. M., a client born into a large and well-known Irish American family in Southie, was continually mortified by the company she was forced to keep at the day hospital and she would refuse to accompany staff and patients on walks to the public library or bowling alley because she said she didn't want to be seen in public "with a bunch of nuts." This same person took offense when during a day hospital group meeting a young patient became upset and ran sobbing from the room. She turned to me and said primly:

> What's wrong with that girl? Doesn't she know how very upsetting that is for us? Why can't she just sit still and quietly hallucinate like the rest of us?

In order to preserve the vestiges of their respectability several day hospital clients pose in public as recovering alcoholics, a more acceptable form of deviance in South Boston. During one day hospital meeting a patient told of her acute anxiety when, the night before, she had been called to "testify" at an Alcoholic Anonymous meeting. "Did you do O.K.?" another patient inquired to which J. responded: "I think so. At least they still think I'm just a drunk" (i.e. and not "crazy").

SYMPTOM EXPRESSION

The Irish and Irish-Americans have frequently been the subjects of cross-cultural psychiatric inquiry not only because of their particularly high rates of psychiatric hospitalization within Ireland (Walsh 1968; Murphy 1975; Scheper-Hughes 1979), but because of the identification of what appears to be a "culture-bound" expression of schizophrenic symptomatology (Opler and

Singer 1959; Fantil and Shiro 1959; Wylan and Mintz 1976). Compared to Italian-American schizophrenic patients, Irish-American patients tend to be more delusional, hallucinatory, and fantasy-indulging, as well as more outwardly conforming in their overt behavior and general deportment (as illustrated above). In addition, Irish "schizophrenics" tend to be more guilt-ridden and conflicted about sexuality than other patients. In all, the Irish expression of schizophrenia seems to elicit more "paranoid" features, and its course is marked by a tendency toward social isolation, and a generally poor prognosis (Opler and Singer, *op. cit.*). By contrast, the Italian schizophrenics observed in Opler and Singer's study exhibited many schizo-affective features marked by a tendency toward talkativeness, hyperactivity, excitement and pronounced mood swings.

It has been suggested that the differences in symptom expression might be reflection of the kinds of behaviors that are either allowed or disallowed in the family (Wylan and Mintz 1976). The question, then, is whether or not there is a greater tolerance for psychotic *ideation* (delusion, hallucination) in the Irish-American family, and a greater tolerance for psychotic *affect* (mood swings, emotional outburst, acting out) in Italian families. I attempted to answer this in two ways: by observation and interview with the family members of day hospital clients, and in the telephone survey of randomly selected South Boston residents.

In reply to the question, "Which symptoms of N. (the patient) most worry or upset you these days?" the eleven Irish-American family members interviewed were less likely to mention the patient's lack of contact with reality than to mention "inappropriate" appearance or deportment. The following responses are illustrative: "the anger"; "her life of indolence"; "his disheveled appearance"; "when she gets out of control"; "the bad words." Rarely did family members complain of hallucinations, delusions, nonsensical language or other cognitive symptoms of psychosis. In fact, in at least some quarters of Southie, alternative "folk" meanings compete with psychiatric interpretations of hallucinations. One day hospital client complained that her parents refused to see that she was seriously troubled as a child:

> I was always lost in a world of my own, talking to imaginary playmates. When anyone tried to say anything about me to my mother she would quiet them and say, "Leave the girl alone. Can't you see she walks with God?"

In some families the symptoms of psychotic ideation are interpreted as creativity, signs of genius rather than madness. This was the case with one day hospital client, R., whose large, extended Irish family "coddled" and nurtured his delusions (and self-delusions). His sister wrote me an impassioned letter in which she defended the sanity of a brother who had been in and out of Boston State Hospital for more than fifteen years:

> R. was the child genius of the family. Unfortunately our parents didn't know how to deal with him. And many of the people who came into his life later on didn't know either. It is a terrible thing to waste such a mind, but I have a marvelous hope that someday R., even at the age of fifty will once more return to his Creative Self (sic) and become the writer-genius that he was destined to be. He has such a gift to offer the world!

Since R.'s life for many years has consisted of sleeping, chain smoking, and nursing the wounds inflicted on his psyche by a world that has refused to recognize his genius, it is not at all clear that there are grounds for his sister's optimism. Rather, one might conclude that both R. and his sister are heir to that Irish trait which McGoldrick and Pearce refer to as "the dreaming," the retreat from humiliation and failure into a heroic and impossibly unrealistic fantasy or family myth (McGoldrick and Pearce 1981:226).

The high tolerance for psychotic ideation is also a characteristic of South Boston residents at large, revealed in their responses to the charge to rank order from *most* to *least* threatening the following commonly attributed traits of "mental illness":[3] hallucinations (described as seeing or hearing things that other people don't); too many mixed-up emotions; unpredictability; dirty or slovenly appearance; strange behaviors and gestures; talking without making any sense; potential for violence. The results, coded by ethnicity of the respondents, are as in Table II.

In each group (but especially for the Irish) the cognitive symptoms—hallucination and deviant speech—were ranked as least upsetting or less upsetting than other symptoms, some of which (like the potential for violence) represent common stereotypes rather than actual symptoms of psychosis. The results of this survey have particular relevance to a paradox created by the medical treatment of psychosis. Although powerful drugs like Prolixin and Thorazine are routinely administered to the chronically mentally ill patients of the day hospital in order to reduce the florid symptoms of psychosis—hallucinations and delusions—their side-effects often produce the bizarre gestures and tics of tardive dyskenesia that may be actually more upsetting to the self-esteem of some of the patients than their primary symptoms, and which may result in even greater rejection and stigmatization in the South Boston community.

RELIGIOUS CONTENT OF PSYCHIATRIC SYMPTOMS

In a community where people still identify themselves by parish it is not altogether surprising that Catholicism should leave a

Table II
Rank order of most to least disturbing psychiatric symptoms

n = 76 *Irish (n = 49)*	*Italian (n = 12)*	*Eastern European (n = 8)*	*White Protestant (n = 8)*
1. Unpredictability	Violence	Violence	Violence
2. Violence	Unpredictability	Unpredictability	Unpredictability
3. Strange Behaviors	Hallucinations	Strange Behaviors	Strange Behaviors
4. Mixed-up Emotions	Strange Behaviors	Slovenly Appearance	Hallucinations
5. Slovenly Appearance	Mixed-up Emotions	Talks Nonsense	Slovenly Appearance
6. Hallucinations	Talks Nonsense	Hallucinations	Mixed-up Emotions
7. Talks Nonsense	Slovenly Appearance	Mixed-up Emotions	Talks Nonsense

stamp on the content and expression of psychotic symbolization. This was true of the day hospital population in general, and not just of the large Irish Catholic sub-group. Themes of sin, guilt, atonement, and redemption predominated in the anxieties, delusions, hopes, wishes and fears of the South Boston Day Hospital patients. This was so strong a characteristic of the patient population that it struck me as patently absurd that so few staff members knew anything about Roman Catholicism or Easter Orthodoxy, which led them to frequently mistake religious beliefs for delusions, and to not recognize when religious beliefs *had* taken on a delusional quality. The following vignettes are illustrative of the fusion of religious belief and delusion in this population.

E., a seminarian before this first breakdown, believes that he has cancer of the brain resulting from his "dirty" habit of masturbation. He is driven crazy, he says, by a constant babbling in his head, telling him that he has a "bad, bad brain." C. believes that God has punished her for her bad thoughts by closing her body orifices: her mouth so that she can speak no evil, her vagina so that she can't have sexual intercourse with her husband, and her anus so that she cannot defecate. F. believes that she is being chased by God as the "Hound of Heaven" and she once ran away from her six fatherless children and hid out in an abandoned building in order to elude Him. L. is certain that a distinct odor of rancid meat comes from her pores and so she carries around a small room atomizer in order to freshen the air that her evil flesh has fouled. But T. has managed to bypass all that [is] tainted, and earthy, and dirty for he was born on the Crystal Planet where there is neither male nor female, no sex, no death, and where everything is pure and crystal clear.

For some of these clients their faith sustains as well as torments them. Belief in God and His providence gives shape and meaning to their suffering. Some believe that their illness is a sign that God has chosen them above others:

> This morning I felt very close to God. Sometimes he tempts me with despair. Now, for example, I'm feeling alone and frightened, like I don't know what else He has in store for me. I try hard to pray, to ask God for forgiveness. Mostly, I offer up my suffering for the poor souls in Purgatory, those who have no one to pray for them. I believe that God afflicts those He loves the most, and that my sickness is the cross I was asked to bear in this life.

Pain, confusion, depression, and other forms of psychological suffering were accepted by some day hospital clients as their fate. A sense of the imperfectability of humans, and of their own flaws and "inner badness" made their suffering understandable, and in a way less chaotic, less random, less disorganizing. Many did not dwell on *why* they had been afflicted; their Catholic socialization had, in a sense, left them with a high expectation of, and, hence, resignation to, human suffering (see also McGoldrick and Pearce 1981).

CHRONICITY: "MAKING IT CRAZY"[4] IN SOUTH BOSTON

Although all the day hospital clients were revolving door or "chronic" mental patients whose low expectancies of recovery reflected the pessimism of their psychiatrists and counsellors, they differed with respect to their adaptations outside of hospital. Since discharge plans today are not contingent upon full remission of symptoms, adjustment in this group generally means learning how to "make it" or at least how to "fake it" while still very "crazy." Ethnic families in Southie also responded differently to the challenge to welcome home their "deinstitutionalized" relatives.

The South Boston Irish in this sample, although seemingly reluctant to label a family member as "mental" or "crazy," were more likely to sever ties completely with a close relation once that person had been hospitalized at Boston State. The public shame resulting from outside intervention into their generally very closed and private domestic lives, and the stigma from association with "Mattapan" were often more than these beleaguered families could stand. The assault to their fragile family respectability was simply too great. Hence, the hapless mental patient from such a family was often subject to a characteristically Irish interactional strategy known in the vernacular as the "cut-off" (see Scheper-Hughes 1979; McGoldrick and Pearce 1981). The cut-off individual is socially and emotionally disinherited. For all practical purposes he or she no longer exists, except perhaps as a negative example. I am reminded, for example, of one elderly alcoholic and frequently hallucinatory ex-patient who spent a good deal of time on the streets of South Boston although he counted among his relations a powerfully political family from the Upper End. His one remaining role in the family was that of emblematic "Blacksheep," an all too visible warning to his many nieces and nephews of the evils of the bottle. One nephew, an aspiring young politician, told me that on many a stormy winter's night when he was still a boy, his mother would tuck him into bed saying, "Think of poor old Uncle Ed sleeping out on a doorstep somewhere in the Lower End, and say a prayer that you will never wind up like him."

In some of the Irish families in this sample there appeared to be a tendency to move from a position of denying the *problem* to one of denying the *person* with the problem. One demonstrable result was the greater social isolation of the ex-patients from Irish families. After their discharge from Boston state these patients often "came home" to live in rooming houses and in community residency programs, not with family members or even within the borders of their home parishes.[5] Among these patients their natal community had evaporated and virtually all of their interactions and social relations were with other ex-patients or with mental health professionals.

Even the local Catholic clergy let these often devoutly religious individuals exist on the very fringes of parish life. They tended to attend very early Masses and to sit in darkened corners of the church. Except for weekly Bingo games, the ex-patients avoided all parish-related activities, saying that their presence would only make "regular" parishioners uncomfortable. Another key neighborhood institution that was "off-limits" to ex-patients was the famous James Michael Curley public bath house (the "L Street Baths"), an Irish social center, working class spa, and hotbed of local political activism. I could not convince ex-patients to come with me to "the baths" where they were convinced they were unwelcome, and where they feared they might run into relatives or old acquaintances. Some day hospital clients expressed anger and hurt at the implicit mandate to render themselves socially invisible:

> My relatives wish I would just disappear. I suppose I'm just an "eye-sore" to them. They don't want to see me any more than a "bad penny."

Another one said:

> All my life I've been poor and crazy. I just have to remind myself that when my relatives see me they think, "What does this loafer want now?"

Hence, pride often keeps them away from situations and places where they might be seen and recognized, and they tend to hold on to and cherish the occasional phone call or holiday greeting from a relative who may live just a few blocks away. *Unsolicited* attention from old friends and relatives was the most precious commodity—and the scarcest—among these ex-patients.

The "cut-off" ex-patient, living in a traditional white ethnic neighborhood where relatives tend to double for friend and where sociability rarely extends beyond family and old friend networks, is left with few opportunities for social interaction. S/he can spend the day dozing on a couch at the day hospital, sitting on a park bench or in a laundromat or in a donut shop until asked to leave. Of all the clients at the day hospital it was the single, middle aged, Irish male who was most isolated, most often left to his own (weak) inner resources and to his characteristic defenses of withdrawal, fantasy, and "the dreaming." A 43 year old male residing in a half-way house in Southie kept a journal in which he recorded the non-activities of his life as a "deinstitutionalized" mental patient. The following is a typical set of entries:

> *Monday.* Record playing is a good recreation if you are losing interest. It might work. Sometimes you might read, or play cards. Take a load off your feet. Well, nothing to complain about today. Everything is going well, except the plumbing.
> *Thursday.* The simple life is good, providing you don't become too simple. Try to be basic. A coffee break or a cigaret will keep you going. Not that life needs to be any more simple.

This does not mean to imply, however, that Italian or Lithuanian ex-patients are not also often lonely, isolated, and reduced to a very "basic" existence. The results of weekend summary files that I kept on thirty clients during 1979–1980 indicated that the most common leisure and weekend activities of the day hospital clients were, in order of frequency: watching T.V., cooking, cleaning house, sleeping, attending Mass, Bingo,

and visiting with each other (Scheper-Hughes 1981:97). However, rarely were Italian and Eastern European clients actually severed from family, friends, and neighbors following hospitalization. In fact, eight of the eleven Eastern European clients in my sample were living at home with relatives. Some were active members of the local Lithuanian Club, and one was a member of a Lithuanian cultural organization and a frequent contributor to the organization's literary journal where she published some of her startling and dramatic verses on madness, suicide and lesbianism.

Among the small sample of Italian ex-patients neither did their status as veterans of Boston State Hospital result in family ostracism. Quite to the contrary, their presence at important family gatherings was often mandatory. One very psychotic woman from a large, extended Italian family that was no longer contained within the South Boston neighborhood, complained that the demands for her participation in family functions were overly taxing to her fragile grasp on realty. (This same woman confided that the only time she didn't actually hallucinate was when she could daydream black). She said that she would have to spend a day of preparation before a family visit, resting and doing special breathing exercises to increase her hold on reality. Since the members of her family lived dispersed throughout the greater Boston area she would often have to take long subway and bus rides which sometimes "unhinged" her before arriving. Once at the gathering she would try to behave as unobtrusively as possible by watching peoples' expressions and laughing whenever they did even though the humor often eluded her. If the "unreality" (as she referred to her persistent hallucinations) would begin to descend on her, she would excuse herself and lie down in a bedroom or take a taxi home, excusing herself with the complaint of a severe migraine headache.

Another Italian ex-patient, the eldest of four siblings, had her first psychotic episode following the early death of her mother. Although L. has been in and out of Boston State Hospital for the past ten years she never entirely gave up her role as surrogate mother to her younger siblings. Upon the death of her father, L. quietly checked herself into Boston State Hospital for the highly stressful days of the wake, but then checked herself out again in order to attend the funeral Mass and burial. Her absence, she felt, would have been inexcusable regardless of her state of mind. She remained out of the hospital long enough to make some important family decisions following the death, but once these were taken care of she lapsed into a seriously psychotic state that lasted for several weeks during which she remained hospitalized. In this case, L's family claims included demands on her tenuous sanity, and she complied to the fullest extent possible. Against this we would contrast the way in which the Irish clients were frequently abandoned to their own "unreality."

CONCLUDING REMARKS

These vignettes drawn from the life experiences of a small cohort of chronically mentally ill patients in South Boston indicate the relevance of cultural analysis to the new work that community psychiatrists have carved out for themselves. This very preliminary and exploratory study indicates that even chronically disturbed and floridly psychotic individuals respond to cultural cues regarding the perception, expression, timing, and meaning of psychiatric symptoms. Madness invariably disenfranchises, but it does not necessarily *deculturate* the individual. Some awareness of the cultural shaping of the experience of chronic mental illness is useful not only in the initial diagnostic encounter, but also during the much longer phase of therapy, rehabilitation, and resocialization.

Deinstitutionalization is a deeply cultural as well as political task. It challenges us all to reconsider what madness is, and what part culture and history play in the ways in which we respond to those who are labeled mad, crazy, psychotic, or schizophrenic. The laudable movement to close down state institutions—those crumbling Victorian "monasteries for the mad" (Scull 1984)—must now be accompanied by the more difficult task of *opening up* communities. We have returned mental patients to our city streets but not necessarily to our consciousness. The majority of ex-patients remain an invisible, marginalized, and mute cultural minority.

While the success of deinstitutionalization depends primarily on the goodwill and common human decency of ordinary citizens—the relatives, friends, co-workers, and neighbors of the deinstitutionalized patient—mental health professionals can help by putting themselves squarely on the side of the ex-patients to help them negotiate the culturally-constructed (and sometimes harmful) beliefs, stereotypes, responses and defenses that have been marshalled against them. This cultural task for an enlightened practice of public psychiatry is one which has, until now, received but scant attention.

NOTES

*With due courtesy to Edward Sapir's seminal article, "Why Cultural Anthropology Needs the Psychiatrist" (1938).

[1]Elsewhere I have suggested that a fundamental ambivalence toward the body, communicated to children through a non-nurturant early socialization and inculcation with the vestiges of Irish Catholic Jansenism, may contribute to the tendency of the rural Irish of County Kerry to likewise misread physical signs and to deny unpleasant psychological or somatic states (*See* Scheper-Hughes 1978; 1979, chapter 5).

[2]All personal names are pseudonyms, and many identifying features have been altered in these excerpts from case histories.

[3]The list of "symptoms" was generated from discussions with community leaders in South Boston: teachers, priests and nuns, social workers, etc.

[4]With acknowledgment to Sue E. Estroff, *Making it Crazy: An Ethnography of Psychiatric Clients in An American Community* (1981, University of California Press).

[5]In South Boston residents identify themselves in terms of their parish communities. There are a half dozen Catholic and a couple of Eastern Orthodox parishes within "Southie".

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