On Dancing in the Rain: An Ethnographic Study of the Deinstitutionalization of Mental Health Care and Agency in Malta

Nikolai Debono

Dissertation presented to
the Department of Anthropological Sciences
in part fulfilment of the requirements for a Master of Arts (by research) in Anthropology.

September 2022

Abstract

The following work will take an ethnographic approach to the deinstitutionalization of mental health in Malta. Based on ethnographic fieldwork within a hostel for men recovering from mental illnesses, the text will discuss the relationship between the hostel and the state run mental hospital, the shifting understandings of health, illness and cure. Using ethnographic insights, the text elaborates on the operation and conceptual limitations of the hostel. Most prominently, concerning the hostel's approach to care. The notion of the resident as 'client' originates in the understanding of mental illness as a circumstantial event, requiring service-oriented self-alteration. On the other hand, 'character' is a moral project requiring alteration of the self. This and other conundrums sheds light on current directions of deinstitutionalization in Malta.

Preface

Mental health is now a well-established issue and practice. Its leading schools of thoughts are exhaustively described and disseminated in updated publications, manuals, and curricula. However, there are also various iterations of its core tenants and key practices. This can be seen in its adoption by, and extension into social work. As old asylums and mental hospitals shift towards community psychiatry and deinstitutionalization in general, the neighbouring social sciences have increasingly come in contact with the psychological. Social work is a big player in this growing subfield where techniques, technologies, and theoretical frameworks are imported into the practicalities of managing mental health. This also occurs in conjunction with methods and literature from social work itself. What this has resulted in is a convergence in mental health between psychology, psychiatry, psychotherapy and social work.

The following thesis will look into the process of deinstitutionalization and the relationship between social work and psychiatry in Malta. It is based on 12 months of fieldwork, continuous between February and December of 2021 and other irregular visits that followed. After introducing the fieldsite, a hostel for recovering mental health ‘patients’ from Malta’s only mental health hospital, the ‘Rain Organisation’ and its origins are discussed. Deinstitutionalization does not entail a quick or sudden shift, transition is still ongoing and unfolding. While trying to establish a separate practical and theoretical structure, the hostel and its social workers also have to rely on ‘human’ and situational understandings. The following chapters will discuss how this process is reflected in concepts of home, labour, illness, ‘cure’, agency, and more.

Acknowledgments

It is a pity academia expects researchers to present their work as the product of an individual. This research could not have reached or completed the proposal, fieldwork, or writing stage if it wasn't for my supervisor, Prof. Jean-Paul Baldacchino, whose guidance and support since the very beginning deserves much more than this mere acknowledgment.

From the academic dimension, I would also like to thank Prof. Paul Sant-Cassia, whose alacrity to share his ethnographic mishaps and almost unanswerable anthropological conundrums early on in this project propelled my eagerness to get deeper into the often troublesome craft of fieldwork.

I would like to thank the Rain Organisation, and their admirable hospitality to this study. Once in the field, it would have been completely impossible to study the hostel if it wasn't for a handful of social workers, their tremendous patience and interest in this project. Equally important are the clients with which I spent so much time talking to. It is only starting to dawn on me the profound effects they have brought on me.

Lastly, but just as important, my mother, for blindly supporting the strange endeavours the ethnographic method often requires anthropologists to partake in.

Table of Contents

Illustrations

Figure 1. Original Plans of Mount Carmel published in Malta Government Gazette in September 1852. From Savona-Ventura (2004).

Figure 2. ‘Mount Carmel in 1905’ from ‘Socjeta Muzikali La Stella Levantina’.

Figure 3. A drawing by Richard, presented with his permission.

Chapter 1: The Hostel, Mental Health, and Malta

1.1 The Hostel: An Introduction.

A 24-year-old man is seated before me. His head reclined and his body strewn across a white plastic garden chair as he puffs a cigarette. Legs shaking nervously, as if trying to shake his boredom away. “So, you're a student? What are you studying?”, he says. I try my best to explain anthropology. “Ok, so you're going to become a doctor at Mount Carmel” he says, sucking at his cigarette with a fixed eye on my reaction. I explain that I am not associated with the mental hospital, that I am here to learn what it means to live at the hostel, to be a client or a social worker. He looked confused. I explained that I'm here to write a story about the place. He took his eyes off me and fixed them into the sky. He seemed satisfied with my second explanation.

As the weeks and months went by I got to know Maurice much closer. We made coffee and cooked together in the hostel’s small kitchen. One day, we cooked pasta for all twelve residents in the hostel. He is very keen on jokes, especially the more raunchy ones. Like myself, he detests football but enjoys watching it in good company. We laughed at the others' reactions to near misses and penalties. He chuckled when a fellow resident fell asleep through the finals. He's only a few years older than me but it felt as if we were roughly at the same point in life. He had left home, university and had a new group of friends built on the remnants of a few old ones. The only difference was that he was adopted and had a brain tumour, exacerbated by severe depression.

“That’s my favourite kind of duck” Richard, sitting next to Maurice in the dining room, shares with me. He is 45, has two sons and a wife whom he rarely sees. He is fascinated with any animal with enough feathers to fly. Eagles, chickens, flamingos, seagulls and seventy more types of birds you never knew existed. Unlike other residents, he does not speak unless spoken to; especially if he's reading his bird encyclopaedia or painting a stork, which he was working on at the moment while watching me scroll through his books.

After finishing it he sets it up in the main office for all to see. Sarah, a social worker, couldn't be happier with it. Unlike a ‘support worker’, she works at the hostel full-time and during the day. She also has a much clearer idea of the hostel's plans; “What we want

from the residents here is for them to be active, however they choose." From picking up groceries to devoting themselves to a skill or hobby, this is the most simple yet always complicated task the staff want their clients to do. There are no female clients at this particular hostel. Oftentimes, it requires wit for a 28 year old woman to convince 30, 40, 50 year old men what is best for them. But Sarah is more than determined. She means well, and does well.

This hostel is not like any other. It operates within the 'Rain organisation' as a home for people recovering from mental illness. After a few months or years at the mental hospital, 'Mount Carmel', patients may become clients at one of the organisation's hostels. There, they learn whatever might be needed to become 'independent', as the hostel puts it. This is not a straightforward task. Rather, it is riddled with trauma, social issues, and emotional wounds which the staff at the hostel must help their clients overcome. A strange mixture of connection and sorrow would be a good way to describe the people I met at the hostel. They are all highly likeable, average in the best possible way. Oftentimes, very direct with uniquely attractive traits. But even for the most amicable residents, behind the jokes and the friendly conversations, there always loomed a recurring story of trauma.

Forty-five-year-old Matthew was celebrating the village feast with others at the local band club late one night. A dumpster laden with the day's refuse caught fire and the blaze woke up the entire street. When it came to the blame, Matthew was the only person anywhere near the fire when it went up.

"It went off on its own, I'm telling you! I've never been so afraid in my life!" he said to me many times in the living room. For some reason certain events stick tightly to the residents' memories and they mention them over and over again. Other episodes are best forgotten. His childhood home harbours few fond memories and ample wounds. He would speak about his mother often, her cooking, his first room. The hurtful children down the road were mentioned once but never again. But Matthew has come a long way since then. He can speak about trauma and "keep it in the past", he says to me. He moves on to discuss the prospects of beating me at the next snooker match in the hostel's basement.

"And the monkey, he came with a shotgun to my door after!" says Matthew. Sometimes it gets hard to tell real from imagined memories or schizophrenic effects, which might have been just as real for him; something I slowly learned. The social workers assured me that

the residents never lie about their past, citing a few episodes where they were themselves surprised.

Julian, one of the older residents, limped beside me during my walk. Neglected by his family well into his sixties, he no longer has the luxury of company. Walking with him, he shared his story. From working on important construction projects on the island he lost his hearing due to a lifetime of the unprotected use of a jackhammer. His hands trembled, but as a side effect of his prescription. He suffered from several symptoms, but mostly from the march of time: incontinence and a severe loss of coordination. Although he was largely independent, he could not sustain it with his deteriorating body. He was in the awkward position of being too old for the hostel but too young for a home for the elderly.

Judith, 45 years old, has seen clients entangled in such issues time after time. She is an experienced support worker but well versed in their clients' methods of subverting the hostel and its rules. She speaks to everyone as if a relative, despite being total strangers, welcoming me and my annoying questions with open arms. As if carrying a wound herself she seemed to have a clear picture of human frailty in her mind dedicated to mending it. Running to and from the office she carries out her duties and tasks with alacrity like any other staff member decades younger than her. Likewise, she shifts and adapts with the hostel as the organisation changes.

When I arrived at the hostel the constant adaptation required of the staff was not something I noticed. Instead I was overwhelmed with the variety of people and their illnesses. Every person had a story to tell or a sentiment to express. Although initially some residents were more chatty than others, by the end of fieldwork I got to know all of them to varying degrees. Some were keener than others to join in on the activities. Some, like 41-year-old Philip, were not interested in anything outside of their routine. Others, like Richard, needed a bit of convincing first. I first approached residents on the basis of the staff's advice. I soon realised that this simple criteria for the staff's choice of who I could approach first to play a friendly game of snooker shed light on the hostel's goals and aims.

What they wish to see most in their clients is a sense of direction. One which, with their assistance, can be followed and fulfilled independently. Slowly but surely, my entire field notes fitted in together seamlessly under the hostel's aim of creating 'independent' individuals. Specifically, characters possessing 'agency' and being 'resilient', qualities which the following chapters will point towards and discuss.

1.2 The Rain Organisation

To understand the hostel, we must first expand our focus to the Rain organisation itself. Before building on the brief description of the environment in the previous chapter, it is important to discuss the origins and larger structure of the organisation, as well as mental health in Malta.

The hostel is a new addition to a relatively new organisation. Rain Organisation was founded in 1980 by a local businessman who noted the lack of mental health support for his workers. This gap in services was filled by setting up the Rain organisation in Malta. Rain is registered as a non-governmental and non-profit organisation. It is also one of two primary organisations which provide community services on the islands. Its official mission being to provide community mental health, promote mental wellbeing and prevention.

Today, the organisation runs several services including but not limited to Mental health first aid courses, psychotherapeutic support services, and residential therapeutic care for children. Following an expected but still overwhelming demand for mental health services, the Rain organisation will be receiving close to a million euros in government funding over the next three years which it will invest in several of its projects. This study concerns its 'assisted living programme' which it provides in coordination with Mount Carmel Hospital. Admission is carried out by reference from a multi-disciplinary community care team at the hospital. The residences offer long-term support without deadlines or time-frames. Discharge from the assisted living programme is voluntary and vacancies arise once a client leaves.

At the present, the organisation runs five such community care hostels. Each has a leader or manager with a team of several social workers (sometimes called 'officers'). The hierarchy extends to the support workers that can be either part-time or full-time. Support workers are usually moved between hostels wherever and whenever they are most needed. Since the hostels are always staffed, every 24 hours is split into 8-hour shifts. Certain hours such as the night shift are usually handled by one support worker before the manager and social workers arrive.

The organisation offers the hostel service for individuals in need of assisted living before venturing onto independent living. The staff makes it clear to the clients that they can only provide a minimal amount of care such as supervision, guidance, and emotional

support. They cannot, for instance, cook, wash their clothes, and clean for the residents. Residents in the standard hostels, the kind in which this fieldwork took place, are expected to have basic budgeting skills, be able to cook and have basic standards of hygiene.

The Rain organisation is also highly progressive, always trying to change for the better and improve itself. Its staff is trained regularly to keep them up to date with new measures and practices[1]. However, while the hostel, as an extension of the larger organisation, has all sorts of plans and ambitions, contacts, guidelines and schemes, the social workers may not share them. Rather, they may have their ideas about what works and what doesn't.

Although the social and support workers operate and constitute the hostel, they are also distinct and separate from it. They implement the hostel's goals, but there is also an open space for interpretation. The staff at the hostel have their own ideas on mental health, community care, psychiatry and the hostel. For this reason, the hostel and its staff will be used to refer to two separate but also possibly overlapping agents. The hostel represents the official, explicit consensus on concepts and methods. The 'staff' and 'social workers' refer to particular, sometimes implicit perspectives. This is especially pertinent when discussing the hostel's guidelines as parallel or conflicting with the social worker's and the organisation's larger projects within the Maltese mental health system. The individual staff members, the social worker team, the hostel and the Rain organisation overlap but also slightly differ from each other. It is worthwhile to keep in mind the possible distinction between staff (or social workers) and the hostel for the purposes of this text.

Except for the Rain organisation's ongoing efforts, mental health has never been at the forefront of Malta's national agenda, let alone social work and hostels. However, along with other national health systems (Kitanaka 2012; Reyes-Foster 2019; Bruun 2019) it has become so. Eager to 'modernise' mental health on the island, removing stigma is one the organisation's principle ambitions. As more people use mental health services (Carabott 2022), even more so during the COVID-19 pandemic, (Orland 2021), mental health services in general are much more discreet and convenient. With the advent of pharmaceuticals and community hostels, mental illness is less inconvenient to accept and address. But such a departure is not new to mental health, or even Malta.

[1] They also develop new services, the most recent being a mobile application for mental health outreach.

1.3 Mount Carmel

‘Community care’ is only the latest model for mental health services imported into the island set to replace Mount Carmel Hospital, itself a legacy of the Maltese colonial experience. Currently, the national mental health strategy places the community model as the core of the national mental health system, as will be discussed further on.

Despite these efforts to provide an alternative, Mount Carmel is still open and running. Healthcare in Malta is free of charge, including the mental hospital. However, it is far from ideal. In 2021, an article published on a popular news website stirred up a long-standing debate on the dire state of Malta’s mental health services. The author spent eight days as a patient and documented her stay with pictures. She quotes from her own diary:

> “Dear mum, I’m in a bed in Mount Carmel hospital. I don’t know if they’ll wake me up tomorrow, but I love you.” (De Jong 2021)

In August of the same year, an infamous case where cats and dogs were nailed to a cross upside down reached the headlines again. The perpetrator, a 38-year-old man, accused the authorities of having illegally arrested him. (Vella 2021). In 2013, the news of crucified animals shocked the island and brought to light the necessity of mental health services. Suffering from hallucinations, he states that his actions were a direct result of terminating his prescriptions. He writes at length about his experiences being hospitalised which, he argues, was unnecessarily lengthy, unprofessional and, as a result, traumatising (Vella 2022). As opposed to the uproar his case caused nine years ago, now, he might just be another case of continuous institutional neglect (Cordina 2021; Farrugia 2021; Barbara 2022).

Presently, Mount Carmel still receives, on paper, considerable investment despite the community-oriented national strategy. Recently, new wards have opened at the hospital following government investment (Farrugia 2021). However the severe physical and organisational problems of the now one hundred and sixty-year-old hospital have no end in sight. In 2018 it was deemed to be in ‘unacceptable structural condition’ (Balzan 2021) and most of its roof was condemned the following year (Xuereb 2019). Meanwhile, the government is still following its plans to build a new mental hospital close to Mater Dei, the national hospital, by 2025 (‘Lack of investment in Mt Carmel’ 2021).

Despite recent reforms, constant petitions and movements, such as the (2016) Alliance for Mental Health's[2] recommendations for minimum standards of care, staff members and professionals are still overstretched. More than 8,000 patients pass through the psychiatric outpatient facility in one year at Mater Dei, the national hospital. In 2019, 1974 of these were admissions, 616 being first-time in a population of around 440, 000 (Taylor-east 2019). Incremental improvements and investments are not received well by local organisations involved in the mental health sector. Their stance is clear on the issue: the government should close down the crumbling hospital and direct mental healthcare to community care programmes. In addition, even if a new mental hospital is to be built, it should only be used for the most acute cases (Farrugia 2019; *Malta Independent*, 12 June 2019). In October of 2021, new premises were leased to take over most of Mount Carmel's functions (Cordina 2021). However, the choice between palliative investment in Mount Carmel and permanently closing its doors remains a critical yet postponed decision.

1.4 The Legal Setting

What is the hostel trying to do? As part of the wider mental health system, it is an important component of the 2020-2030 national Mental health action plan titled 'Building Resilience-Transforming services' (ODPMMH 2019). In the plan a community care model is intended as the national mental health system's 'flagship' (p.13). The authors of the report suggest that the plan's primary goals are:

> mainstreaming mental health services, moving the focus of care from institutions to the community, moving acute psychiatric care to the acute general hospital setting, supporting rehabilitation through specialised units preferably in the community, and providing long-term care in dignified facilities. (ODPMMH 2019. p. 13)

The strategy leans on community-care as a way forward. It emphasises reform in the delivery of care and a general orientation towards strengthening mental health at the individual level buffered by family and community, before institutions and government. It

[2] The Alliance for Mental Health is a local organisation including several subsidiary groups such as the Maltese Association of Psychiatry. Its aims are to lobby for and advocate for better mental health services.

also aims at countering stigma as part of a ‘seamless integration’ of physical with mental health, boosting promotion through education and a digital presence. Not only as an alternatives to the asylum, better embodying the ‘values of dignity, autonomy, and rights of all people with mental disorders’ (ODPMMH p. 15), but also a critical part of the larger goal of sustainable development. If Malta's workforce is not resilient enough to thrive in its current drastic changes, it can only expire eventually. The national mental health strategy addresses the notion that we need better, resilient, people to have a better, dynamic economy. Deputy Prime Minister and Minister for Health, Dr. Chris Fearne addresses this understanding in the strategy:

> Preserving a good state of mental health, therefore, involves policies and actions within and beyond the health department. As a government, we are doing this already by implementing policies in line with our ethos and social conscience; by creating employment opportunities, by reducing material poverty, and by modernising our approaches to education and substance misuse. (ODPMMH 2019)

The document justifies the proposed expenditure plan in light of estimated ‘rapid socio-economic’ and socio-demographic change which it describes as a shift ‘from a conservative traditional society to a multi-ethnic, multicultural, more liberal and post-modern society with a booming economy’. It also emphasises health-care as a humanistic value ‘enshrined in Maltese legislation’ and the increased importance of community care. The strategy is quite candid in its assessment of the current situation. Oftentimes, justifying shortcomings by reference to the delicate and still-developing nature of mental health which it defines as:

> ‘The capacity of thought, emotion, and behaviour that enables every individual to realise their own potential in relation to their developmental stage, to cope with the normal stresses of life, to study or work productively and fruitfully, and to contribute to their community.’ (ODPMMH 2019)

Legal reform concerning mental health started with the 1959 and 1976, British and Maltese mental health acts respectively (Fino 1989). The latter’s main aims were to, where possible, provide treatment of a more voluntary and informal nature and to ensure adequate provision for the cases where ‘compulsion is necessary’. Moreover, to create a legal definition of mental illness and the processes following its diagnosis in legal proceedings.

In the 1976 Mental Health Act, a mental disorder is defined in four categories:

1. Mental illness
2. Arrested or incomplete development of mind (on several degrees)
3. Psychopathic disorder
4. Any other disorder or disability of the mind (Fino 1989)

The 1976 act also allows compulsory admissions. One of its initial motives being to delineate the appropriate conditions in the event of an involuntary admission. There is also an emphasis on the distinction between the ‘mental patient’ and the ‘mental offender patient’. The latter, entering the mental health care system via the criminal court or even prison. Lastly, the Act also introduced the idea that care should be, ideally, provided within the community rather than institutionally. More so, for the first time, it introduced community care as a right. The struggle for the implementation of community care would carry on into the turn of the millennium (Galea and Mifsud 2004).

In 2004 Malta became a member of the European Union. This entailed legal harmonisation of local to European law including a ‘rights-based’ approach to mental health-care as endorsed by the official charter of the union (FRA 2011).

In 2012 a new mental health act was introduced. Arguably this was also imported from the United Kingdom’s updated 1983 mental health act (Camilleri, Zahra, Cachia 2014). This gave a new legal framework that increased the rights of mentally ill individuals. In an endeavour to standardise and further codify medical practice it provided detailed schedules concerning the variety of treatments, observation, assessment, custody, certification, and their extension or termination. This document improved on the 1976 definition, providing a definition of mental disorder as:

> a significant mental or behavioural dysfunction, exhibited by signs and, or symptoms indicating a disruption of mental functioning, including disturbance in one or more of the areas of thought, mood, volition, perception, cognition, orientation or memory which are present to such a degree as to be considered pathological in accordance with internationally accepted medical and diagnostic standards and "mental illness" shall be construed accordingly, and for the purpose of any matter related to criminal proceedings, it shall include ‘insanity’ as understood for the purpose of the Criminal Code. (Mental Health Act 2012, p. 3)

The act brought considerable attention to mental health, especially by establishing the Office of the Commissioner for Mental Health (Borg et al. 2022). It also gives considerable attention to community care as a form of 'treatment'. One can also observe that, following professional approval, the individual is once again given the conditional right to 'receive care primarily in the community' (Mental Health Act 2012, p. 4). However, it can be argued that the eligibility, viability, duration, and execution of this 'treatment' are still in the sole remit of relevant medical authorities as it has been for the past 500 years.

1.5 Madness and Illness in Malta

The history of mental health in Malta shifts from church to state, from complete change to decades of stasis. Its documented history and emerging aspects from the 19th century onwards is well recorded (Chircop 2013; Savona-Ventura 2004; Farrugia 2016; Mula, 2010; Abela 2003; Mallia 2009). Most pertinent to this study is Vassallo's (2008) ethnographic study of a psychiatric half-way house in Malta, with a brief overview of what are, in hindsight, the nascent years of community care and deinstitutionalisation on the island. There have also been a few studies on mental health nursing (Camilleri 2012; Gouder 2013; Incorvaja; 1999) and the experience of mental illness for relatives and family members (Fenech & Scerri 2014; Galea 2009; Grech 2003). In the de-institutionalized setting, there is one study by Borg (2000) that compares the organisational culture between the outpatient centre in Mount Carmel and Villa Chelsea. More recent studies of the mental health system are generally related to internal reform or governmental policy usually associated with the University of Malta (Ellul 2015; Pisani-Scalpello 2019).

However, To understand the hostel, the Rain organisation, and the seemingly problematic hospital one must take a few steps backwards to the beginning of psychiatric care in Malta. This entails a brief but necessary detour through the development from sanity to illness in the local context which cannot be visited in passing. For this reason, the study is informed by the paradigms introduced by Foucault (1964/2013), Rosen (1968), Scull (2015), and others who have endeavoured to write the history of madness with a broader scope.

The beginning of community care can be considered as the second major turn in the provision of mental health in Maltese history. Hitherto, developments usually entailed the establishment of new or improved institutions wherein revolution in healthcare was conceived of in terms of different orders of confinement.

It is difficult to understand mental health during such periods utilising the modern-day concept of madness as identical to illness. From 1530 until 1798 Malta fell under the rule of the Knights Hospitallers. As a charitable order, mental health was part and parcel of its mission to aid the 'mad'; who could be somewhat categorised alongside the ill. However, no evidence exists that this wider mission was extended into practice (Savona-Ventura 1997). Just as their ideas of health and mind are unclear so too are the actions taken towards it during their rule. Only some sparse notions of demonic possession have been documented (Cassar 1964). Responsibility towards the 'mad' largely fell on the Church who set up several infirmaries and shelters for the elderly, infirm, and needy.

The beginning of institutional action specifically for madness can be attributed to the establishment of the Santo Spirito Hospital in Rabat, but a more definitive action was taken with the creation of the *Casetta* which formed part of the reputable *Sacra Infermeria*, a hospital, built by the Knights of Saint John in 1574. The *Casetta*, was an underground space fitted with street-level windows leading to undignified comments towards patients/inmates from the passers-by. Subsequently, the walkway was referred to as Lunatic Street. Admission to these quarters seemed to have rested on a general definition of 'odd behaviour'; as a result, multiple individuals with varying disorders and needs were left intermixed with others of the same vague classification. Most were treated as inmates, chained to walls, and immobilised. Carers were employed providing minimal physical care often under the supervision of Chaplains (Savona-Ventura 2004). Madness was too mental to be considered a total bodily effect. However, some notion of illness, or malady in the individual necessitated their incarceration to occur just below the hospital where *bodies* are treated. It is almost as if madness was an accepted but forcibly discarded medical affair; floating somewhere between mind (or spirit) and body.

The 18th century saw decisive changes to the notion of madness into illness. It is interesting to note, for example, the separation of male and female individuals in 1783, further approaching the notion of the patient. Evidence suggests that admissions to the *Casetta* were very low over the years, amounting to just 18 individuals between 1787 and 1789 (Savona-Ventura 2004). However, the attitude towards the mentally infirm was

largely still one of seclusion and containment, with notable and wealthy patients being confined to remote areas of their own holdings. There was no strategy to reform, convert, or 'cure' beyond efforts from the clergy, and no clear distinction was made between incarceration, containment, or hospitalisation.

In June 1798 Napoleon landed on the quayside of Valletta heralding a sense of timely emancipation, followed by two years of turmoil and revolt on the island. In 1800 the British captured the island turned colony in 1813. The intentions of the Empire were ultimately to 'civilise' its dominions through the social exclusion of those who offend the public with their polluting bodies such as paupers and the insane (Chircop 2013). Three years later Sir. Thomas Maitland, then governor of Malta, set up the Committee of the Charitable Institutions. From then on, the primary responsibility for healthcare fell into a centralised administration and, later on, an office, to reduce excess expenditure (Cassar 1964). During the same year, all male patients[3] at the *Sacra Infermeria* were relocated to the *Casa di Carita'*, later named *Ospizio,* in Floriana which had started taking care of the elderly and the mad since 1729.

Built within an old *polverista* (a gunpowder magazine, storage facility) the accommodation was far from adequate (Cassar 1964). Although still a far cry from today's standard of mental health, the residents of the *Ospizio* could, at the very least, enjoy living above ground in an environment of containment rather than incarceration. Located more centrally in Malta's busy Grand Harbour area, the mentally ill were, however, more subject to harassment from the local population. Local children would find ample entertainment hurling stones into the courtyard and petty theft to induce the resident's enraged reactions (Cassar et al 1949). Nevertheless, in Floriana it was much more accessible, encouraging family members to visit. Relatives were also able to cook meals for and speak with their relatives, keeping them somewhat active in society. The role of the family member was a considerable asset to the *Ospizio*. So much so that, at one point, the over-crowded institution offered to pay for the temporary care of its patients by their own relatives (Chircop 2013).

By 1835 *Villa Franconi* was established even more centrally in Floriana to meet the ever-growing *patient* population. In particular, to separate the mildly from the acutely insane at the *Ospizio*. It was the first dedicated institution set up to treat 'madness' in particular, as opposed to all sorts of ailments. Arguably, it was also the beginning of the association between madness and institutional, structured confinement. As is noted in

[3] Women were not part of this transfer initially (Farrugia 2016).

multiple sources, this is the origin of the colloquial term ‘Ta’ Frankuni’ (meaning ‘from Villa Franconi’) utilised in much the same derogatory fashion as ‘nuthouse' in English (Savona-Ventura 2004; Mula 2010). To this day it is still present in common parlance and carries with it a considerable stigma.

The therapeutic orientation of the new hospital also inaugurated the experience of ‘illness’. Instead of incarceration, an alternative experience of hospitalisation was now possible. In addition, admission was sometimes beneficial in that it removed a social, psychological, and financial burden from the family. But the admitted individual could have also been the family’s sole source of income, in which case the Ospizio and Villa Franconi resembled much more prisons. (Chircop 2013; Savona-Ventura 1999, 56-61).

During the early 19th century one can also start to see a clear turn towards the medicalization of insanity in Malta. In 1838 Dr. Tommaso Chetchuti, who graduated and practised as a doctor and surgeon (Scerri 2010), would introduce then-contemporary psychological approaches to the institution. Restraint and physical punishment were reserved solely for the most dangerous of the patient population. The general trend was towards balance or calmness. This included the use of baths, venesection, laxatives, and re-orientation towards psychotherapy.[4] Chetcuti was also a firm believer in the therapeutic power of the asylum, as a concept: a haven from often troubled homes and ephemeral routines. Chetcuti would also abolish the use of any epithet resembling ‘madman’ (Cassar 1964).

By 1848 the patient population at *Villa Franconi* amounted to 170. Four years later, instead of the traditional expansion through the purchase of adjoining buildings, plans to build a larger dedicated institution were published in the Government Gazette. After ongoing pleas for modernization and complaints of overcrowding, the colonial administration set out to improve the situation (Mula 2010). By the mid 19th century the concept that the mentally disturbed could be cured through therapy, which could mean simple things such as a calm environment and care, was well established. In 1860, the comptroller of the charitable institutions writes:

> ‘My conviction has now grown deep that good food, kind treatment, and rational amusements are among the best doctors in the management of lunatics’ (cit. in Cassar et al. 1949).

[4] Not be understood as it is today ie. the Freudian tradition, Cognitive behavioural therapy etc. The term psychotherapy at this time referred to something completely different. Possibly meaning ‘moral treatment’ and hypnosis.

A new ‘Asylum for the Imbeciles’, also known as ‘Hospital for Incurables’, was completed in 1861.[5] It opened its doors to 253 patients on the 16th of July (Cassar 1986), the same day being the feast of our Lady of Mount Carmel from which its name derives. Its location and spacious grounds were of ample aid to the residents who oftentimes required a place of quiet recluse and recreational space. It was deemed capable of supporting a population of 653 by 1898. It made use of a radial plan with which patients could be monitored efficiently. A popular design for prisons at the time, it points at the carceral agenda behind the new institution.

Keeping up with institutional time through schedules, meal-times, and daily tasks were deemed essential to one’s recovery (Chircop 2013). At the new Asylum, several activities such as weaving and gardening were highly encouraged. ‘Musical entertainment’ was considered the most beneficial to the patients[6].

The therapeutic, healing effect of the institution and environment took centre stage from the very beginning. Blue-coloured glass was purchased and wards also painted blue in the belief of its calming effect, despite comments by clinicians denying such claims. During the asylum’s first years certain substances were also used extensively to induce calmness, especially among the most ‘excited’ patients. Apart from clinical chemical sedation, the use of ‘snuff’ or tobacco was highly encouraged[7] (Savona-Ventura 2004).

[5] However, it received immediate criticism for its structural situation. The brand new asylum was deemed unoriginal in architectural design and riddled with practical and structural defects. Constant alterations were needed to maintain and improve the asylum. Some have even suggested it was built by an Italian refugee who impersonated an architect by copying the plans for the Lunatic Asylum in Wakefield (Mula 2010, p. 11). This bizarre story is barely researched.

[6] Somewhat surprisingly, at the hostel music is always playing in the background. Most residents sit and watch the music channel, singing to the songs together. When asked why they enjoy it so much they state that they find music the most enjoyable thing to be entertained by.

[7] However their use was deemed harmful by 1895 (Cassar 1964).

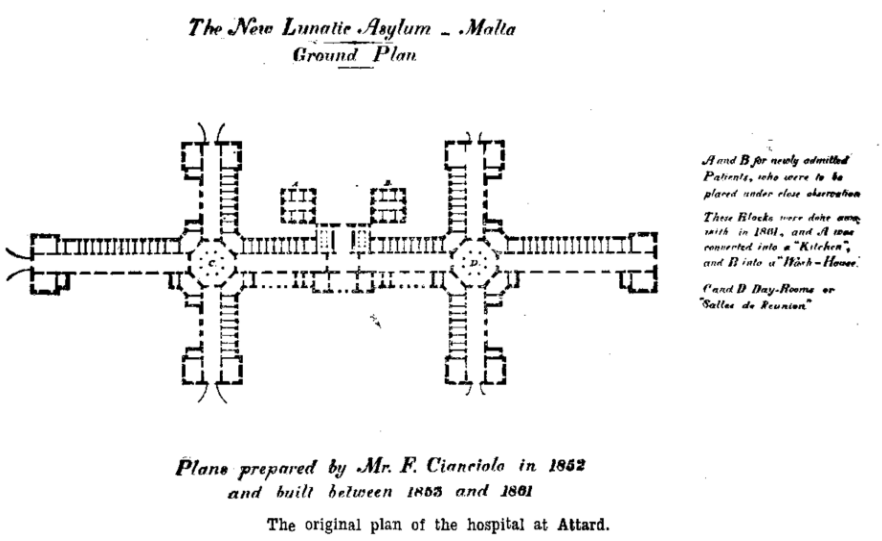


Figure 1. 'Plans for the 'New Lunatic Asylum'

Figure 2. Mount Carmel in 1905

Mount Carmel was built with the aim of therapy as opposed to incarceration, at least explicitly. The medical orientation, tasked with curing[8], was still ever present in lobotomies, electro-convulsive therapies and other efforts to rid illness from bodies. We must also pay attention to the remoteness of its location meant to provide the general public safety from its residents. Nevertheless, it was a major improvement over Villa Franconi, better aligned to the then-new 'law of lunacy' which declared that:

> 'The hospitals for mental disorders should be as much as possible incorporated into ordinary stays of domestic ease and refinement.' (Mula 2010)

The decades following its opening also saw considerable effort to expose its patients to social life. Outings were organised to the afforested areas of the Boschetto and in nearby Rabat. Some select groups of patients were even taken to the Royal Opera House in Valletta and others to the adjacent village of Attard to attend religious festivities. All of which made life and recovery at the asylum less constricting (Cassar et al. 1949).

Admission to the asylum was always deemed voluntary unless it stemmed from a criminal proceeding or official medical diagnosis. From 1867 onwards admission was only allowed by reference from the general hospital. This measure was implemented partly due to overcrowding. Discharge involved fewer steps but still had a process involved. At the Ospizio, administration could not reject a relative's wish to take care of a patient at home unless a court order prohibited the release. But as early as 1862 discharges from Mount Carmel were only allowed by a special board (Mula 2010).

Such requests were often accepted on the condition that the relative in question had the means to care for the patient without putting the public at risk. Here, for the first time, medical authority emerges as a power in charge of the individual's body irrelevant of the relatives' and the patient's will. This in turn started to shift the local conception of madness. The heightened medicalization at this time set the most solid foundations for the already established concept of mental *illness*; in addition, the relevant authority's duty to address it on a national scale. As Foucualt argues, mental health coagulated into a 'normalising' force, tasked with producing citizens whose body needs to be managed (Foucault 2006). The administration of bodies took precedence over the patient's wishes.

[8] In 1871, the asylum saw the gradual introduction of nursing roles by the Nuns of the Sisters of Charity of St. Jeanne Antide. Most nursing roles were taken up by the sisters, some were even transferred from branches in Italy for this purpose (Savona-Ventura 2004).

The new asylum was free for paupers but a fee, relative to income, was charged for the occupants that could afford it. The socio-economic position of the patients seems to have had a bearing on the experience at the hospital. Records show that there is an increased interest in building appropriate accommodation for patients of differing social standings, adding that 'the want of which has been long felt'[9] (Mula 2010).

The recognition of the therapeutic role the environment plays in the patient's recovery also coincided with the conviction that cultural diversity impedes this process. Differing understandings, habits, and practices were thought to be disorienting to the local patients trying their hardest to fit in a stable community. The few foreigners receiving care at the asylum were segregated from the Maltese and transferred to facilities in their original countries as soon as possible. (Cassar et al. 1949).

One can observe a shift in aetiological understanding most clearly at the turn of the century. Admissions to the asylum show a considerable increase in 'moral causes' such as religious excitement, anxiety, overwork, and love affairs. Physical causes centered around sexual activity, puberty, old age, disease, congenital defects, and more[10].

The early 20th century also saw a remarkable increase in the official interest in the provision of healthcare. Throughout the first world war, wounded soldiers streamed onto the island from Gallipoli and Salonika. In reaction, the empire opened multiple medical facilities to support the influx of casualties[11]. It should not be surprising, then, to find the peak of institutionalisation set in the 1920s. However, the following decades contained the beginning of its dissolution. The hospital had for some time undergone a series of reforms additionally emphasising its therapeutic, healing orientation. In 1928 it changed its official name from 'Lunatic Asylum' to 'Hospital for Mental Diseases'. Systemic

[9] N.A.M., C.I., vol.62, 22 Nov, 1873, Letter from the Comptroller of C.I. to the CSG. Excerpt from Mula, 2010.

[10] By 1920 categories of the mental disease had considerably increased to include: 'idiocity [cases: 16], imbecility [46], moral insanity [2], mental degeneration [4], mania [68], melancholia [32], lypoemania [33], maniacal depressive insanity [162], delusional insanity [198], obsessional insanity [7], neurasthenic insanity [7], hysterical insanity [19], epileptic insanity [40], dementia praecox [58], cerebral arterio sclerosis [2], senile insanity [8], dementia [39], toxic psychosis [2], alcoholism [21], cerebral syphilis [2], general paralysis of the insane [1], psycasthenia [3], confusional insanity [1], and choreic insanity [1]. There were a further four cases that had not been classified' (Savona-Ventura, 2004).

[11] In the later stages of the war, Malta's role in the soldier's recovery shifted towards mental health. Malta's moderate climate and quiet countryside were utilised and effectively transformed the island into a convalescence depot. Hospitals were erected or modernised, such as the one in Bighi which even had an 'insanity ward'. Theatres, social hubs, and other facilities for relaxation sprung up during the conflict. They were not solely there to strengthen the casualties' morale. It is also evidence that a keen appreciation for the mind's recovery, battered by artillery fire, and the worst of war, was established. (Azzopardi 2019,pp. 6-7, 48-50)

reform can also be seen in the removal of the Office for Charitable Institutions in 1937. This was replaced by the 'Chief Government Medical Officer' with various dedicated departments under his administration (Cassar 1964).

The ensuing years also presented a host of ever-recurring problems. One of which was overcrowding, resulting in the opening of the first outpatient department in 1939 (Farrugia 2016). During this period, one can also observe the beginning of an appointment and referral-based system. Besides the general hospital, the institution started to organise itself alongside general practitioners around the islands. Admission was also systematised with a series of evaluations necessary before providing the adequate form and scale of treatment.

During the Second World War, admissions reached an all-time low most likely due to the state of turmoil the island was in, only to return to pre-war levels afterwards (Farrugia 2016). A revival of education among mental health practitioners was noted in 1947 with the publication of dedicated manuals by Dr. Paul Cassar. International research was also published in Maltese for clinicians and staff to benefit from then-current developments in psychotherapy.

After the Second World War mass unemployment struck the island. The Labour party emerged as a strong contender for the re-building of Malta's infrastructure, economy, and health. Outpatient clinics expanded in the post-war years, particularly during the 50s and 60s. Contrasted to the rate of unemployment and 'brain drain' of the previous decades, one can see a direct relationship between the economic state of affairs and investments in health care. This is something that is just as important when making sense of the present.

Malta was granted independence from the United Kingdom on the 21st of September, 1964. Consequently, the island's healthcare system was no longer administered by a governor-appointed individual and a more 'democratic' administration ensued.

In 1966, an outpatient centre known as *The Kennedy Memorial Clinic* was set up in St Julian's. Two years later *Villa Mons Gonzi* in Siggiewi opened its doors for the physically and mentally disabled. It was also used to train social workers on a volunteer basis. This added another alternative to the hospital environment. By 2004, Malta's mental health institutions were decentralised to a greater extent. St Luke's Hospital offered 11 beds as a short-stay psychiatric unit. Mount Carmel Hospital accommodated 520 beds with long-term, forensic, and specialist treatment facilities. Psychiatric outpatient clinics are

also located within Mater Dei, the new general hospital for Malta, and in the Gozo General Hospital on the sister island. There are also a number of private organisations involved in advocacy, promotion, and rehabilitation including the Catholic Church.

For now, Mount Carmel still regulates mental healthcare for the islands with assistance and advisory services from external medical bodies or social services such as the National Agency against Drug and Alcohol Abuse (Sedqa), Caritas, Richmond foundation, the Mental Health Association Malta, and other privately-owned organisations[12]. A local study suggests that people who are able to get access to psychiatric professionals in private practice have 'a better overall service' as it enables the long-term bond between patient and professional that is missing in current out-patient services (Abela et al. 2016, p. 326). Another study suggests that government-provided psychotherapy is severely lacking relative to its demand. Focusing on mental health services for asylum seekers (Taylor-east et al. 2016) researchers note a lack of translators and 'cultural-mediators' assisting the provision of an already short-staffed health care infrastructure. A 2019 study of public health workers notes that:

> The increased demand for services over the years has not been matched with the necessary injection of resources. Indeed, in a series of one-to-one meetings with consultant psychiatrists carried out by one of the authors in 2016, consultants felt that they were continuously being asked to "deliver more and better with less and less." (Camilleri et al. 2019, p. 32)

The constant search for rights and the availability of choices is a recurring theme in the history of mental health. From the Ospizio to the allowances and socialisation encouraged at Casa Franconi in Floriana, to the optional and encouraging activities organised at the old asylum, this search for the patient's capacity to choose for himself, to possess a will, has only been extended and elaborated at the Rain organisation's hostel nowadays.

Being one of the alternatives to the asylum on the island, the hostel inherits from the more negative aspects of Malta's psychiatric history and its ongoing problems in the present. A small cat called Stanley sits on my lap everytime I visit. The first time it happened, Matthew told me he loved her. They chose the name themselves and care for him collectively. He reminded him of the hospital. "A cat gave birth under my bed at

[12] Some have adopted a 'business model' such as 'TAASC' and 'Willingness'.

Mount Carmel once", he said. The hostel and its residents are constantly and inevitably intertwined with the hospital, their past experience of neglect in it, and the inherited stigma of suffering from mental illness. As clients, such stories are commonplace from their time spent as patients.

The hostel's explicit aim of assisting rather than controlling the residents can begin to shed light on the questions left unanswered. What is so different about the hostels than Mount Carmel? In what way is the hostel radically new? To what extent does it have to do with 'assisting clients' rather than 'curing patients'? Lastly, can these questions be answered along the long-established approach towards the insane or ill: as a dilemma resting upon the individual's capacity for 'independence'?

Chapter 2: Madness to Illness: Agency in Anthropology and Mental Health

Oftentimes, when trying to understand culture, anthropologists have run into the problem of explaining it while accounting for its changes. This was the first preoccupation of the structuralists and the development of anthropology ever since (Brettel 2002). The relationship between the individual and culture is one of, if not perhaps the central conundrum of the discipline. From Weber (Campbell 2009; Weber 1905) to Boas (1911), Durkheim (1915), Turner (1969), Levi-Strauss (1972), Bateson (1972), Latour (Latour & Woolgar 1979) and Bourdieu (1984), the elusive and divisive question is how the individual is shaped by and simultaneously shapes culture. Put simply, whether or not agency exists in some shape or form.

2.1 Agency and Anthropology

'Agency' here refers to the possession of the propensity to act according to one's own intentions, assuming they exist within some idea of the person. It is the ability to harbour desire and, if not determined by it, at least propelled towards its goals. Hence, the notion of 'agency' immediately implies all sorts of assumptions. For instance, the possibility to think rationally and somewhat independently of any influences. More so, an entire understanding of 'self' and 'person' as the agent for this ability. Perhaps also a decisive gulf between the 'I' and 'we': the individual and the social. They can support each other, but every 'person' said to possess 'agency' can think for his/her own, to some extent. One can easily see the web of concepts agency implies and holds together as a lynchpin. This is only the tip of the iceberg, without notions of 'self-actualization' (Scharff 2016), 'individuality' (Rapport 2002) 'independence', the 'postmodern self' (DiGiacomo 1992) and, highly pertinent to contemporary discussions of mental health; 'resilience'.

Being 'resilient person', 'individual', 'self', and 'agency' are oftentimes used interchangeably. Each however carries their own genealogy. 'Person' implies the concept of 'personae', an additional quality to the individual. The idea of an individual is itself

often wrongly immediately associated with individualism (Carrithers, Collins, Lukes 1985). One can find individuals, unique units within a society, but not always the accompanying concept that they are free and independent (Carrithers et al 1985). Other articulations of the singular human experience, such as 'self', can be found within all sorts of cultural contexts. Related but separated from all, 'agency' entails looking at a particular ability, or condition.

The question troubling anthropologists is precisely where creativity, will, consciousness, and/or agency end and culture or social structures begin (if it can even be understood through such a dichotomy). The same debate on culture against individual human creativity is also shared in neighbouring disciplines from philosophy to psychology (Marcuse 1964; Freud 1930; Sartre 1943; Žižek 2014). Social theory and ethnography have often overlapped when trying to understand agency (Karp 1986). In particular, when discussing the anthropological object of study (Heiss & Piette 2015; Kein 2003); from Malinowski's (1939) 'individual' to more sociological approaches towards human action. Notably, the Durkheimian understanding, positing that agency only existed as a manifestation of collective consciousness. True 'free' action was only a product of more animalistic impulses; a clear separation between the biological and social (Rapport & Overing 2000).

Bourdieu (1984) builds on this long-standing dilemma with the concept of 'habitus', in which social agents possess some form of agency, but only to navigate through distinct structural and semiological roles. Put simply, the individual has the capacity to choose and think but only within and with some form of *milieu*: his cultural background or social environment. What is immediately perceived as conscious is only a re-articulation of established forms of being or habits. 'Habitus' in turn, can be said to reproduce the social structures whence they came from. Despite several theoretical departures from Bourdieu, there remains a space for such anthropological theory, such as the understanding of the social as a relationship between 'actor' and 'network' (Latour 2005; Law 2004). Another example worth mentioning is Mazzarella's (2017) return and re-utilization of 'mana' as a way to understand individuality as extimate; both within and beyond the social subject.

Turner (1969) similarly thinks through the problem via duality. The individual's agency is eliminated within a specific structure, but this is only possible through a constant return from 'communitas'; anti-structure. In this second social environment, navigated through ritual, what was before transfixed is creatively manipulated to reconstruct the individual. Through symbolic action, such as Ndembu ritual (Turner 1967), or Gennep's (1960) rites

of passage, in ‘communitas’, the individual attains some form of directed agency. By temporarily subverting the official, structural and socio-cultural roles, one returns to them in a different way, position, and/or re-organized state of affairs.

A discussion of agency, as an argument about what the individual or person wants to do and be, often entails temporality. The shift from the present to the desired future state of affairs could be the quintessential aim of agency. The relationship between it and temporality has also featured in anthropology (Clough 2020; Munn 1992). Everywhere the individual or entire communities take command of their condition to alter it the way they deem right. In other cases, it could be due to social and economic pressures, forcing an induced reaction to alter one’s trajectory.

There are multiple ways to conceptualise and utilise the plethora of understandings of agency (Gell 1998). In this particular case, ‘agency’ is often seen to be that which is missing in illness, and what is required in order to be ‘cured’ and attain ‘wellbeing’. The individual with a capacity for self-improvement, self-actualization and, most importantly, agency is what the hostel is trying to create. This is not a new or revolutionary endeavour. Rather, one steeped in a particular history or movement: deinstitutionalization. For this reason a brief historical/theoretical background is necessary before discussing the renditions of agency present in the Maltese mental health system and the hostel in particular.

2.2 From Asylums to Community

Madness, or what we can now call mental illness, shed the institutional nature it acquired in the 17th century in the latter part of the 20th. This general movement can, arguably, be traced back not only to medical developments but also to philosophical, social, and economic underpinnings such as has been outlined in the works by Deleuze (1983), Foucault (1964/2013), Fromm (1955), Laing (1969), Szasz (1974) and many others (Scull 2015; Rosen 1968). A decisive turn (in the ‘west’) towards the study of inherent power structures and individual independence has been the topic for various socio-philosophical debates. From Fromm (1941) to Marcuse (1962) a growing body of critique revolved around the politics of freedom, from national policy to the minute practices of daily life.

Deinstitutionalization is one of many historical turns mental illness has taken, which ample authors have traced. De-incarceration, or decentralisation are different terms for the dissolution of the previous century's approach to madness. However, even outlining the history of deinstitutionalization might be an essentially ‘western’ discussion. We have to keep in mind that this was not a universal or a homogenous development. If, as Foucault argues, every era moulds its human, community care is the product of a particular time and place.

In ‘Madness and Civilization’ (1964) institutions are described as a product of a decisive thrust into incarceration. This is a reversal from the liberated madness of the renaissance, an unfortunate turn which Foucault refers to as ‘the great confinement’. Asylums are the birth child of this spirit of separating the sane from the insane. But they worked with completely different criteria: the sick and the healthy. With the concept of Asylum was born the idea of ‘mental health’ and the institution as a form of healer, carer, and sanctuary (Foucault 1964/2013).

In the 20th century with the advent of Freudian psychotherapy, mental illness-although still connected to the scientific, medical, and the biological domain-was also attached to the social realm through language. The talking cure of psychotherapy fused the treatment of madness and speech, positing the illnesses of the mind as a problem in the unconscious. The Freudian approach to therapy was different from its predecessors. Here, one could find the patient and the doctor sitting together speaking about madness as if it was Schopenhauer’s ‘long dream’ (Freud, 1965; Makari, 2008). Here we can begin to see the medical authority on which the asylum stood begin to shake. In addition, human agency was now in question as the ‘ego’ was no longer in complete control of itself.

The beginning of psychoanalysis was not some alien intrusion but a product of its time. In Gellner’s words, it satisfied some ‘deep and pervasive need’ (2003). The First World War left millions shattered and thousands suffering from new and peculiar illnesses. Seemingly able men broke down into strange habits, nervousness, and total melancholy. The individual inhabiting his mind was a guest in a stranger's house. Psychoanalysis, ‘the talking cure’, emerged as a remedy to the seemingly incurable ailments of the mind increasingly associated with the stresses of war, what would come to be known (and later forbidden to state) shell shock. The link between environment and mind, well known since the opening of the first lunatic asylum, was now affirmed as a cause rather than solely a cure for madness.

And yet the Asylums remained open. Those that could not be cured and returned to combat would then remain within institutions which were growing in numbers. The expensive and ineffective costs of the Asylums emerged strongly in the Great Depression, and later during the Second World War (Brown 1985; Gnob 2014). Asylums were then overflowing with these 'newly ill' with unmanageably large patient populations.

Added interest in alternative cures and developing (psychodynamic) trends in psychiatry led to the beginning of 'community clinics'. The need for an alternative and specific care was present all along during the emergence of psychotherapy as a medical practice. Within psychiatric practice, medical research would also point towards community care. However, it would only be possible alongside other developments.

In a similar instance to the therapeutic turn in 1918, the Second World War demonstrated the effectiveness of location. Soldiers who were given treatment close to home had a much better chance of quick recovery (Brodwin 2013). But this novel empirical discovery was not enough to confirm the future of community psychiatry. The post-war era turned out to be a paradigmatic time where new articulations of power and repression surfaced. In the years leading up to and just after the 60s, debates about control, civil rights movements, and progressive literature proliferated in mainstream media. The counterculture, which many had opposed for its advocacy of liberation, slowly became the establishment: an opposition and suspicion of all forms of dogma and systemic control.

Psychiatry and Psychoanalysis found themselves close to the eye of the storm as the science of the self, then trying to get rid of its chains. In America, this anti-psychiatric movement developed into an entire spectrum: from advocates of institutional changes to the total disavowal of mental illness. More direct and total critiques developed as well such as anti-custodialism (Brown 1985).

These developments collided in different places at different times between the 50s and 70s allowing the 'anti-psychiatric movement to gasp its first breath. Proponents such as Laing (1964) and Szasz (1974) influenced the challenge to what had hitherto been scientific dogma, bringing social sciences and critique into the medical world (Balbuena 2021). Conceiving a new understanding of society and mental health, this strand of the already diverse anti-psychiatric movement would propose a total reversal of the traditional institutional asylum in favour of a form of therapy fundamentally based on the

notion of community. Albeit influential, they remained on the fringes of the establishments and the ongoing mass deinstitutionalization in America[13].

The Asylum, in its traditional state, was deemed no longer necessary if not counterproductive to the unfortunate occurrence of madness in society. Incarceration, isolation from society, and general neglect could not be separated from the outdated asylum as an institutional structure. What the Basaglians-and other facets of the anti-psychiatry movement-emphasised (Foot 2015), was that society had some form of agency over illness; that social settings could transform the experience of illness, if not cure it. The extent of which varied within the movement itself. Put simply, there emerged an alternative to dealing with madness: a blatant critique of the asylums and institutions.

The foundations of de-institutionalization as a movement and process across Europe can be seen most clearly in the revolutionary literature of the age. In 1961 Erving Goffman published his sociological account of Asylums. An immensely detailed account of a previously discarded, alien aspect of society suddenly emerged; a professional, 386-page account of life within these mysterious, unknown, and frightening places. Goffman leaves no stone unturned as he speaks about the very first days of admission, adjusting to life within the walls, thwarting the rules, making and faking the image of healing[14]; from acquiring an extra meal to securing privacy in a transparent environment.

Through the work of Goffman, Foucault, and Primo Levi, Franco Basaglia found tangible evidence for the misuse of institutional power and this pervasive loss of individuality, or more specifically 'self' (Foot 2015). But the institution, or at least its structure and relationships were a useful tool nonetheless, even if through their negation. Other anti-psychiatrists picked up this very lesson: its potentiality to shape its subjects in new and beneficial ways. If mental illness was constructed one could, tentatively, deconstruct it. If asylums contributed to the former, their negation paved the way for the latter.

---

[13] In other places, critique emerged from within institutions. Notably, the Gorizian experiment, spearheaded by the Basaglian équipe (Foot 2015). In their asylum, philosophically charged ideas disseminated onto practical principles for the resocialization and the marginalisation of institutional treatment. Much like Foucault's understanding of madness, Basaglia would approach psychiatry as a discourse of power. For both, illness is not an external process that degrades the individual's sanity. Rather, a completely internal dimension of society itself.

[14] Observation is an important aspect of the medical establishment Asylums provide. By doing so the individual is assessed for symptoms qualifying him as a patient. Goffman is quick to point out that the asylum itself alters its patients. More importantly, their only way out is *through* the identity presented to him by the asylum. Negating the institution is a clear sign that the individual needs care and therefore belongs in it. Goffman writes: 'A refraction of conduct thus occurs, the walls of the institution acting like a thick and faulted prism. Unless one argues for the validity of testing persons under this particular kind of stress, the ward would seem to be the worst possible place for a server's observations' (1961, p. 360).

From self-liberation and medical re-orientation emerged the notion of 'community psychiatry'. It shined as one of the most viable alternatives to the 'dogmatic', 'antiquated' and stigmatising Asylums. However, it was not intellectual developments alone that brought the end of asylums. Consensus in medical research was that socialisation, the decrease in stigma, participation in the larger community, and striving towards independence were all positive factors in mental health. Nevertheless, besides the counter-cultural and medically researched positions in favour of deinstitutionalization, there were still more figures at play.

Since the late 19th century the pharmaceutical industry has been busier than ever developing a vast array of drugs for mental conditions. By the Second World War, sedatives, methamphetamines, and other psychotropic drugs rapidly diffused from the military to the medical world. Prior to this, electroconvulsive therapy, restraint, incarceration, and (somewhat rarely) psychoanalysis were some of the standard responses to acute mental illness. The 70s in particular saw considerable advances in psychopharmacology. These new and effective medicines allowed a form of tangible, biological cure parallel to other medical establishments, heralding the downfall of 'talking cures' such as psychoanalysis in popular culture (Metzl 2003).

Their effects on the conception of mental health were and still are immense, bridging the gap between mental illness and other bodily diseases (Healy 2012; Jenkins 2011). Despite several side effects, most (like Valium and Prozac) came to be considered as indispensable sedatives. Consequently, patients could no longer be seen as dangerous, hostile, or in need of staff supervision. The sedated patient could slowly be referred to as the individual or, at least, the client. The psychiatrist now had a more solid foundation in biology than ever, far from long-term and quantitatively unmanageable methods.

Arguably, the new drugs were the very lynchpin of the entire shift in mental healthcare. These new pharmaceuticals significantly reduced the cost of care for the mentally ill. Instead of long-term stays, patient care, mineral baths, and the plethora of therapeutic initiatives, the patient could be cared for with a few pills[15]. The ill could even avoid the

[15] One must also point at the positive dimension of such developments. They have played a very important role from the inception of community psychiatry. Drugs are what allowed institutions to open the proverbial 'back door'; allowing care beyond the hospital environment (Floersch, 2002). This would also allow the Asylum to begin closing its front door. That is, to divert would-be patients from the institutional environment into long or short-term community care. They could provide better care in an adequate environment, away from the depreciating stigma the Asylum inadvertently imposes on its residents. Even if the patient proves difficult, pharmaceuticals levelled the risk. Towards the experience of deinstitutionalization, drugs would also serve as the last remaining source of the meaningful medical narrative some clients and professionals take up (Smardon, 2008).

system completely, sufficing with medical examination and a prescription. It no longer made sense to contain a large patient population in dedicated centres when most residents could be treated adequately with supervision and pharmaceuticals alone. With the ascent of psychotropic drugs, the asylum was no longer tenable as an economic solution to the problem of mental illness.

The ‘community clinic’ model would also require less staff, upkeep and could cater for different locations instead of centralising mental health services in one location. Most importantly, the inclusive and socially active environment the asylums tried so hard to provide their patients came for free in the community; social life on its own became a resource. On the other hand, this model would also care for select communities instead of larger populations. However, care could also be targeted to those in need which often rendered it a cost-effective crisis-management solution (Mcbride, 1994). The reduced costs in expenditure made and still make community psychiatry the preferable model, with some reservations.

Deinstitutionalization was an acephalous movement, untethered and vague in its aims. The thrust towards liberation took several different roads and avenues, some of which leading right back to their beginning. One might argue that the asylum provided a safe environment within which the individual could heal, that the confining walls of the asylums were protective. Now, the patient has arguably become lost to the confusing barriers society provides (Barrett 1996). Research suggests that community psychiatry does not provide a large enough increase in its quantitative or qualitative efficiency to merit its current esteem (Avivaram 1990; Jain & Jadhav 2008). The idea that community psychiatry is simply the best possible rendition, or a contemporary evolution of traditional mental health services can be very misleading.

If anything, it encounters several critiques. Namely, and relevant to the general paradigm of professionalised medicine, is the ‘iatrogenic epidemic’ (Illich 1977). Where medicine was primarily tasked with curing disease, it is now largely occupied with fixing its own mistakes. This is still the case with the hostel, where a significant portion of the client’s prescriptions consists of medicine whose function is to suppress the side effects or withdrawal symptoms of others. This argument can and has been extended to psychiatry itself. In order to psychologize the human experience and medicalize its suffering, some argue that it has failed to see its patients and clients as manifestations of very *social* crises (Fisher 2009; Podgornik & Covačič 2014).

Even if the hostel presents itself as a bastion protecting its clients from such an approach and understanding, it may not be a paradigm shift at all. Foucault is prompt to tell us, the repressive role of the 'medical gaze' can work just as effectively from within the patient (or client). In 'the new form of the hospital' (Hancock 2018; Foucault 1980, pp. 146-65), in community psychiatry, it could be argued that although doctors, psychiatrists, confinement, and incarceration were seemingly evicted, but their function persisted cryptically throughout the privatisation of mental health, for the population and the patient.

Where government-run asylums were transformed into privately managed organisations, in parallel, the patient transitioned to a client. A movement towards the privatisation of illness, self-care, and the patient's self-repression which Malta was not part of until recently. Medication still acts as a vector for the sort of 'gaze' which defines its user and object. Pharmaceuticals are still present and vital for community care. In this study, they were a means through which the clients could place their cure in the scopic field: they could literally see their cure. Doing so, they could also support the idea of their illness as a biological, bodily effect; separating it from their real 'self'. It was, therefore, something their 'self', in possession of agency, could manage, as will be discussed in Chapter 6.

However, even explicit forms of normalisation and repression exist in the form of the 'social-worker-judge' (Foucault 1977, p. 304). The hostel's idea of being cured is entirely based on the state of being independent. But this is not meant as a state of total freedom, only a specific kind of freedom. The neoliberal subject, expected to 'become the best version of him/herself' could be one way of stating the sort of individual the hostel deems its cured clients to be; unique and radically independent in an average way.

While it is immensely beneficial to approach mental health, or any medical event, as an 'archipelago' of power relations (Hancock 2018), it leaves the client's ontological understanding of illness and the social worker's moral relation to social work untouched. The notion of 'client' sponsored by the hostel deserves a more total anthropological approach; incorporating but not limited to power and its inflections.

If anything, Foucault can only bring us to the beginning of a medical anthropology. After all, it was him who suggested that medicine emerges alongside the inception of the social, binding the two from their outset (Hancock 2018, p 454). Foucault assists further departures from this fundamental concept. For instance, the realisation that societies might be experiencing the medicalization of life itself; an invisible hegemony of medical

institutions over what was previously external and separate to it. This analysis will build outwards from this point. One can and should trace the politics in caring, the currents of neoliberalism in health, and perhaps even the ways in which healthcare has been adopted by neoliberalism (Cumming 1990; Dowling 2021, 2012; Illouz 2007).

If we can take something with us from this brief tour through the decline of institutions and the emergence of community clinics (or halfway houses) it is that mental health is not an entirely medical domain, and neither is medicine. The way we understand and approach mental health always points back to specific socio-cultural and politico-economic trends. It is a wholly social endeavour, and perhaps the most important one, tasked with ensuring the existence of society itself. The anthropology of deinstitutionalization, of healthcare and the body, is precisely the study of this struggle.

2.3 Agency and Resilience as Mental Health

As in the history of psychiatry and psychotherapy the question of agency has gained an increasingly prominent role in current developments in mental health, and within the anthropology of psychology and deinstitutionalization specifically (Newton 2001; Hutten & Bruun 2022; Stewart 2014). In recent history, entire schools of thought have emerged that provide a cure through the acquisition of ‘control’ over one’s ‘self’ (Clemmensen & Køppe 2021; Magalhães 2019; Illouz 2008).

More so, they have ushered in a renewed understanding of temporality and one’s relationship to it. Cognitive Behavioural Therapy (or CBT) is one highly popular form of therapy with emphasis on dealing with problems in the present (NHS 2019). Bruun’s (2019, p. 146) study of CBT’s advent in the UK sheds light on its concern with the here and now, or ‘the conscious mind’. It takes a decisive stance on solving mental ‘issues’ rather than ponder about their origin and existence. Indeed, recovery periods and the ability to calculate, dictate, and control them, have been a prominent feature of modern day psychiatric concerns and wider debates on care (McWade 2015; Wright 2022). ‘Temporal agency’, the intention or ability to alter events and trajectories in the process of healing (Otake & Tamming 2021; Sidenius et al. 2020) within mental health systems

and institutions has also come under anthropological scrutiny (Richoud & Amin 2019, Cooper 2015, Haas 2020).

The current push towards ‘agency’, like that of resilience, is multiple, even within one health system. For example, it can be understood in terms of emotional control, the ability to communicate, and independence from support (Romakkaniemi & Järvikoski 2012). In Myer’s (2015) ethnographic study of mental health services in America, agency is framed as a moral concern by his informants. Within the given medicalised regime locating one's agency often involves some conceptual gymnastics. In Lakoff’s (2003) study of a psychiatric ward in South America, medication did not alter the person but restored subjectivity and the ability to possess some form of agency. Another dilemma concerning agency is the way in which the introduction of new disorders alters the cultural conception of behaviour and actions. One example is Orr’s (2019) study of hoarding as described and addressed through DSM-5, and the role of ethnographic analysis to re-articulate agency in that debate.

Within the context of the new concept of the hostel in Malta, the question of agency is synonymous with, and perfectly obfuscated beneath the terms ‘independence’ and, more so, ‘resilience’. The ubiquitous question of ‘resilience’ will be just as prominent as ‘agency’ in the following text. In particular, the intersection between the two and the specific concept of agency employed and lived through at the hostel.

‘Resilience’, as a concept that is widely used across mental health systems, from migration to adolescent studies (Raghavan 2019; Anderson & Priebe 2021) This could be partly because of its vagueness as a concept, useful to imply all sorts of notions, even outside of psychiatry and mental health. It can be found as an ongoing process, a state of character, or even an unexpected adversity or ability (Windle 2011). In particular, an exemplification of ‘resilience’ is especially pertinent to an increasingly hostile and problematic world in terms of mental health: demographic shifts, climate change and other crises (Wulff et al. 2015). However, it is arguably a simplistic understanding of an immensely complicated issue (Brady 2022). More so, it runs the risk of reducing the multitude of subjective and culturally specific understandings of mental health, if not also ‘depoliticize it’ in the process (Tanner et al. 2017, p. 17-18). It can also engender a socio-ecological view of progress, expansion, and adversity, rendering crisis into the normal state of affairs (Vardy & Smith 2017).

In Malta, resilience certainly builds on but is also shaping notions of person, self and subjectivity. As stated in Malta's current mental health plan, quite literally entitled 'building resilience', the aim is to create a society composed of independent 'individuals', who:

> should be truly empowered to seek and obtain the right help at the right time, free from discrimination and stigma and most of all expect recovery to fully enjoy their rights and be independent and fully integrated in society. We want people in Malta to live healthy, fulfilling lives. We want to support the development of a fairer community where everyone is able to reach their full potential and be as independent as possible. (ODPMMH p. 27).

To be independent, individual, and agent is interwoven into notions of health and wellbeing. At least, that is the explicit goal of the Maltese healthcare authorities and the Rain organisation, wherein this study was conducted. Concurrently, the absence of such forms of agency are associated with illness and its causes. In community care this lack of agency is present when discussing the social origins of illness; a time when the individual was bereft of agency. Family trauma, social problems and related social issues always also enter into such discussions. Somewhat paradoxically, at the same time, 'the community' and society at large is seen as a key player in the client's recovery. Gaining control of and/or detaching oneself from society is the desired idea of health; that one is capable of living and thriving in society, but only with the capacity to also be a distinct agent within it. Not doing so entails the loss of agency and 'self'.

The Rain organisation's hostel can be found in an awkward tangle with 'the community' and its understanding of health and 'wellbeing'. This is the central question this text will address.

Chapter 3: Studying the Hostel

I cannot escape behind my pen as if I were a scientist behind some 'ethnographic microscope'. As the reflective turn in anthropology has shown (Clifford & Marcus 1986; Spivak 1988), and is additionally pertinent to this text on agency, with some reservations (Geschiere 2010), reflexivity is central to ethnographic research. The anthropologist's own agency has often come into question. The extent to which an ethnography is a wholly rational endeavour, merely written by the anthropologist, generates ample critique and discussions (Clifford 1986; Khosravi 2016; Rogachevsky 2001). Previously passive informants have increasingly become active interlocutors and co-authors equally capable and/or lacking agency (Spivak 1988). In addition, through auto-ethnography, the anthropologist has also become an object of study; which is both the greatest assertion of agency as well as its complete inexistence. I will, therefore, begin by trying my best to write about my motivations and the circumstances that led me to my fieldsite and the methods with which this research was conducted.

3.1 Pandemic Fieldwork

Initially, I wanted to study suicide. During the Covid-19 pandemic suicide rates were rising world-wide alongside the demand for mental health services. Perhaps, it also resonated with my emotional lows through covid. In 2020, I thought it would be worthwhile to expand my focus to such a timely topic. As Geertz (2002, p. 14) argued, 'interesting times' have become commonplace for anthropologists, something for past generations to envy rather than those in the present to disregard. Eventually, I switched my attention to the neighbouring (if not overarching) topic of mental health and psychological anthropology. Keeping in mind the importance of historical and current context (Hsu 1969), I first set out to read and write as much as I can on anything related to mental health, Malta and everything in between. In particular, how local newspapers portray the current state and developments in mental health.

With my supervisor's assistance and suggestion, I contacted the Rain organisation, one of the most prominent organisations in the field of mental health in Malta, asking if I could conduct fieldwork at one of its sites. Before doing so, I was under the expectation that the

best place to carry out fieldwork on mental health was Mount Carmel, Malta's mental hospital, but it proved difficult to access. After meeting formally with one of the Rain organisation's directors, I was put in contact with a manager of the hostel where I would end up doing my fieldwork. Before meeting her, I also completed a course in Mental Health First Aid provided by the same organisation.

With a few research questions in mind, but no definite theoretical expectations, I pinpointed my fieldsite. Despite the growing advantages of digital anthropology, netnography, (Underberg & Zorn 2013; Costello et al. 2017). I was relieved to have found a somewhat tangible fieldsite in a world increasingly slipping into Zoom calls, Facebook and the digital realm. Nonetheless, it felt very strange to travel such a short distance to where I would conduct my research. If there is such a thing as anthropology 'at home', I was, comparatively, doing it in my own bedroom. This has all sorts of advantages, especially in medical anthropology (Fainzang 2012), such as possessing Maltese as a first language, the depth of observations, and the ease of access to the field (Anderson 2021; Hayano 1979). Nevertheless I never knew how unhomely home can feel.

I had never noticed there were 'community care' hostels nearby, nor the fact that they even existed in Malta. I was a complete outsider to anything related to mental health. This distance can seem an obstruction to the ethnographic process, attracting assumptions and overestimating intimacy (Greenhouse 1985), but it may also be a crucial factor when analysing things holistically (Ellis et al. 2011). In hindsight, this was more advantageous, since it initially allowed me to work my way through as a complete stranger, to my informants and the field in itself. The only problem was the immense amount of literature to review and a lack of understanding of what the field entails and how best to navigate it. Despite this, no matter how strange the experience of dismantling what I felt was a town I knew well, I was determined to get as close as I could into this new 'layer' of Malta.

Due to pandemic lockdowns and restrictions, I had few opportunities to socialise. At that point in time my life was mostly taken up by travelling to and from university for lectures. The day I met the hostel manager was the first entry in my fieldwork diary, which reads:

> It's been a while since I talked for this long to a stranger. My social muscle is weak. It hurts to speak. I also never spoke about my project in Maltese. Trying to translate it *in situ* was harder than I could have anticipated. I think I sounded like a snob: switching from Maltese to English.

By January of 2021 I gained all necessary written permissions to study the hostel from my University and the Rain organisation. I had a fieldsite, all that was left was to start interacting with the people who live in the hostel, and gain their legal carer's consent aswell as their own.[16] This meant planning to understand both the social workers and the residents, and all the other roles on the fringes and in between. Although I initially set out to study the hostel and its staff only, I quickly realised it was possible to perceive the hostel as a client. Soon, I was allowed to follow up not only on introductions with social workers but also residents, made possible by the staff. This change did not come without methodological, if not also personal constraints.

Walking through the hostel for the first time, I didn't know what to make of it. I felt a measure of disgust, hygiene was not the best feature of the residents. Perhaps it was the normal sense (Maltese) people get when they walk into someone else's home. It was as if I was touching someone, and being touched at the same time; like entering an intimate space, experienced by all the senses. After the first few visits hygiene did not bother me. I even came to be impressed by the standards the social workers and the clients managed to keep.

The typical tools of the trade for the ethnographic method were out of the question, as was the case in other studies in similar settings (Newton et al. 2000). It was out of the question to take photos or document the place through film since anonymity had to be strictly adhered to (Lemelson & Tucker 2017). At the same time it did not make sense to film the residents in their own home. It is their personal space, they barely frequented anywhere more public. Likewise, the staff were in a workspace where photos were not allowed by their own regulations. I couldn't employ other, even more simple methods, such as long walks or 'drive and talk' (Drew et al. 2022) for the fact that the residents did not like to spend much time out of the hostel. For the exceptional social visits beyond the hostel, I managed to map, as part of 'spatial data' (Cromley 2012, pp. 120-199), places such as bars and park benches which the residents frequented.

My initial approach to 'spend time' with the residents failed because we did not share the same concept of time. There was nothing to 'spend it' on, no difference between 10 am and 2 pm. There was no activity at the hostel whatsoever besides smoking and small talk. The residents shift from room to room, idling the day away. They might do some chores,

[16] The latter did not occur to me immediately. It is, perhaps, just one of the many ways where I myself denied the client's any form of agency.

watch television, but very little else. The usual way anthropologists 'fit in' and conduct participant ethnography did not apply because there was nothing to join in on, or gain access to. In my view, initially, from the resident's perspective, existence is one long stare. It took me some time to realise that to understand mental illness there is nothing more to it than to simply accept being bored; in a very particular way. This entailed, as in Ben-Arl's (1995, p. 11) study, ample opportunity to speak and converse with my informants but very little else. Perhaps I thought illness was an exciting thing to study. In reality, it is a very sad sight to behold. If my perception of mental illness changed in some way throughout fieldwork, it is just that: that mental illness is nothing more than a debilitating condition. At least, the effects it engendered on the individual: the symptoms or the medicinal side effects one endures in prescriptions.

One way of remedying this problem and assisting the social workers was to come up with activities. I chose to adopt play and recreation as a method towards interlocution which, although seemingly trivial, can lead to many profound insights (Ferret 2021) and is increasingly a standard avenue for ethnographic research (Malaby 2009). I created appointments and invented 'times': a cooking session, a painting class or a snooker game. Doing so, I could find moments to explain my project more clearly and gain their interest in participating.

Initially, I thought about getting the residents to write, only to realise most were illiterate. However, painting and sketching sessions were well received. Richard, a long-term client, and I spent many hours drawing all kinds of birds which he gifted around the hostel. Another resident, Maurice, used to work as a stonemason so I loaded two slabs of limestone on my e-bike. A few days later he taught me how to sculpt a leaf. Little gestures like these do so much for the clients. However, the social workers are often understaffed and have no time to figure out and implement such activities. This is where I came to be most useful and helpful for the hostel.

For the rest, apart from a game of billiards, little else was achieved. Simply passing the day away was a task better tackled through sleep or daydreaming. Coupled with Covid restrictions and intensifying debates on vaccination (Borg 2021; Soler 2021; Times of Malta 2021), the residents had no choice but to learn and live somewhat confined to the hostel and their illnesses.

Despite the pandemic, I never felt at risk of contracting Covid-19. I only felt tremendous anxiety at the thought that I would not be able to do any fieldwork if another 'lockdown'

was announced. This happened soon after I started. I spent two months at home, between February and April 2021, reading around hostels, care, social work, psychological anthropology and everything in between. I also took time to expand on my reflective journal, and started practising a more 'analytic' auto-ethnography with my notes and feelings as objects of study (Anderson 2006). After which I returned with a renewed motivation to carry on with the project. Between October 2021 and January 2022 I had to shorten and reduce my visits, forcing me to 'patch' (Günel et al. 2020) several field notes and accounts together previously written as separate fragments.

Covid was not the only obstacle to surpass. Besides the dramatically shifting world that anthropologists heading into the field inevitably leave behind or encounter (Faubion & Marcus 2009; Johnson & Sargent 1990), 2021's summer was one of the hottest ever recorded on the island. The heat made residents much more lethargic. During the summer months, it was not uncommon for me to arrive at the hostel to find everyone asleep or unable to converse or interact at all. Besides beating the heat, when everyone got vaccinated, I opted not to. What seemed to be a personal choice had all sorts of implications for my fieldsite. Not because the hostel had any reservations about being unvaccinated (at least explicitly) but because I could not join in on the occasional social events such as going out to restaurants and going to the cinema with the few participating residents, all of which I was legally forbidden from attending. I adopted direct social distancing, always wore a mask and shortened my visits, spending time in whichever other way I could.

Initially, I shared Estroff's (1981) concerns about being perceived as a staff member barring me from the residents' world. Soon enough my expectations shifted drastically. It was much easier to speak with the residents than the social workers. It was quite easy to sit down and be bored with other residents, stare at a television or start a conversation about any topic. This was also worrying since it amplified the ethnographic 'melancholia', the ephemerality of fieldwork created among anthropologists and their interlocutors (High 2011). This was especially preoccupying since my interlocutors are understood to be vulnerable, often suffering from issues stemming from abandonment. In the end, as agreed with the hostel, I slowly reduced my visits, rather than ending them abruptly. However, I couldn't help getting attached and detached from the clients sporadically, especially as Covid restrictions waxed and waned.

In contrast, I had to schedule half an hour or so with the busy social and support workers in advance. However, they were all very helpful and answered my questions with alacrity

and honesty whenever they could. I owe some very deep insights to two very kind social workers whom I had the privilege of asking some exceptionally awkward questions to.

Through basic activities, conversations and some scheduled interviews I slowly learned what it means to live in and run a hostel. I would try and spend as much time with both social workers and clients, despite the fact that they occupied different spaces in the hostel. Although I maintained a regular schedule (as suggested by the staff) I tried to be flexible, following, as Cohen (2015, pp. 104-24) states, 'natural' flows and occurrences happening that day, week, or month. If the residents were particularly tired I would try to spend time with the more active ones. I would also conduct most visits in the afternoon when they were more relaxed and open to interact. Put simply, I tried, as much as possible, to study the hostel by dwelling in it as if I were a client or a student on placement[17], rather than strict formal interviews. However, attempts to join in on weekly staff meetings and client's errands simply failed. For the former due to confidentiality, and in the latter to prevent the clients from becoming dependent on me.

Despite this, I managed to spend ample time at the hostel and witnessed all sorts of scenarios. Within the first few months of fieldwork it was clear that I was producing an analysis of deinstitutionalization in Malta through the hostel as a key part of that process. I oriented myself towards trying to produce an account of the 'culture' at the hostel, as a fragment of mental healthcare in Malta. However, I did not want to over-generalise and solely drift into descriptive symbolic exploration, as the globalisation of the 'term' culture has often ended up in practice (Strathern 1995). As time went by, I practised both ends of the spectrum, trying to make sense of the hostel through formal categories but also open field notes and observations. Writing about the hostel, I utilised whichever model best represented my experience inhabiting it with the staff and clients, between established structures, semi-applicable theories, and ventures into the particular.

3.2 Compassionate Frustration

Four months in, as an anthropologist I was doing reasonably well, but not so much as an individual (to the extent that the two identities can be separated at all). Fieldwork was a

[17] This is a role within the hostel the clients are very familiar with. On rotation, every week a new student studying mental health nursing or social work would arrive. This is also why I was told by the social workers not to worry about the impact of my departure from the hostel, since the clients are used to seeing faces 'come and go'.

very slow, delicate and incredibly frustrating experience. I could not ask the residents directly about their illness and their experience as clients. It was not as if I was asking someone about his job or hobby, or anything one would be eager to speak about. I never prompted any conversation about mental health or their lived experience, constantly moving around the subject. In the end, the clients would usually start speaking of such things themselves. Looking back, I realise it was a form of catharsis for them. Explaining their gruelling journey from Mount Carmel to the Hostel was also a chance for them to put things into place. Narrating it to me could have helped them organise what always inches closer to a fragmented series of repressed memories.

The tediousness with which fieldwork proceeded also applies for the other aspect of the hostel: the staff. Due to Covid-19, only two staff members could work at a time. In the evening, just one. To speak to specific staff members I had to coordinate my visit with their shifts. Being a social or support worker is also an extremely busy job. Any sort of lengthy formal interview was out of the question, but I did manage to hold long open-ended conversations about the hostel with them on several occasions. Oftentimes, as in other studies (Salzmann‑Erikson 2018) 'focused ethnography', discussing or investigating one specific entity or occurrence at a time, helped contain the time-limit of such informal interviews and served as a starting point for my own ethnographic reflections.

However, on most occasions, I had to adapt and ask certain questions in passing or whenever the staff member had a few minutes to spare. Certain decisions and questions could only be followed through with the appropriate consent from a higher authority. I felt it was very important not to upset the emic structure of the facility. Any disturbance could be detrimental to the service and their clients, and in the medical world there are very few second chances. Most of the time I chose to observe and shadow the staff. Following them around, helping them do chores or simply sitting in the office I could witness several unfolding events.

I worried a lot about the clients, even though the staff specifically warned me not to do so. I could not get attached, I wasn't allowed to. But how could I not? I would see clients shuffle out of their rooms with their eyes glowing red, unable to get out of bed because of the medication's effects. I would listen to people explain their deep dissatisfaction with their current state; their failed hopes and dreams, their lost lovers, and estranged family members. Illness tore their lives apart and with every visit, I got to know just how much of them it shredded. How could I just forget what I witnessed? Somedays I did not go to

the hostel because I wasn't emotionally ready to receive another 'dose' of the resident's stories.

Oftentimes I would peddle back home on my bicycle and start reading any sort of explanation on schizophrenia, PTSD, depression, hallucinations, visions or anything related I could get my hands on. Medical and psychological anthropology does an excellent job of explaining how illness is understood and experienced around the world. However, in those moments, I needed a direct explanation as to its cause to complement its 'cultural' expression. If I studied what exactly depression is, I felt, I could come to terms with seeing someone suffer from it. One can easily find hundreds of articles explaining mental illness in terms of biochemical processes, but they weren't enough. Perhaps it felt too simple or too unfortunate that such an arbitrary illness should befall on so few people, I found myself attracted to psychoanalysis and its basics: transference, the unconscious and neglected utility of carefully analysing everyday speech.

Going into the study, mental health was a foreign field to me. However, as I started to read up on the subject, I went into fieldwork trying to withhold my doubts on psychology, psychotherapy and psychoanalysis. By the end of it I must have read more Freud than strictly Anthropology. In particular, the notions of 'drive' and the fundamental idea that 'The ego is not master in its own house' (1917/1955, pp. 135-44). This simple idea single handedly gave me some relief from the frustration of watching people pursue all sorts of self-destructive behaviour and seemingly irrational goals. Although it breathed some sense into my ethnographic experience, it was only the starting point of more anthropological questions, such as: how is the self understood to be ill and cured? What does the 'community' mean and how does it work with the 'hostel'? Why is it even called a 'hostel'?

Reading about how people studying medical, high stress, or professional environments ended up being quite helpful. Nevertheless, while doing so, I always kept in mind the hidden dangers of excessive involvement in ethnographic fieldwork (Trundle 2018). I got to know many things the social workers did (or could) not. For everyone's benefit, I shared information on their own clients with the staff when asked by the clients themselves; everything which the clients personally wanted me to bring up with the staff. If a client was feeling particularly low, if someone felt he was treated unfairly I communicated their state and resentment to the social workers. The latter could better address the situation.

Even listening attentively to what people had to share proved beneficial as a psychotherapeutic practice (Bosk 2003). I did not expect to find myself in such a position with social workers, but I certainly did. Staff members, by way of explaining the hostel, would also explain their worries. Demonstrating the hostel's approach would also prompt their opinion on it. It was an opportunity to express themselves to a total outsider without any repercussions. Asking about their views on things, they could quite adequately reply by venting. Besides enriching the ethnographic data, it was a very humanising turn of events. The social and support workers that seemed so contained in the beginning started to look more like flawed, all too human individuals.

Tracing the physical paths and spaces the clients take and use also opened up a discussion of the hostel beyond itself. As in other studies (Kidd et al. 2016; Knowles 2000), the facilities and services external to, but forming part of the fluid definition of 'community' in mental health were worth tracing and investigating. In retrospect it would seem that addiction in particular, although not ubiquitous within the hostel, left an indelible impression on me. This is partly due to the fact that two of the most impressive scenarios I witnessed involved severe cases of addiction. One resident was dragged across the street completely unconscious from alcohol intoxication. Another almost lost his leg due to his uncontrollable sugar intake. The latter lost so much sensation in his legs that flies nested in his living flesh. Inevitably but unbeknownst to me, such striking scenarios left their mark on my mind and writing. I felt deep compassion for the residents. Oftentimes the social workers themselves would ask me to stop asking so many questions about the sick clients; not because I wasn't allowed to, but to prevent my own attachment to them. At the hostel, there is such a thing as worrying too much about clients.

Compassion was oftentimes replaced with rage. It took some time to adjust myself to the fact that mental illness has seriously debilitating effects on the mind and body. What I mistook for laziness was an effort to remain awake. If a resident went to sleep in the middle of a conversation, later in the fieldwork, I would be surprised he wasn't sleeping before I even got there, as opposed to disappointed he had given up. It often felt like the residents went through their life as if they found a shortcut. As a student, working a part-time job and involved in multiple organisations, I saw these men before me as idle. I saw them as anathema to what I thought was the way life should be lived. The lack of effort to do anything with their time got under my skin. Although I came to adopt the social workers' long-term perspective and came to see how far they had come, I still cannot shake off the fact that they might do so much more with a bit of added help and some coercion.

One client, after 22 years at Mount Carmel and six years at the hostel, never learned to cut his own nails. Another client cannot stop drinking energy drinks despite being severely obese. The shop from where he buys his drinks is no more than 40 metres away from the hostel, literally the next street, and he still has them delivered to the door. Not only is he allowed to follow through with such a devastating habit but he doesn't even walk up to get his fix. As one social worker put it for the aforementioned client: "Kieku jistgħa qas jiċċaqlaq" (If he could, he wouldn't even move).Thinking about this and other cases from a long-term perspective, the clients had improved ten-fold relative to their previous state at Mount Carmel. The social workers explained how both clients just mentioned wouldn't even get out of bed before. In addition, the former would collapse at the thought of speaking to somebody, and the latter would consume copious amounts of alcohol. With this in mind, tolerating the nail-cutting situation, and the other's energy drink addiction seemed like a greatly improving case to manage.

And yet I always felt like someone needed to step in and be direct with them. Who are they to receive so much protection? I always thought that the residents have spent and will spend the great majority of their life travelling within the national health system: from hospital to mental hospital to hostel to nursing home. Like a conveyor belt, they will be passed onto the next stage of production; but each one failing to produce anything. At least now they have found themselves in the only egress from this system: the hostel. Yet, they still weren't appreciating the opportunity they found themselves in. What really frustrated me was the residents that wanted to remain clients. As if they never wanted to be 'healed', or refused to admit they were so. Of course, why would anyone want to declare his ability to do things by himself if that meant terminating assistance; the hostel's services?

Sometimes I would leave early because I simply couldn't take it anymore. It felt like betrayal when I tried to help someone with my utmost effort only for him to refuse all of it. In this context my journal fulfilled a particularly cathartic function as well as providing a space for me to process my own feeling during fieldwork. On one particularly frustrating day, my journal reads:

> "There's nothing to do here" says resident A. "There's always something to do" says resident B. A, the person I have been bugging for months to join in on activities, to play snooker with me, to let me teach him English, to write Maltese, to go for a walk, to join him the next time he decides to go to his favourite bar in

> Hamrun, says there is nothing to do. [...] something about what he said burst me at my very core. Could be countertransference on my end: as if to say here I am forced to grow up and you are here, with all these safety nets, too lazy and afraid to go one step further. Without any shame you take ten backwards to a mother's boy. Strike three and I'm out."

A few days later:

> "No description can do justice to the amount of frustration I am withholding. The residents find every excuse to lay in bed and do nothing. Admittedly, these are crude words to describe such a sensitive subject; but that is the fact of the matter. Doing nothing, having no form of responsibility or agency is their ideal goal. If it's too hot they will not go on with their plans - which is usually something as simple as a BBQ in the courtyard or another relaxing activity. How long can someone keep up the image of illness and tolerate a life spent in idleness? On top of which, they complain that nothing goes on in the hostel, and that such a boring environment is detrimental to their health. Oftentimes at the hostel I am about to explode."

This project required some sort of change within me, if not a reconstitution of what I felt was myself. Although I sometimes had to leave the hostel out of anger, after calming down I could almost always reason my way out. Perhaps residents had just gone through a prescription change or a family member had passed away. Maybe his depression was acting up, perhaps even suicidal thoughts. And yet I still have crumbs of intense frustration lying about my perspective of the hostel. I had to learn how to be incredibly patient. I also had to learn how to forgive, and more importantly, forget. I couldn't let my mind slip into the thought that I was dealing with a 'normal' individual. To further safeguard the anonymity of the vulnerable clients, some of the clients' accounts and statements have been grouped under one pseudonym. This also allows the reader to grasp the client's experiences through well representable yet specific characters, rather than a multitude of individual names.

Writing about my frustrations and obstacles got a clearer picture of their sources. As Frankenberg suggests, the temporality involved in writing up served as a '(temporary or permanent) dissolution of transference' (1989, p. 184). Besides exposing larger trends and theories implicit in my own and other's stories (Boyer et al. 2015), I unearthed

several assumptions and feelings I held and repressed. As noted by other anthropologists (Varley 2008) the most troubling parts of fieldwork turn out to be the most fruitful, at least towards making ethnographies more real and honest (Young, 1987). In particular, the anthropologist's emotions (Kleinman & Copp 1993; Allan & Arber 2018). Looking into my frustrations, and the often hidden qualms anthropologists have with their interlocutors (Graham 2022), I realised that I was trying to push people towards my own goals, my own ideal version of them rather than their own.

In my mind a 40-year-old man should have been thriving, or at least attempting to become independent. Seeing an adult man shy away from any sort of responsibility, preferring the sheltered life of the hostel, enraged me because it goes against my personal convictions of what life should be. I inevitably forgot to accept their current state 'as is'; as a valid way of existing. Perhaps the neo-liberal ethos of constant improvement, of never settling to become a 'better version of oneself' adopted a certain realism in my mind. Although the hostel was trying to change them, to make them independent, I still felt it should do more. Instead, I should have realised that both the residents and the staff were already doing their utmost in a different way. The hostel and its clients were not dysfunctional but, to an extent, fully functioning at its best possible ability.

This is not to say that mental illness makes people abnormal, in fact, I think the obverse is more true. I do not wish to romanticise schizophrenia, depression, anxiety disorder, or any other form of mental disorders. But neither do I want to place the people in which it manifests as victims. Appreciating the socio-cultural ways illness is understood was one way I was able to fall in love with my fieldsite. I learned to see how they saw their illness, how they suffered from it, and dealt with it through humour. Having lived the worst of it they practised a somewhat stoic attitude to life. The residents are quite selfless and will empathise with each other quite easily. They have no aspirations, no hidden agendas, no reason to belittle each other and every motivation to accept life as is, one day at a time. Living together in the present brought a lot of camaraderie among the clients and myself. For this reason, I felt welcome at the hostel. At the peak of my fieldwork, between June and October, I used to visit almost every day of the week.

There is a general tendency to treat individuals with a mental illness as if they are only suffering from it. Obviously, illness is a deep wound in their lives. However, this does not justify the excessive padding or perhaps buffering through which their social interactions occur. If you treat such individuals with excess caution, with deliberate distance and extraordinary warmth they will feel like victims. Throughout their life they have received

too much pity, they have no use for anymore. Within a certain limit (not mentioning certain traumas, not prompting any discussion about their illness, refraining from intense debate) one should not be afraid to speak and act honestly. This varies extensively from client to client. However, I think maintaining honesty could be a crucial key to the client's trust.

Stark (2006) asks, if illness becomes a way of being, doesn't curing it becomes 'cultural genocide'? I think a rejection of what the 'ideal' adult should be would have helped me understand the hostel better. Without knowing, I harboured a very definite understanding of what an individual, even if mentally ill, is. I hope that this section concerning my experience of the hostel will deconstruct any image of completeness the following text has or that its protagonists will portray. In other words, that it demystifies the positive agenda any thesis should have. Humanising my research, just as the hostel humanises its clients, is a critical agenda (Racine 2021).

Lastly, one should note that the hostel's residents were no strangers to research. Every few weeks I would see a mass of papers on one of the desks in the office about a study to be conducted at the hostel. Sometimes the residents would tell me that a student or researcher is coming to ask them questions. The topic of focus varies widely. Most of the time it concerns their experience of pharmaceutical side-effects. Other times it is a general study on unhealthy habits or individuals undergoing treatment, but also a few studies focused on deinstitutionalization and the experience of living in community care. This is also another reason why I discarded the use of interviews for the clients. I was already struggling to explain how my research was not about their illness or Mount Carmel but about their life. More so, I truly wonder what one can gather in a few interviews. I really question how much of the big picture the method captures: the total frustration verging on fatalism the social worker suffers from, or the client's seemingly never ending days.

I often wonder if the recommendations they come up with to better improve the mental healthcare systems are structural alterations or policy changes. I truly believe the core of the issues, the chronic lack of education and guidance among the clients, are left untouched. No matter how many policies and guidelines as possible, the residents will still have some disagreements, feel hopeless, lack direction and self-esteem. As time goes by the root of the problem seems to me more and more social, at least in origin. 11 un-educated, unsocialized men cannot be expected to suddenly function. The people that fell through the unequal cracks in society are scooped up by the mental health system and

labelled patients or clients. It is almost as if the hostel is some renewable energy plant: people fated to idleness turned into workers, from economic dependencies to minor assets: bio-power from social waste.

This ethnography is only an encounter between myself and the hostel, I am not just an author but, through unavoidable reflexivity, a protagonist. If there is one moment in which I felt I was actually getting somewhere, it was the realisation that the frustration and general confusion I felt at the hostel is ordinary and expected, when I became a participant in my own study. After all, understanding that one's dilemmas are likely meant to be experienced is one of the quintessential aspects of any ethnographic fieldwork (Murphy 1992, pp. 173-183).

One day, I opened up to a social worker about how tricky it was to feel compassion and frustration at once, my dilemmas, whether or not to pity or detach myself from the clients. She explained that it was a quite normal reaction to the hostel. The staff experience frustration out of compassion for their clients and encounter other emotional impasses daily. On a case-by-case basis, the staff react to such feelings accordingly. Much like anthropology and fieldwork (Pfeilstetter 2017), emotional dilemmas are indigenous to social work. Put simply, there is no general rule on how to react and feel for certain things nor how to 'process' them. The frustration engendered by the incoherency of the hostel, the peculiar conundrums it faces, and the emotional labour it requires to sustain it, was an emic feeling after all. The contradictions I felt was the hostel in and of itself. I can only hope that the reader will come to perceive his own reactions to the hostel in the same way.

Chapter 4: The Hospital and its Spectre

Independence is 'placed' upon the client, who is a client at all because he has managed to gain some independence at the hospital beforehand. New, modern facilities often cater to the less acute client with a higher potential (Barrett 1996), and the hostel is no exception. The client is re-allocated to the hostel because he has demonstrated the capacity to renew himself entirely.

Clients arrive from Mount Carmel or, as they themselves call it, 'the hospital'. In the hospital, if the risk of suicide is high, no shoelaces are allowed. No mobile phones or laptops are permitted or are restricted and the possibility of exiting the institution is far from likely. The client is then placed in the hostel where all of the above is quite normal and is only the very beginning of a list of freedoms granted to the client. This is often the hardest obstacle towards deinstitutionalization (Newton 2001). In contrast to the crumbling 19th century asylum, the client at the hostel suddenly finds himself in a new building infatuated with a heightened sense of freedom without a clue what to do with it.

4.1 The 'Independence Cure'

At the hostel the client has access to most things, including the freedom to purchase recreational drugs and alcohol. Although he is heavily discouraged, dissuaded and actively advised against such choices, he remains free to decide for himself. One such choice, smoking, is a liberty at the Hostel highly coveted by patients at Mount Carmel. It is one of the reasons why sometimes clients who went into voluntary admission to Mount Carmel from the hostel return after a few days. Likewise, the new resident will most likely take to smoking profusely to practice his newfound freedom. He might even venture to buy new shoes and clothes to mark his renewed identity. However, once he exercises all of his new liberties, locates his new coordinates of freedom, he is suddenly faced with an immense opening of possibilities and responsibilities[18], one which only he can guide himself through.

[18] Indeed, the residents genuinely miss the care-free environment of Mount Carmel, where their only concern was to make the days bearable through social interaction. As already mentioned, in comparison, the hostel is lonely and tiresome. Going back to the hospital appears much more feasible than starting life anew as a client.

Apart from encouraging freedom, emphasis is placed on the resident (and he is indeed expected) to find out his short and long-term ambitions: how he wants to spend the day and where he wants his life to go in a few years. Put simply, the resident is expected to act freely so long as he defines what he wants to do with his freedom. The slow development of direction and agency is one of the principal services offered at the hostel.

The staff is there to assist their clients to reach a level of independence where their assistance is no longer required. They have to help the residents to not need any help at all. When a resident explains this notion it is very clear: the staff is readily there to assist them, to help them do things they cannot do alone or until they can do so. The question is when to deem a task as worthy of help, temporarily requiring assistance, or reject a request which they see as originating in 'laziness'. In practice, it is much more difficult to find a boundary between the three categories.

In most cases the difference is obvious. If a new resident asks about the procedure regarding pill signatures, the weekly chores timetable, or access to the food cupboard he will immediately get help. When an individual has never used an ATM, a washing machine, or a cooker alone, someone will show him how, by doing the task with him step by step. Even if a long-term resident is asked to cook a laborious meal he will be assisted by a staff member or another resident. If any resident has gotten into a complicated social conundrum, a social worker will guide him through it.

Nonetheless, the residents cannot expect to ask for assistance indefinitely. There comes a point when the staff will simply ask the resident to recall what they had originally taught them to do. In a few cases, this approach does not apply. The duration of repeated assistance can be extended due to severe cognitive or long-term challenges. For example, one resident cannot read or write and finds it very hard to learn. After 6 years at the hostel, he still requires a staff member to write and fill in his paperwork for him. Were any other resident to ask for assistance in such a task he would surely be told that he is capable of doing it himself.

Unfortunately successes are rare. A few residents will try to avoid having to run their errands or do their chores at all costs. They will try to ask the social worker to put their beverage in the fridge, pick up their laundry from the courtyard, take their dirty dishes from their bedroom or fetch their mobile from another room. For the residents these are all huge victories if they can get someone to do it for them. One resident attests to his

'love affair' with laziness: "I love comfort"[19] Philip says with a cheeky smile after I reject his request to do some petty chore for him. He is particularly keen on avoiding as much discomfort as possible. Meanwhile, the staff encourages him to be less idle and more active, especially due to his severe obesity. However, his self-professed 'love' of comfort overrides him.

Cutting corners is a way of maintaining stability, avoiding confrontations and troubles which the residents might not be fit to deal with. However, depending on others can only mean swimming against the current as the hostel constantly pushes towards independence. The residents have to be accountable for their wrongdoings. They have to learn to fix their mistakes and handle their problems. The hostel is only a safe place where they can begin to live alone. This sense of independence, of being capable of doing everything as a single individual, instead of finding shortcuts through manipulation and coercion, is the epitome of the hostel's moral environment: living together, but not *with* each other.

On a passive and smaller scale, the residents do help one another, albeit subtly. Pointing out a shirt worn inside out or an unevenly shaved beard are common examples of minor and informal dependencies. However, it is certainly forbidden to assist further, even as a fellow resident or roommate. Small favours one would overlook in everyday life such as washing someone else's plate or buying some snacks for one another are frowned upon by the staff. Unless a charitable act without any expectations or returns the residents cannot 'do things' or purchase gifts for each other. Although this still occurs, they cannot offer a cigarette nor lend petty cash to other residents. This measure is partly enforced to prevent amassed debts and conflicts. But it also exists to get the clients closer to total independence, and ultimately resilience.

The same reasoning meticulously extends to simple events. If a resident drops his fork he is encouraged to pick it up himself. If he forgets to bring something from his room he does not ask someone else to fetch it for him. If he forgets his towel while in the shower he will walk to his room in his underpants rather than ask for someone to get one for him. The residents are as independent as possible, and the hostel nurtures its clients as individuals. They should and are mostly capable of living in complete isolation. Although the hostel is oriented towards re-integrating its clients towards the community and living with other residents, the individual is encouraged to sever all of his dependencies. In this sense, completely rejecting beneficial social relations precedes re-integrating into the

[19] "Inħobba l-kumdita."

community. The client has to demonstrate his independence from society to be deemed to fit inside it again. The hostel hopes that this results in a renewed sense of self.

It is often difficult to embrace the idea of constant self-improvement, a sharp contrast to the stasis of life at Mount Carmel. However, once embodied by the clients they begin to exude independence. They go the extra mile to take care of things themselves. They will openly state that they have things to do, chores to take care of, appointments to manage. The independent, responsible self allows deep changes in one's identity. These personal shifts and the social worker's guidance steer the client towards a healthy and fulfilling life; one with a severed, distinct temporality beyond that administered by institutions: a central tenet of community mental health (Floersch 2002). Beyond medicine, being independent is an additional prerequisite to being healthy. The embodied morality of independence is presented by the staff and initially understood by the clients as secondary; a superficial prescription. However, it is slowly accepted to be parallel with any medical cure.

Julian, one of the oldest residents, had a particularly sharp pain in his leg. Periodically losing his balance and unable to walk alone, I was asked to accompany him to the local clinic to get it checked. He limped down the stairs and started making his way there. Walking back, he felt particularly tired and stopped to rest several times. On the way, he told me how he ended up in the hostel, his family, his past occupations, his relation with other residents, etc.

Now and again he would start walking back stating that he doesn't want to waste my time. He consistently argued that I was probably busy, or that he was keeping me from going back home. In that situation I was, in retrospect, providing him much more attention and interest than he is accustomed to. Understandably, he felt overwhelmed. However, his utmost refusal to be assisted, even with something as basic as walking or engaging in idle conversation, was novel. He completely refused to be treated as if he needed care, rejecting long conversations out of self-inflicted guilt. After the visit, he prevented me from keeping a slower pace which would have been more comfortable for him. Julian almost feared to be in need of care. In fact, he tried to care for me instead by offering to buy me hot chocolate.

Similarly, other clients will reject help to dispel the image that they require assistance. Several clients would not ask for help directly, but minimal instructions. When the washing agent was lost, and a social worker offered to help look, several clients rejected

the offer and only asked her to remember where it was. On most occasions, Albert, one of the youngest clients, would cook for himself if he didn't feel like eating the communal meal, and so did other residents. Residents with jobs or considerable means would often offer single cigarettes to each other by way of expressing their financial independence.

The 'independence cure' is, over time, so accepted by the clients that dependence appears unhealthy. This is contrary to those that try to avoid as many responsibilities as possible, searching their social connections for any favours owed to them by others, or simply testing other residents for their philanthropic alacrity. The majority of the residents feel guilty if they are given too much attention or uncalled-for assistance. If their independent identity is tainted they start to feel a failure in their career as clients. For those that embody the hostel ethic, gaining unnecessary help or attention is a real moral crisis. Once accepted, being cared for feels like a retrogressive step towards illness.

4.2 Nostalgia and Trauma

Individuals requiring hospitalisation due to mental illness inevitably find themselves at Mount Carmel, there is no alternative. Consequently, the shared experience of Mount Carmel is an indelible aspect to any person suffering from acute mental illness in Malta. Being hospitalised, even if voluntarily, entails entry into the community of mutual suffering. Hence, being acutely mentally ill is synonymous with possessing an experience of Mount Carmel. Unfortunately, it also entails sharing the same experience of stigma and social abandonment; a ubiquitous fact noted in several studies of ex-asylum patients (Grob 1994; Saris 1996).

Residing at the hostel, the clients possess a collective memory and identity. They see themselves as a community sharing some form of mutuality. 'Living' at the hostel, they form part of an identifiable group of people. One which is distinct from yet overlapping with their previous membership in the patient population of Mount Carmel. No longer bound towards beds, they are now referred to as 'residents' or 'clients', but certainly not 'patients'. However, they are not simply adults. The hostel allows for this liminal identity between patient and individual, productive citizen: the 'client'.

Even as clients of the hostel, despite their new identities and 'independence cure', part of them remains a patient. Their past hospitalizations at Mount Carmel vary from one year

up to twenty, continuously or as several admissions. The majority have spent five years or more at the hospital. Only a few have been hospitalised for longer. All regard the hospital as a rupture, and all possess some form of trauma from their time spent at ‘Mount Carmel’, to different extents.

Trauma is here understood as a certain ‘ontological unhingement’ (Lester 2013), a wound opened in the fabric of cultural existence itself. It is a decisive and unprecedented break in the way one understands his environment, himself and any relationship between them. The hospital was a time and experience in which their constitution of self and the world were violently shifted or transformed. Before becoming clients and residents, they first had to become patients with all the inherent emotional wounds.

Their time (or lack of time) at Mount Carmel is manifest in their behaviour at, and conception of the hostel. The ex-long-term patients pace around the hostel or spend most of the time seated. They are the quietest and most idle. This might also be attributed to their older age which is, on average, well into the 40s. They adhere to routine and follow all the required guidelines. When a new task or an alternative method is presented to them they might say ‘that’s not how we used to do it at Mount Carmel’. In other situations, such as when presented with a good meal they will state to each other non-specifically ‘this is much better than Mount Carmel’. Such situations usually spark a trip through their collective memory of their experiences at the hospital. Most of the time, a few residents get visibly upset and the conversation is directed elsewhere.

The hospital is a distinctive mark in every client’s temporal constitution of himself. In most cases, he can tell you the time and day he was first hospitalised. Likewise, the time and day he was accepted into the hostel. Entering and exiting Mount Carmel inaugurates the beginning and end of an era in the client’s life. It is when he was most sick, when his life was radically transformed and took a different trajectory, and perhaps even adopted a different temporality. The hospital is often a painful turn of events; a stain in the client’s story of himself.

This is not to say that the hostel is always a positive exit from the hospital. The comfort some residents find in the hostel others experience as pain. Parr (2011) notes how people with mental health problems often re-interpret social spaces to make them familiar. For the many who embrace the hostel as their only alternative, it is experienced as a set of discrete spaces. Such residents do not inhabit a coherent and total location but a series of unique spaces like the courtyard and living room under the collective title of 'hostel'.

Maurice attributed this conduct to long-term institutionalisation as if passing from one ward to another. The mental map of Mount Carmel, where patients inhabit and pace around different wards and wings to meet all sorts of individuals throughout the day, is projected onto the hostel. Thus the clients may act like patients and spend their day pacing from room to room as if from one section of Mount Carmel to the other. Walking into a room is akin to entering a new space so they exchange greetings. While strict routines and rituals have been strongly attributed to 'home-making' (Vaness 1993), for the briefly institutionalised residents, this conduct is only tolerable. On some occasions, Maurice would express (in an outburst) how sick and tired he was of feeling forced to exchange hello and goodbye throughout the day to another resident whom he lives with.

Other residents express the spectre of Mount Carmel haunting their life at the hostel through varying expressions. Mattheus, 41, stated that "This is a hospital environment. Nobody talks to each other, nobody does anything". When questioned further on the meaning of his statement he says "because nobody here has a life, no gumption ('ħeġġa') or motivation". Certain residents live highly scheduled lives that barely differ day after day. For the others that constantly seek to learn new things, alter their position and social networks, the more regimented residents' indifference is almost offensive. As co-residents, the latter find the former interesting and essential to their entertainment. They are usually the ones sharing new songs, information, and news and weather reports. But they, in turn, find the more 'stagnant' residents boring and 'unhealthy'.

Their experience at the hospital is also reflected in their social networks, which mostly comprise of patients and ex-patients. At the hostel, they speak of mutual friends or even family members of other residents whom they knew at Mount Carmel. To a limited degree, they still have some contact with them. As ex-patients, the residents are interested in any news about their friends back at the hospital and those discharged from it. When the news bulletin appears on television however all the residents unanimously reject it and the channel is switched immediately. Politics, economic developments, and other information are deemed irrelevant and unimportant. However, updated information about

Mount Carmel, their friends, some well-known doctors,[20] staff members, and developments in the local mental health sector are followed avidly when available.

The residents at the hostel, along with the patients at Mount Carmel, form a clearly defined and contained universe of meaning. What goes on beyond it is of no use for them to know. Only that which can impact and help those who share the mutuality of mental illness is worthwhile investing their time in understanding.

Although the clients did not possess any predisposition to seek exits from their world, as Scheper-Hughes (1979) suggests in her study of mental health institutions in rural Ireland, once they enter the system they do find another world to enter or, perhaps, involuntarily be admitted into. The hospital becomes a community of permanent members. When residents return from their appointments at Mount Carmel, they are questioned on the current state of the hospital and its patients. Sometimes, especially if transferred from another hostel, the residents would have already met before at the hospital, or at least know who the new resident is. When two female clients were temporarily relocated to the hostel due to Covid, one of them was well acquainted with a resident's mother. Being hospitalised together for a while they enjoyed a very close friendship.

So contained yet large is the world of Mount Carmel that some residents still rely on the hospital to make friends and even find love. This is partly because it is where they have spent or are still spending a significant amount of time. They socialise with patients and meet new people during their psychiatric appointments or short-term relapses. In comparison, the hostel can seem socially bereft of new individuals to interact with. To a considerable extent, they look forward to getting in touch with their old friends during their visits to Mount Carmel. More so, since they are most comfortable getting to know people with the same conditions: someone who perfectly understands what they are going through without judgement.

[20] In most cases well known doctors are also public figures in Malta. It engenders all sorts of questions such as the boundary between a private professional and a public intellectual (Chua, 2013). One resident was an avid follower of a popular staff member in Mount Carmel whose patients extended their clinical trust onto his political and social opinions beyond mental health such as immigration and social equality, on which he openly wrote and spoke about via social media. Likewise, other doctors lose their trust with the same patients because of their lack of professionalism or opinions beyond their expertise. For both client and psychiatrist, any opinion on mental health is synonymous with a particular understanding, positive or negative, of sucide rates, poverty and a pervasive sense of boredom; often falling under the pharmakon and cliche title of the 'modern condition'.

Nevertheless, other residents have far less positive or even ambivalent relations with Mount Carmel. In the past, they found no community within it, no network of mutually suffering friends but total deprivation. For two clients, Mount Carmel was an unnecessary detour in their life which, unfortunately, altered their entire plan. Some residents state to have only been hospitalised due to neglect or pressure from their families, as is often reported to occur (Galea 2021). Albert, 28, was constantly relapsing and re-admitted to the hospital. With nowhere else to go he was initially institutionalised for three years with short-term hospitalizations ever since. The thought of returning to Mount Carmel, even for a visit, is unbearable to him.

Maurice constantly shared his disdain for Mount Carmel but could not tolerate life at the hostel either. To escape its ‘boring’ environment he accepted a voluntary admission at Mater Dei (the national hospital) for an unrelated condition. He was offered a discharge with a visit every morning for a check-up. However, he opted to stay at the hospital to escape from the hostel, at least for a few days.

Mount Carmel constantly looms above the residents whenever they think about their trajectories in life. They have come a long way since their first admission to the hospital. Their condition and residence at the hostel is a major improvement in their lives, one which has brought back some form of ‘comfort’. More so, they feel they have reached a ‘peak’ in their careers as people suffering from mental illness, something which Estroff (1985) refers to as ‘making it crazy’ for her interlocutors: the best possible scenario shared by those who are ill.

However, the clients sometimes suddenly reject their current state and direction. When the idea of the hostel as their permanent residence, as their only home for life, loses its appeal and collapses, they find themselves standing in an abyss: no family left, capable, or willing to care for them directly. No money to purchase or rent a property but more than enough to live comfortably yet reluctantly at the hostel.

Despite the initial attractiveness of the hostel, it falls short of being a 'complete home’. As Albert puts it: “I have to get my life together, then I can start thinking of leaving this place”. Arriving as a patient at the hostel is initially a massive leap in one’s career as an ill individual. The new client has some personal space, and has a select group of people he can form long-standing relations with; both of which are difficult to access at Mount Carmel. However, once one “gets his life together”, the hostel suddenly loses its ‘charm’. If a client starts to make friends outside of the hostel and holds a stable job, the hostel

suddenly appears crowded. It becomes an infringement of his new or newly desired life. In other words, it becomes home to an outdated rendition of himself. That which was a newfound location of certainty becomes deeply ‘un-homely’ (Strava 2017).

However, for some, leaving the hostel can even be equated with returning to the hospital. When the residents reflect on their life amidst most idle days, returning to Mount Carmel can sometimes feel a progressive step. At the hostel, they have to pay for their rooms and services. They have to wash their clothes, cook their food, and care for themselves. Their status as patients in the hospital, at the very least, rid them of these responsibilities. Exchanging their heightened independence for a bed and medical supervision can appear alluring at times. The ‘independent’, ever-progressing, improving self the hostel nurtures seems immensely difficult to uphold next to the convenience of being hospitalised. In fact, some clients are quite candid about their wish to spend their days as they used to in Mount Carmel, socialising and lounging around without any obligations.

Along with the commitments entailed in independent adulthood present outside the hospital, there is also the heightened possibility of quarrels with a fellow resident or, much rarer, a staff member. Hospitalisation can sometimes feel like an escape, and there are moments when the residents might ponder their return to Mount Carmel quite seriously. On almost all occasions this wish is actively deflected by the staff members, or ultimately discarded by the residents themselves. The clients can think through their request, oftentimes being encouraged to replace it for the hostel’s advice: to exit the hostel through independence rather than total dependence on the hospital. On other occasions, hospitalisation can be averted by managing to spend some time away from the hostel. Perhaps, a few days spent back at their childhood home or as little as a few hours waiting for a very late bus.

In some cases, even after several attempts and opportunities to quell such a desire, there remains the will to be hospitalised. On one occasion, Maurice, without a car or any means of transport, called an ambulance to the hostel in order to circumvent the hostel’s decision that such a service is not required, superseded by the medical institution. Such persistence can be attributed to a yearning for the total care available at the institution and the hospital. Perhaps, mostly out of tiredness and self-attested unwillingness to become an independent individual, Mount Carmel retains its allure.

Beyond a yearning for the perks of being a patient, other reasons are often undeclared by the residents and only speculated by social workers. Despite their traumas, their

uncomfortably shared memories of neglect, and lack of hygiene, the hospital is still present when considering their future. Especially when the hostel and its intentions become all too demanding, Mount Carmel is still considered to be a viable place to live, which is almost what the hostel wants itself to be.

The hostel constantly promotes itself as a wholly positive alternative to Mount Carmel, albeit sharing, to a certain extent, the same goals; they both want and manage to provide some form of 'cure'. Where the hospital can be seen as a medical, total institution (Goffman 1961), the hostel positions itself as the necessary alternative to a failed system. It offers a small-scale, holistic 'cure': helping the client towards dignity and independence as the only true and long-term medicament. For this reason, it always upholds a symbolically complementary identity to the hospital. The hostel exists because the hospital does.

Although almost absent in the client's life, the hospital remains present as a traumatising temporal marker and a gauge to one's progress with illness, but also a source of nostalgic reverie. The hostel is, for the clients, both a right step and the wrong direction. It is an ideal future compared to the hospital, but also a somewhat retrogressive period in relation to childhood and the comforts of being a patient. Likewise, the concept of it being the client's new residence and home is at once ideal and devastating. The hostel is suspended between such contradictions.

4.3 A Temporary Home?

Travelling through the island one can find all sorts of homes. The older ones are made of firmly placed limestone. Although more recently, besides concrete, homes are smaller and compact, with different features and layouts, the extent to which the meaning of this space has changed is debatable. For the hostel, the clients, and staff, home is a permanent residence. However, the client may have or have had several homes throughout his life; it is not singular nor final. Home is always being reaffirmed; not given but made.

On their arrival, the clients receive a bed within a room and they are instructed to 'make it their home'. They are encouraged to decorate their private spaces to their liking. The social workers actively discourage the lingering feeling that they have only been 'lent' a

home; that they are only temporarily possessing it and are, as Miller (2011) notes, ‘possessed by its demands’. With consent from all, even the common areas are ideally touched and marked by the resident’s creativity. Drawings, information, pictures, and books adorn the walls. Fragments of the self, their memories, and possessions scattered across the hostel make space ‘home’ (Hecht 2011). This is explicitly encouraged by the hostel. Unlike other community-care centres that come to rest on metaphors only resembling home (Larsen & Topor 2017) the hostel is a building inhabited by residents that produce its spaces, that explicitly call it home.

Figure 3. Sketch of a buzzard by Richard.

At the same time, the clients are not allowed to create mutual possessions, they cannot share items. They are encouraged to make the hostel a home in their own individualised way. Although they are allowed to stay as long as they wish, as with any hostel, their residency is officially known to be definite. More so, the clients are only expected to make the hostel home to find another, more suitable and permanent home. How can the hostel become a home while still functioning as a hostel? Permanent, but also fleeting?

Anthropologists have shown how home is not necessarily a building or even a static idea. Home could be a practice, routine, or dream, often expressed in one's environment with

other beings (Ingold 1995). It is bound into ideas of past, present, and future, with one's identity, and sexuality thrown in the middle (Fahrahani 2015; Pilkey et al. 2015). At the hostel, the gap between moving in and finding the 'real' home is always widened. The hostel is at once accepted as a 'final' and temporary home.

For the younger and frequently relapsing residents, the hostel is a transitional home. Their idea of 'settling down' lies beyond the hostel. They expect to exit the hostel and leave their illnesses behind someday. This is also true for clients returning from a brief re-hospitalization or appointment at Mount Carmel; the residents return with a renewed sense of doing something about their situation. They acquire a minimal sense of alacrity towards taking certain risks and adjusting their current state of affairs. They apply for jobs, quit (or try to reduce) certain addictions or habits, and begin to ponder their escape from the mental health system in its entirety. For these particular residents, the hostel is nothing but a stepping stone leading them to another, hopefully better life.

The hostel's turn towards a transitional phase is not immediate. One particularly quiet resident was never open to chatting, nor did he have any plans for his future or ongoing events in his life to speak of. In retrospect, I watched Albert dwindle into a violent relapse. He had recently been hospitalised for a few weeks at Mount Carmel before returning to the hostel. A few weeks later, clean, well dressed, and sipping coffee outside he suddenly asked me to help him find a restaurant where he could send his resume. He also shared his interest in black holes, white dwarfs, and astronomy with me. "I need to look into this," he says as a staff member locks the courtyard for the night behind us, realising we had spent a few hours in conversation about his newfound interest. "But I need to take a break first. All my life I've been in noise. Now it's time to spend some time in silence". He expresses his wish for some semblance of predictability and consistency. His recurrent relapses, and failed attempts at social and economic opportunities, are all "noise" ("storbju"), he explains. However, having spent three years at Mount Carmel this particular resident did not see the hostel as a long-term alternative. The hostel is only the 'least annoying noise'. Nonetheless, an impediment to the peace he seeks. For this resident and the few others of his age, the hostel is only one part of their life.

This is in stark contrast to the residents that view the hostel as their permanent home. For them, the hostel is the end of a series of unfortunate residences. Such a view is likely to be accompanied by disdain for their childhood home and locality. One resident sees the hostel as his new and better home. He abhors the thought of returning to his original residence in the South of Malta. In comparison with their previous residences and their

hospitalisation at Mount Carmel, the hostel is the most stable and safe environment they ever lived in and they would like to keep living in. The residents will sometimes express their negative trajectories in life: how they and their family members were bullied and how they were insulted or taken advantage of by their neighbours. “Now I am here,” says Philip as a concluding remark to such mnemonic tours. For him, the hostel is a resting place preventing him from the troublesome environment of Mount Carmel and his childhood home.

4.4 Leaving Home to Find a Home

The option to live in a shared flat has been offered to a selection of residents. They are the ones that have achieved the necessary criteria for independent living (maintain a healthy diet, hygiene levels, economic independence, etc.). For such residents, the hostel is a plateau of stability. Consequently, moving out for them is a retrogression. Living within it, residents strike a balance between independence and safety. Some clients have family members pass by before they go to work. The clients state that their families feel they found a place to stay, a valid form of household, rather than a temporary arrangement. All the while, in certain tasks or at their discretion assistance is available. Help is readily available for such things as going to the bank, negotiating prescriptions, keeping in touch with family members, not to mention the encompassing emotional and moral support the hostel provides its residents.

Financially, for the client the hostel is a cost-efficient alternative to independence; meals are prepared in turn, ingredients pre-purchased, and amenities bills paid for by the hostel. The residents pay a low nominal fee every month to live in the hostel and have access to its support services. Instead of cooking and cleaning every day they only have to be responsible for such chores once or twice a week, although for the whole hostel. Embracing the liminality of being a ‘client’ entails all the benefits of living in the hostel along with the independence it allows.

What is the alternative? Living in a shared flat, also administered by the Rain organisation, the residents would be detached from most of their troublesome yet ever-relatable co-residents. They would still be clients to the foundation, they would still receive the necessary care for their condition but missing all the camaraderie of the

hostel. Beyond friendship, the clients have a shared experience of suffering. Despite the hostel's protection, they are inevitably exposed to all forms of stigma and abuse. This is the crucial point differentiating any relationship from mere friendship: the feeling that one is part of something bigger, collective as opposed to in it with someone else. Engaged in such selfless, uncontrollable pain, the residents 'seek to lose their identity' in their relationships (Hedges, 2002). At the hostel, illness does not make them unique. However, by staying at the hostel and creating an alternative and authentic life for themselves, their choice to submit to the hostel could itself be a way of separating themselves from the crowd (Chapman, et al. 2002).

Even after clients move into a shared flat they occasionally visit their old hostel to enjoy the company of their ex-housemates. The hostel retains the treasured quality of being the place where they are completely accepted despite their conditions. The clients and ex-clients converse about their lives, how they've been getting on with the drastic shift from assisted to independent living. However, as time goes by, the 'mutuality of being' (Sahlins 2013) the clients have as residents diverges from that of the clients in private flats; their shared experience of living with a mental illness takes separate paths. The resident in the hostel has no change to speak of, only the stasis and minute, usually negative, occurrences at the hostel. On the other hand, the client living in the flat has been forced to take all sorts of risks in terms of trying new things, adjusting to his job, meeting new people, and experiencing heightened independence: he enjoys the good and bad dimensions of risk. As time goes by, visits to the hostel become less frequent for the flat-client as his ex-co-residents seem more and more distant from his new life.

For all clients, for good or for worse, the hostel is their home. It is where they feel 'at home' with themselves in the present, somewhat comfortable in their current way of being, be it temporarily or permanently. Moving out of the hostel is synonymous with a profound change in oneself. The ambition to move out of the hostel is always accompanied by the motivation to be radically altered; the latter preceding the idea of exiting the hostel. For the residents that wish to remain at the hostel, they have no aspirations to alter themselves, at least not in any radical way. He is accepted as a client, as an ill individual in need of minimal care. There is no commitment to change, just as there is no pressure to leave the hostel. It is a home, and one can be himself at home.

By slowly motivating the client towards independence, he begins to recognize the need to do things himself and to take care of his problems alone. When the client starts to feel a stranger to himself he begins to see his 'home' as a 'hostel'. When the client starts to feel

that he is no longer a client, the hostel becomes an alienating experience. Consequently, looking for a new residence, he begins to see his new flat or house as a space compatible with his newly independent identity.

Paradoxically, the clients very rarely want to take the final leap into total change and move out of the hostel into an 'independent life'. For them and the staff, the epitome of independence would be to move out of the hostel. One can never become the new and ideal independent self inside the hostel. By being there, by calling it a home, one remains a client. And yet, very few want things otherwise.

"Let's be honest Nikolai," Judith told me while we were discussing one particular case, "it is in their [the client's] interest to remain at the hostel". She explained that here, at the hostel, they always have someone ready to assist them, ready to guide them through their difficulties. Despite the hostel's explicit denial of attachment, the client's hostel is full of deep-seated bonds between clients and social workers. For the client, the hostel is the only place he could converse with a friend, and even a member of the opposite sex about his deepest most awkward problems[21]. Growing alongside the social workers, through thick and thin, the highs and lows, the clients cannot help but feel themselves emotionally invested in the hostel and its staff and residents. Leaving it feels like a step back towards the instability they left behind at the hospital, their childhood home, or in their married life.

However, staying at the hostel still represents certain notions of 'return' to their life before Mount Carmel. As Bachelard perfectly put it, 'our house is [...] our first universe' (2014, p. 38). Here, they have 'returned' to their days before Mount Carmel. Here, they eat hot, tasty meals prepared by a familiar face. Here, at home, there is always a female figure caring for them, ensuring their safety, providing advice and support. Like any home, it is the place where one can be 'himself', at least one of the more predictable versions. The client feels that he can invest himself into some form of stable identity for the first time since he was hospitalised. The hostel represents the first residence the clients have been able to call home since their childhood, unless that too was impossible.

[21]A few times the staff had to hold special meetings on masturbation. Judith explains how she is well aware that her clients are single men with certain sexual tensions. The hostel has no explicit rules for masturbation, so it bundles it alongside those for other bodily and hygienic needs. Judith recounts how she had to clearly explain that masturbation should only occur in the bathroom, alongside other 'sanitary duties'. Like excretion, masturbation is presented to them as a natural discharge they must take care of, hence in the same place where other discharges are handled. Judith is also frank about how strange it feels as a woman to explain how to manage one's sexual urges to older men. However, she is adamant that someone has to 'explain in simple terms', clearly and bluntly, where and how to masturbate without obfuscating it behind polite and over-technical language.

In this sense, it represents a return. As Richard puts it: “after my mother’s home, I feel most comfortable at the hostel”.

Fitting into the hostel the client already accomplishes a great feat. He has radically altered himself. Oftentimes beyond anyone’s expectations, including his own. Despite this, when the client has settled into the hostel the social workers must begin constructing his egress from it. At the zenith of the client’s recovery (up until that point) he is asked to take another leap into yet another home. Instead of perceiving it as a further opportunity for change and autonomy, as noted in other studies of community care (Duyvendak 2011, p. 68), it is more commonly seen as a possible downfall. For the clients, it seems an additional step beyond the hostel, beyond the care they were promised. Coming from Mount Carmel, moving into the hostel was the original radical change the hostel intended for them to do in the present. Consequently, yet another relocation amounts to asking a settled individual to become unsettled again. The client would rather sacrifice his potential for further independence and change for life at the hostel than risk it all again.

Presented with an obstinate client, the social workers must decide what their reaction should be. They hold meetings and discuss the best way to persuade their client towards total independence outside the hostel. More often than not, keeping him outside of the hospital remains their priority. The client’s rejection of a flat or any other arrangement for independent living can only be accepted. As consumers, the clients have a right to choose the hostel’s services. It can only terminate when they want it to.

Far from being a routine problem the recurring negation of independent life is a constant conundrum for the social workers. It is the final step in the hostel’s plan, the keystone in the hostel’s masonry that is seldom placed. Leaving the hostel towards an independent life, the hostel completes itself as a project of deinstitutionalisation. If the clients reject this final step, the hostel’s transformative promise and its entire identity as a temporary institution is challenged.

If the clients do not move on from the hostel, even after long-term care, the hostel becomes yet another appendix to the mental health system. One in which people enter but never get out of. Perhaps only finally ‘exiting’ when one is eligible for a transfer into a neighbouring closed system: nursing homes. The hostel must (but constantly fails to make explicit) produce independent individuals to exist as a hostel at all.

The staff, the hostel, orients itself as the opposite of the hospital. It aims to provide a fresh start for the clients, a new chance at ‘independent life’. Opposed to Mount Carmel, it sees itself as, and most of its clients understand it to be, a progressive, better version of mental healthcare in Malta. While the hostel wants itself to be an alternative to the hospital, it also wants to be something completely different and separate. Unlike its clients, the hostel does not only see itself as whatever is missing in Mount Carmel but also constantly attempts to be a radical departure from the hospital. The hostel is intended to be a total replacement of the way mental health and being cured is understood. It wants to eliminate unnecessary long-term stays, over-medicalization, bureaucratic administration, and social neglect, replacing all with ‘independence’ and ‘resilience’. Despite this, it is still understood to be an alternative to the hospital, and sometimes even just a smaller, cleaner hospital or home for the clients. But the hostel doesn’t want to be a ‘home’, it wants to be an interim home.

Chapter 5: The Hostel and ~~The~~ Hostel

Deciphering ontological differences in medical anthropology seems to be, almost, the standard approach (Barg et al. 2014, pp. 177-80.). It is relatively easy to find unique details in what should be-or is at least presented to be-a unified and closed system as 'healthcare' presents itself to be[22]. For the hostel, this is no different. In fact, it utilises this universal ambiguity, between established and still becoming systems, for its own purposes.

In effect, this transforms the study between a somewhat structuralist analysis and, what Biehl and Locke refer to as the 'geography of becoming' (2017, p. 12). We will look into the many facets the hostel uses to identify and constitute itself in its world; from formal definitions to identities in practice.

I must state that utilising the barred 'the' to imply the hostel as a multitude of varying and incomplete interpretations is directly inspired from Jacques Lacan's writings. To understand the ways in which the hostel existed but not necessarily experienced as category I found Lacan's use of bar in the subject, the Other (Lacan 2007) and feminine *jouissance* in his Seminar XX (Lacan et al. 1999; Barnard & Fink 2002) a conceptual rock to hold onto. Similarly but unrelatedly, the hostel can and cannot be constituted as oppositely related to anything else; is defined but also undefined in other ways. Building on this use of the barred 'the', in the following chapter, we will look at what the hostel presents itself to be and what it wants itself to become, or have been.

5.1 What is the hostel?

Since the hostel is not a hostel in the colloquial sense, a residence that provides affordable lodging for travellers, we must first outline the definition of the hostel from within the field site itself. Why is it called a hostel in the first place? Is it meant to be the

[22] In medical anthropology many authors have compared medicine and illness across and within cultures (Berg & Mol et al. 1998; Lewis 2021; Young 1982), even though the extent that this is even possible is debatable (Candea 2018).

opposite of something else? Perhaps, a reaction to an established system? Is it a mere question of marketability; constructing a more professional face? Is it meant to reduce the stigma for patients or to provide a completely different understanding of care? Does it have to do with the fact that it treats clients as opposed to patients? Why do we need hostels?

As discussed, the hostel exists within the larger national mental health system. It is not a standalone service. In addition, it forms part of a network of similar hostels managed by a foundation. As an organisation it works closely with the mental hospital and receives funding from the Maltese government to provide mental health services; most prominently, its hostels.

Conceptually, they are closely related to the idea and practice of half-way houses. In Malta, in recent years, this translates to a building within the exterior grounds of Mount Carmel hospital. It is a separate building housing the less acute patients. Once admitted to a half-way house, patients are gradually treated as residents. This means that they are taught how to clean clothes, cook, and care for themselves as opposed to being completely cared for. As opposed to incapacitated patients in need of total care they transition into partially independent adults, and discharge from the half-way house entails possessing the possibility to become fully independent. They must demonstrate the capacity to not need any sort of service in the near or distant future. Much like half-way houses, the foundation's hostels are designed to be a transitory stage, a social buffer, between the mental hospital and independent life. Why are hostels not considered half-way houses then?

Presented as a service, it cannot possibly accommodate patients, or recovering patients. It is only intended to cater for clients: individuals with the capacity to desire the hostel themselves. They are, of course, referred to the hostel by their doctors at Mount Carmel. But the decision to move into one of the foundation's hostels should be entirely their own, a choice made by an independent individual. He does not move into the hostel to gain independence, like a half-way house. He already possesses, at least part of it, by being offered a place in a hostel. The initial perception is captured by an article on Times of Malta describing the new hostels:

> The hostels are different from half-way houses or rehabilitation facilities as residents will not follow a programme, although a rehabilitative environment will still be maintained. Staff will provide psychological and psychiatric help as well as

> support with daily living skills. Also, the hostels could end up becoming the residents' permanent home while other facilities are only temporary abodes. (Times of Malta 2006)

Every room is a collection of distinct beds, the cupboards a series of individual storage spaces. The hostel itself is shared but used individually. Like a hotel, one can stay as long as one pays for his room and obeys the rules. Unlike a hotel, ‘hostel’ implies a certain sense of hospitality. One cannot simply request to live there but can only arrive upon invitation. The residents did not show up at the door and ask for a bed, nor book a room online; they certainly don't see themselves as living in a hotel either. At the same time, the choice to stay there is not entirely their own, and they do perceive the hostel as a service since their stay is against payment. The hostel is much more, but also exactly that.

The hostel is, oftentimes, the client’s new home. However, they are selected through a clinical process, a waiting list, and the hostel's final consent. They become residents and clients because they truly need it, not because they would like it. One does not request help dealing with schizophrenia whenever it is convenient (although he certainly can do so). By signing into the hostel, the staff will actively provide their services. They will schedule one-to-one meetings, offer assistance whenever they themselves feel necessary. Without being asked, they constantly care for their clients, to an extent; always ensuring their safety, health and happiness.

When a new client arrives at the hostel, he is explicitly told that this is now his home. Although it would further distance the hostel from Mount Carmel, and place adequate emphasis on the duty to care, ‘home’ does not reflect its liminality. There are no deadlines for him to get better. He is informed that this is his new residence from which he can start his journey to total independence, and the client may or may not include the hostel in this endeavour. Whatever the case he certainly cannot be kicked out unless he breaks any rules. He is, essentially, given a residence.

The hostel’s crucial aim, to offer the capacity to transform dependent patients into independent individuals is presented as a by-product. Utilising the term ‘Hostel’, the foundation can present the programme and building as a permanent residence. Albeit, one in which people live in temporary conditions.

‘Hostel’, is the closest term one can use to describe what it actually is. Much like its etymological origins from the word ‘hospital’, it is a place where people can find refuge

from a ‘host’. However, unlike the more common definition of hostel, it is fundamentally oriented towards the long-term care of individuals suffering from mental illnesses. Thus, it returns to its 14/15th century roots as a charitable lodging for the sick and ill.

It does not exist solely to provide shelter. There is more to the hostel. It has an office and a dedicated team of social workers tasked with supporting its clients. Its location is not arbitrary, selected to be as close to its local community as possible; offering ‘community’ itself as part of its services and ‘treatment’. Unlike a hostel, it is not a profit-oriented establishment. The residents pay a very small fee to live there which only partly covers the monthly expenditure. If anything, fees are put in place to encourage attaining a job and independent income, as part of the greater moral project beyond living at the hostel itself.

Put simply, the best way to describe the hostel would be that it is not an asylum or a hospital, not a half-way house, not a care centre, a nursing home or a hostel. It is something beyond its title, that is not reducible to any replicable or identifiable structure. Even among the local network of hostels, the client and social worker experience, there are radical differences, conceptually, operationally and in everyday experience. ‘Hostel’ does not adequately describe the fieldsite. Even if client and social workers' understandings overlap, there is never a complete consensus over what the hostel means. Every hostel is something beyond and less than itself. There is no one hostel, no such thing as *the* hostel.

5.2 Where is the Hostel?

An essential part of the hostel is completely outside of it: the community. What truly makes the hostel different is the fact that it provides ‘community care’. This refers to the ideal approach wherein cases from several localities around the islands are treated *in situ*, within appropriate facilities located in or close to every town. Therefore, each hostel would be caring for its community. Secondly, it also means that the community is included as part of the client’s cure and care.

Put simply, the community, its neighbours and sociable areas, are directly part of the hostel’s prescription to its clients. Providing its clients the opportunity to fit into a

community, integrating in society and participating in social interaction in general is one of the hostel's primary aims. This could be as simple as a local sports club, a class or private tuition, a meeting place, or a comfortable bench. It is anywhere the client can find social interaction with friends and strangers. On the other hand, for the residents, the community can take on a variety of meanings. It could be coming to terms and spending time with one's family, or making one good friend. His community is not necessarily made up of strangers. However, the clients sense of community mostly extends to sporadic family visits and small-talk with neighbours. The only real community in which he feels part of remains the hostel.

Part of becoming independent (and therefore 'cured') is being fully 'exposed to life'. When a client successfully takes care of his own errands, visits a family member or starts a conversation with a passer-by he is learning to manage himself in the world; choosing who to speak to, what to say and how to handle what is said to him. Moving away (yet within) from the protected and mediated environment of the hostel proper, a form of 'foster community', the 'external' community should, ideally, give the client participation in social life itself. Doing so, he can find a place and a distinct identity preceding his increasingly independent self.

Unsurprisingly, one of the more popular locations at the hostel is just outside of it: the front-door steps. Sitting outside the hostel door the residents (and clients) can be within the hostel and the hostel's 'community' at the same time. They can chat with their next-door neighbour about last night's football game, their work and social life. They will be able to visit the occasional family member who lives nearby or chat to the odd stranger looking for directions. In the liminal space that are the front-door steps the residents can acquire, as Goffman put it for asylums, "a minor sense of participation in the free world outside" (1961, p. 238). Except that here, the free world outside is not in contrast to any dogmatic constitution on the inside.

It is not the client that is liberated 'outside'. Rather, it is (social) life that is unleashed onto him. The 'free world outside', the 'community' is only one in which life freely affects the individual, unmediated. But if the hostel relies on the community surrounding it to re-socialize and reintegrate its clients, why does it need to exist as a mediator in the first place? Why does the hostel erect a semi-permeable shield around its clients to control the effects of the community? Is it not entirely positive?

Although the community is inseparable from the hostel's structure, it is also part of its antithesis. As aforementioned, the community threatens to breach the relative safety of the hostel. As a barrier between the sheer incomprehensibility and unpredictability of social life, the staff (as part of their services) dampen its effects for the client. They might negotiate an interaction alongside the client, accompany him to his visits and errands. They can, on request, also speak and write on his behalf. On a day-to-day basis they counsel their clients on their best choices concerning social aporia: how to go about the sheer puzzle of existence, its ups and downs. Outside of the social worker's domain, the physical hostel, there is no such service.

The community can also be hostile to the client. People judge, insult and shame. In fact, some of the residents attribute their initial mental decline to the community in their hometowns. Matthew rarely, if ever spoke about his first home. When he did, he always cited it as a time when he was severely bullied and tormented. He was adamant that it was the beginning of illness for himself and his brother. Incessant abuse and 'village politics' is deemed by the clients and staff as a valid and possible contributing factor to mental illness. Even if there is just one hospitalised family member, the stigma is enough to orient the community against the individual, viewing him as genetically 'flawed' and insane.

The local community around the hostel is no different; some clients might even be locals themselves or have families residing nearby. Although most of the hostel's neighbours are friendly and overwhelmingly helpful one cannot but detect a hidden animosity towards the residents. This might not be shared by the community in its entirety, especially not from the residents who go out of their way to assist and donate to the hostel.

When one resident had drunk too much and lay intoxicated underneath a neighbour's garden wall, no assistance was provided. Only when I approached the client's strewn body did people gathering around him acknowledge that the body was a living person. The first sentence I heard was not derived from compassion or concern, at least not for the resident. The immediate reply was to take 'care' of him because he is annoying the residents of the area, that he might be a threat to their children and a general nuisance. Perhaps, a sentiment I might have almost shared when I first entered the field. It was suggested that I call the police, not an ambulance.

As long as the residents remain in the hostel, insulated and secure, the neighbours are more than happy to live next to them; this is the community's contribution to 'care'. By

merely tolerating the hostel's existence, it gives them a passive sense of action, of doing something towards the community and mental health. So long as the hostel cannot affect them, the community accepts it. In fact, they may even donate clothes or wares. This is all beneficial, but not as much as the odd conversation and general company friendly neighbours provide. The hostel relies on the community to care with its staff for the clients to provide them a minimal form of social life. On the other hand, the neighbour relies on the hostel to contain its clients and keep its surroundings safe (and sometimes unpolluted) from them[23].

Consequently, the staff are wary of the benefits and danger the community poses to the clients. More so, the constant pressure on the hostel to present a positive image; an unceasing public-relations campaign to establish the necessity of the hostel itself. To this end, the staff consistently push out a consistent image of the hostel. Their vision for the national mental health system is clear, ambitious and, most importantly for them, entirely possible. They must have processes ready in place for any event, a succinct and immediate reply to any query. The staff must work closely together to maintain a unified image of *the* hostel, a professional and distinct entity from the community. However, simultaneously, it wants to remove itself as a buffer to the community and act like any other household.

5.3 The Roles of the Family

One could argue that the staff are not just those persons employed by the hostel to provide its services, but also include the individuals actively involved in ensuring the wellbeing of the residents. Without the former, the hostel would not be physically present as a place of work with set hours. Without the latter, the hostel would be incomplete and ineffective.

[23] The staff take complaints very seriously. The slightest complaint is immediately addressed. If a neighbour complains about loud music emanating from the courtyard the staff will immediately reprimand the client, or the hostel population in its entirety. For this reason, the courtyard is locked after a specified hour to minimise disturbance. The staff recognize the fact that they are unwanted in the area and must strive to reduce their annoyance on the community. Perhaps, part of 'community care' is to generate a consensus towards the concept in the first place in the targeted community. They have to justify their existence in the locality. On top of which, they have to convince everyone that it is a positive presence for both the clients and the locals.

The social and support workers are the primary sources of care for the clients. They provide their services on a daily basis, consistently and to the best of their ability. Their relation to the client is strictly (at least explicitly) as a service provider. It is their only rationale for knowing the client, and the only task carried out in their presence. Every conversation, chat, phrase, encounter, visit, gesture is oriented towards the client's recovery. Anything other than the scope of increasing the wellbeing of the client is beyond their interest. They are present at the hostel in order for the client to get better, to be given care.

There are, however, gaps in the social worker's efficacy. They cannot spend the time required to nurture the kind of 'intimacy' required to care as effectively as they would like to. More so, and consequently, they might not possess their trust. Providing their advice and support might turn into an unwelcome confrontation with an unwilling client. For the hostel to function at all there has to be a strong, yet strictly professional bond; a close relation practised at a safe distance[24].

It is precisely in this gap between the formal staff and the clients that the unpaid staff members of the hostel, the friends of families, are found. In this crevasse between the client and the social worker, family members, close friends and other individuals whom the client trusts can be found bridging the unlikely gap in between. Although uncommon, family members are called and asked about certain information on the client. This is all done with the client's consent, who states his person/s of trust during his formal introduction to the hostel. From then on the individuals he places his trust upon can choose to assist the staff at the hostel when asked to. Most of the time, the entrusted individuals are family members of the client, usually parents. However they are also sometimes siblings, children or even unrelated people who still care, such as friends.

If a staff member needs to figure out how to handle a certain client, the contact point she has for the client should be able to offer substantial advice. They should know the best way to approach the client, how best to place a proposition, how to get him to take his medicine, and do his chores. The client's contacts work alongside the social worker in the interest of the client's wellbeing, as defined by both the client and the hostel. In effect,

[24] For this reason, when interviewing an aspiring staff member the clients' verdicts are given utmost importance. Their first impressions of them are weighed into the professional decision of the hostel's upper management. If the clients do not consent to a new applicant, the capacity for the future staff member to care for the clients is likely to be heavily reduced, as well as his chance of getting his job. The innate ability to care for and get on with specific clients is tantamount to any conventional qualification.

they are part of the team at the hostel. Although their advice and input is rarely required, they can be essential for all sorts of situations.

Albeit entirely outside the hostel, family members and close friends form part of its centre. Down-sizing from hospital to hostels, community care inevitably and increasingly relies on family and neighbours to function at all (Dowling 2021), even to dispel the institutional, 'cold' facade of total institutions (Thetel 2015). Without them the social workers' job would be much harder if not impossible from the outset. But this is not to say that they cannot be a negative influence as well. After all, most of the residents were hospitalised at Mount Carmel due to complications arising from family trauma (or unnecessary coercion from their end)[25].

The client's family often means well, however, they may not always be as trustworthy or understanding (of the hostel, medication etc) as the client originally perceived. In such scenarios, the client requires the hostel to step in for him to advocate for his interests, and the legal guardian/family as well. When this occurs, it is an extremely delicate situation. The hostel has to articulate the client's wishes, respecting his autonomy whilst simultaneously protecting its agenda of wellbeing for him. On the other hand, the family upholds what it understands to be its inalienable right to its member as his only legal protector.

Occasionally, the hostel finds itself wedged between the client's wishes and his person of trust's demands. At one point, Richard started to be more reclusive, refusing to engage in conversation, and spent much more time in his room. After a psychiatric appointment, his prescription was altered to include new drugs, some of which he had to purchase with his own money. He set his mind on rejecting the new medicine. However, when he called his mother she did not accept his decision. Richard was adamant that she should pay for them if she wanted him to adhere to the new prescription. His mother then asked him who the social worker on duty was so that she could call her. In the end, the social workers ended up negotiating the psychiatrist's decisions with the client and family member. Likewise, their client's wishes with the psychiatrist's. In the end, the social worker intervened and, once the necessity of the medication was verified, she calmly convinced the client to take it along with his family's support.

[25] The hidden familial agendas behind their hospitalisation are extensively contemplated by the residents. For others, the same family members are still in contact with them and exert their damage in the present. Contrary to Philip, his family does not support the hostel's 'lenient' approach. However, the staff can never approve a decision that contradicts their relative's wishes, and cannot amend their services without their consent. This also applies even if it impedes, to some extent, the clients well-being; such as refraining from joining certain activities or allowing certain habits. Consequently, such encounters delay, if not disable the hostel's intentions and overall project for its client.

Family members can help persuade a client that the hostel's, or the psychiatrist's intentions are in his best interest. However, they may also reject and contest it. While there might not be much resistance towards prescriptions, as in the previous vignette, from family members, there is hesitancy to some extent among social workers. Knowing the side effects, such as incontinence and impotence, and their constant increase, some social workers, kin and/or (rarely) friends, oppose a change in prescription or an increase in dosage. They may, after the client himself complains, discuss the prescription with his psychiatrist directly.

Knowing the clients all too well, the social workers may even interpret the symptoms themselves for the client. Excessive diarrhoea, belly ache, nausea, lethargy are all bodily effects the social workers help the client source from his illness or his medicine; from his condition or the drugs. Although disregarded as 'unprofessional' in other social services (Montigny 1995), and partly by the hostel itself, sometimes, the social workers agree that a client's original illness has a wholly social cause, such as troubled friendship or a family visit gone awry. This is similar to the unclassified diagnosis of 'social case' in other mental health systems (Freidman 2009). Taking it a step further, the hostel reads the client's body as a biological and social effect alike. When asked to what extent mental illness can be treated with medicine or social intervention (welfare, therapy and counselling), "For me", Judith says, "you cannot choose. You need both".

By interpreting symptoms, close friends, family and social workers provide a 'social grid of meaning', beyond medicinal interpretation (Longhofer, Floersch & Jenkins 2003, pp. 24, 57). They work against the pervasive atmosphere in medicine of an idealised self, unable to cope (Illich 2007). By looking for the social origins and uncovering institutional discourses, the social workers can also be seen as 'local' social scientists (Moore 1995). Doing so, the influx of causes, stemming from a surge in diagnosis, is de-activated by the hostel's own explanations. Kin and kith do much more than share information about the client: his reaction to drugs, his thoughts on the hostel etc. They do not only provide information on the client alone, but actively interpret the client and mental illness in Malta with the hostel.

During a particularly bad heat wave, several clients spent their afternoons sleeping or lounging around the hostel. Some had an evaluation scheduled during this period. The effects of the arid summer-induced lethargy were inevitably reflected in the evaluation. Some, like Maurice, ended up with a modified prescription, which he did not contest. On

the other hand, one social worker was furious at the liberty with which medication is prescribed. On other occasions, this led to the social workers contacting the client's doctors to ask for a re-evaluation.

In effect, the hostel, including the family, acts as a counter to over-medicalization. Perhaps more specifically, by explaining symptoms, they constantly separate the illness from the resident. What might be easily deduced as a worsened state of depression may be shown to be an excessive sensitivity to the summer heat. The client is allowed to interpret his experience, removing the often generalising mask of diagnosis, towards a subjective understanding of symptoms, giving a voice to pain (Scarry 1985). Here, a variety of causes are presented beyond those reified by the hospital; against the 'object' of medicine (Good 1994; Lewis 2021; Marsella 1981; Taussig 1980).

On the other hand, when the staff feel that certain behaviours have a more clinical origin, and are passed off by the clients as a temporary episode, perhaps caused by lack of sleep or a bout of bad meals, they seek to persuade him to seek the appropriate prescription. The reverse action is always available: to link biological problems with medical solutions. Nevertheless, to what extent the client is suffering from a disease or an illness is always being deduced and its distinction fleeting.

Daily the hostel finds itself between the client and his psychiatrist, negotiating for or against both. Meanwhile the roles of the family, similar to the way the staff is explicitly said to be external, ideally invisible and passive (Vassallo 2008), find themselves within the hostel's operation and the social workers' resources.

5.4 Being a Social Worker: Futility and Emotional Labour.

At the hostel, the youngest social worker is 23, the oldest in her 40s. They studied at the University of Malta for three years, obtaining their undergraduate degree in social work before being employed with the foundation. The support workers on the other hand may have a diploma, or simply sufficient experience. Although not academically educated, they are deemed much more knowledgeable. At a surface level, what distinguishes both workers from any other adult is their education and subsequent specialisation. Acquiring

the title of ‘social worker’ implies the appropriate qualification, but it also connotes a certain ‘mentality’, including patience. It is said by the social workers that ‘you cannot do this work unless you love it, it’s not really a part-time job. It is a vocation’. This has all sorts of implications.

Firstly, there is no job description fitting enough for the day-to-day tasks they face. No list comprehensive enough to cover all possible scenarios and the appropriate reaction to them. The term ‘vocation’ here implies a certain will, or perhaps faith, towards the role of social worker. The individuals who take up the role find themselves in unprecedented situations. Oftentimes it entails large amounts of paper work and filing, meetings, cross-checking and training sessions. Sometimes it means consoling a client, persuading him to attend a hospital appointment or resolving a familial issue. Less often, it could mean mending relations between the residents, assisting them on special errands or defusing an unfolding crisis. ‘Social work’ implies working in whatever falls within the unclear rubric of ‘social’.

The motivation for the selection of the job itself cannot come out of any incentive aside from passion. There is no motivation to become a social worker in wages. They are only average at best (Doi 2022; Magri 2021). Nor is there social capital, prestige, or glory in the job title. Oftentimes, they are not held anywhere close to high esteem. In popular culture, and in the social worker’s own understanding of people’s perception, social work is perceived to be a low-effort job, taken up by the poorly educated or career locked individuals. In other words, a job that nobody would volunteer to do given an alternative. Perhaps, only chosen by the select few who, somehow, find something worthwhile in caring for the sensitive echelons of society.

At the Hostel this is very far from the emic understanding of the staff’s job and role. Social work is a total ‘vocation’ precisely because one is deeply motivated to do the job, to complete its mission to assist those in need. The social workers affirm that no individual would apply for the job if they did not have the primary motivation to care for others, especially those who need it most. Despite somewhat decent wages and all sorts of superficial attractions towards the position, in the end it is “not worth it” without one’s will. There are ample jobs with less effort and better pay. For the staff at the hostel it is a known fact that their line of work requires the possession of a ‘vocation’. Without this ‘calling’ for the job, one quickly finds it futile if not pointless.

Not only do social workers operate in an unbounded field in terms of job-description, but also their commitment to it. Put simply, as Sarah puts it, one cannot 'clock out during a crisis'. If need be, social workers take on longer shifts, come to the hostel outside of their working hours albeit within the secondary roster. They cannot limit the amount of care they give, nor the attention they provide or the emotions they invest. Limiting the time a social worker spends at the hostel in terms of 'shifts' does not, in any way, contain the 'surplus mental value', the social support they must provide. On some days their minimum is required. On others they must give much, much more[26].

Most support-workers operate on a part-time basis, their presence fleeting and their emotional investment minimal[27]. In addition, they are assigned shifts at different hostels which naturally impedes any growing attachment to a particular client or hostel population. The part-time support workers follow the instructions given to them. They manage a skeletal form of administration, one which can be run by a single person, until the full staff resumes its shifts.

This is very far from the full-time, social worker's relation to the hostel. The major force propelling the social worker's work is a particular relation to care. A long-standing, invested relationship exists between the clients and their social workers. Although they have legal and ethical boundaries between them, they enjoy a very close relationship. They spend days and, eventually, years together. Working in the space wherein the clients live, the social workers inevitably become just as connected to the particular hostel they are assigned to. They both spend a significant amount of their life at the hostel, both depend on it, in different ways.

It is highly unlikely that social workers make someone as independent as he was before his illness. That being said, the social workers do not position their role in relation to any evidence-based success. Their primary goal, that which makes them feel authentic and competent social workers, is a sense of giving back to the clients; of at least making the best attempt to make things right. For some social workers, their real labour is love. Specifically, an unconditional supply of care and understanding.

Sitting at the other extreme is the service-oriented ethic. The conception of social work as a product or service one is providing. For the latter, they perform a mechanical service to the hostel's intentions. They are paid for their skills and capacity to provide the service

[26] The social workers know and indeed see their energy as a resource, replenished by time and their own self-care. Besides training from the Rain organisation itself, some express their concerns with another colleague in private.
[27] Support workers often approach the hostel as a 'service' rather than 'vocation'.

they are qualified to do. Although still in possession of a passion to care, it is measured, quantified and used precisely.

For the rest, monetary remuneration is only symbolic. It is said that no amount of money quantifies the value of their labour, as is also noted in Vassallo's (2008) study of staff members in a local half-way house. Their paycheck only exists due to the material necessity of living. The most important and pervasive aspects of their work are not, and *should* not, be compensated. The genuine attention they give to the residents, the will to help them get better cannot be purchased. In the moral cosmos of the social worker, money and genuine emotional investment are mutually exclusive. One can only truly care and cannot be paid to *actually* care. Being a social worker is therefore a natural quality that cannot be thought, only acquired. One can possess but not learn the incentive to become a social worker out of genuine, unintended wish to help others.

As opposed to other studies where the main preoccupation for social workers is to withhold, absorb, defer, and/or exterminate emotions (Moesby-Jensen & Cecilie 2015; Gregor 2010), at the hostel they are more concerned with creating the required emotions and attitudes when necessary, such as, decisiveness, creativity, compassion and empathy. Explaining her motivation to work, Judith shares with me her reflections. The hostel expects her and her colleagues to be in a "good mood" ("burdata tajba"). If not, she is allowed to take a break, seek assistance, or make amendments such as substitute her shift with another. She is cautious that her feelings and emotions are easily transferable to her clients. If she is not capable of withholding the ones that can damage, she'd rather not work. However, the social workers very rarely need to go so far. Most, like Judith, have ample experience in doing just that: channelling the right emotions. "It comes naturally" she said "when one is genuinely a caring person". It is understood to be impossible to teach someone to be intrinsically caring. The skill has to exude from within: perhaps from past experience caring for a relative or a sick friend.

Delving deeper into the social worker's understanding of 'vocation', I asked several staff members on their own experience of identifying and confirming this feeling, state, or identity. As opposed to more neo-liberal critiques of the emotionally exploited 'self' (Lavee & Strier 2018; Whitaker 2019), the social workers find satisfaction in putting their caring 'character' to use. While using the word 'caring' directly, the social workers also described their 'character' as intrinsically sensitive to other's needs. In addition, a certain 'natural' impulsiveness to help in any way possible. In this sense, the social workers state they and other have the 'vocation' towards social work.

‘Caring’, in its english form, was often used when trying to explicitly explain their role in the hostel. However, the social workers also use it alongside ‘vocation’ (‘vokazzjoni’) as well as possessing the ‘right character’ (‘karattru tajjeb’). In practice, but implicitly, the real term used is that a person is inherently ‘loving’ (‘ikun iħobb’), despite the fact that they cannot state declare this emotion to the clients, nor to themselves. On the other hand, the clients do not use the word caring at all but directly state that the social workers ‘love’ them (‘iħobbuna’). While the staff see this as a positive perception of their role, they have to demarcate its limits, for their role is declared to be that of managing and caring for the residents (‘nieħdu hsiebkom’) and not to love them. Despite this, an essential quality and motivation to be a social worker is still said to be this ‘loving character’, the emotional complexity of which will be discussed in the following chapter.

It is important to note that on most accounts, this motivation stems from very personal backgrounds. Perhaps after being cared for the social worker may want to care for others. Oftentimes, staff members have come across the complex and saddening reality of mental health through close friends, family members, or even themselves. Caring for the clients at the hostel is a means through which they can extend their care of loved ones through their loved strangers. This is certainly the case for Judith who doubly cares for her own mentally disabled family member. When asked if she cared for her family any differently than the hostel, Judith argued that she often sees no difference; she has to use the same words and methods to care. Most importantly, she stated that she felt the same ‘kind’ of care towards her clients, albeit professionally. In this sense, the social workers care for the same individuals, caring for the same illness through another person. Perhaps, also, in some way, caring for themselves.

As one social worker puts it: “you have to be crazy yourself to work here, if you notice carefully we're [the staff] all a bit crazy”. This notion, ‘being crazy’, is an overlooked but entirely necessary quality to be a social worker at the hostel. Besides living with an average wage, one has to be flexible, capable of handling the most absurdly awkward situations as ordinary, to be emotionally resilient yet extremely sensitive. One has to travel between extremes on a daily basis without any compensation except for their own ‘vocational’ satisfaction. In this sense one has to be ‘crazy’: to have no set and standard idea as to what a normal day requires of them, with a passion to help others as a sole motivation.

However, one social worker did not derive her “energy” to care from her past or her training. Sarah, one of the younger social workers, finds the monthly staff meeting particularly helpful. In it, staff members gather and are expected to state how they feel about the hostel and each other. The session can range from minor explanations of behaviour to heartfelt expressions of disappointments and losses[28]. Where the social workers are usually emotional strongholds, capable of brushing off most things such as relapses, depression, and grief, this meeting is where she can let herself loose. Sarah explains that it's not optional to express oneself truthfully but a requirement, for the sake of the hostel. Being witness to her colleagues and herself expressing into words all their emotions, and deciphering her clients arguments and behaviours with others, she felt renewed to retake her duty to care. After these emotional meetings, Sarah could re-orient her will to care which might have previously waned under the assumptions that her clients and staff were not human, not in desperate need of care themselves.

Rationalisation, neutrality, and always seeking an answer to all occurrences at the hostel isn’t always the best course of action. Over time the staff certainly meet their clients half way to their malady; the same way the clients sometimes ‘reach’ the staff’s ‘exemplary’ independent selves. On particular occasions the staff let themselves drift; they express themselves with what could be deemed by the hostel as ‘excessive emotion’, perhaps to angrily or lovingly. As a vocation, self-sacrifice is one prerequisite. The staff must give part of themselves, their peace of mind, to the residents. They cannot hope to come out of a career in social work untainted by their job in peculiar ways.

Most acquire phenomenal emotional dexterity; they can look and act composed in the worst of times. No crisis can falter an experienced social worker. What would appear odd and nonsensical to the outsider appears normal and ordinary to the staff. The bold line between normal and abnormal becomes unclear and fuzzy. Blurring this boundary the clients, unknowingly, leave their mark on them. The staff, as possessors of the vocation towards social work, bear the brunt of this reality by virtue of the fact that they are not signing up for a job, but to carry out social work, all its unique duties and personal costs. In this boundless world, untethered from clear borders, social work is 'dirty’ work'. Much like ‘dirty anthropology’ (Jauregui 2013), it exists without a definite and static object of study or, in this case, care. Being a social worker implies change, the job itself requires being influenced, shifting world-views and managing an ever-growing repertoire of experiences.

[28] I am relying here on Sarah’s own description of the reflective sessions. I was never allowed to attend these meetings.

For most of my fieldwork, Albert was severely alcoholic and often ate fast-food. The staff would carefully and caringly advise him on the effects his diet had on his health and the first steps to resolve the issue. He would break down in tears, admit his recurring mistake and promise to try his best to change his life. A few minutes later he comes into the hostel slightly drunk, with a distinct stench of whisky. The staff would be itching to reprimand him on his decision, especially after all their energy invested in advising him merely minutes before. How can he do such a thing right after all the effort and promises? Does he do it on purpose out of spite? Just like the hostel's staff, such questions started to dwell in my mind. Out of severe frustration, I expressed these sentiments with my supervisor at the Hostel. She promptly stated, in a somewhat exhausted and relatable tone to my own feelings at the time: “do not try to understand it”.

Albert also wakes up many times every night in a sudden burst of energy and falls back to sleep in random bouts of tiredness. The social workers continue to try but have stopped expecting results. They face a problem they cannot understand let alone resolve. They embrace futility not to safeguard their own sanity; they would be willing to go beyond their limits for their clients. Undergoing ‘emotional numbing’ (Lavie & Strier 2018), which normalises what would seem extraordinary, they accept the incomprehensible nature of his addiction as the reality of illness, a foreign, external force acting on the client. Providing the best possible care for the client entails accepting the limits of one’s capacity to help him which, in this case, the outer edges of the social worker’s capacity is their advice. Pushing beyond just that might entail all sorts of regressions.

As opposed to a rare expression of frustration, sharing my concern with the social worker turned out to be a normal event. During the ‘handing-over’, the half an hour overlap between the social worker’s shifts, they discuss what they managed or failed to achieve in their shift. Usually a particular client could not be persuaded to give up certain unhealthy food or to clean his room. Other times, it might be that a client still refused his medication or could not be brought to understand a new rule for the hostel. This inability to perform what is required, a failure to care for the client is inherited by the following shift. An individual failure becomes collective: a fault in the service provided by the hostel and foundation. Just as a success story is attributed to the whole hostel, so too is futility.

Although the staff do their best, and sometimes manage to process their shortcomings, they remain lingering in their esteem. Consequently, there always comes a point where

the source of one's futility cannot be disassembled and understood. It must simply be ignored and abandoned by keeping busy at the hostel. Perhaps, even replaced by another encounter with futility.

This is not to say that futility is a negative state bearing down on the social workers. There is a very positive (or at least practical) aspect to it: embracing their incapacity and inability to 'cure'. The social worker, caring for the client, shares the goal set for the client. Reaching minimal yet crucial improvements for the client is synonymous with being successful for the social worker. Put simply, accepting futility makes social work entirely flawed and human, any minor progress becomes a miracle, extensively bolstering the hostel's morale. The hostel's best remedy for its fatalism are minute yet clear signs of improving clients. All their hard work is only manifest in the smallest improvements which, over time, fulfils itself in drastically improved lives. The hostel rejoices when a resident learns to cook rice by himself, makes his own bed, or figures out a solution for a particular problem without assistance.

However, success is rare. Daily, the social workers deal with disappointment. The sinking feeling of ineptitude hovers above every social worker. They never go to work to find a suddenly improved client: only a violent relapse occurs so suddenly. What they usually find is a whole lot of short and long-term problems to resolve, which can only be re-organized and framed as an improvement in hindsight.

To counter this, they attach their 'social worker' persona to the hostel, distinct from the one at home. What happens at the hostel and their explicit or implicit reactions to it are said to remain there. The social life of the hostel is insulated from the social worker's personal lives, which is a strategy noted in other organisations that constitute themselves as a 'service' (Guy et al. 2014; Hochschild 2012). Otherwise, besides tainting the hostel's record, they risk 'burn-out': a state of emotional exhaustion and overwhelming stress.

However, since social work can have repercussions on the worker's life, their identity within the hostel is inevitably attached to the one outside of it. More so, they bring to the workplace certain skills, knowledge and "energy" that is said to be acquired or produced outside the hostel. However, nothing created within it should exit the hostel. No affection or disappointment should follow the social worker home. Consequently, the hostel constantly consumes such resources with few, if any, returns.

When asked if they felt 'emotionally invested' in the hostel, Adam, a support worker, replied "only before the shift". He explained how, before any shift, he had to focus in order to "pause" his "life" and adopt his 'support-worker' persona. However, alongside and before adopting the necessary distance from their own job, the social workers try to express themselves cathartically. Whenever possible, being honest with their clients is the first course of action. Doing so, social workers avoid the exhausting practice of emotional management: making sure one says the right things, feels the right way, expresses the appropriate emotions. From the social worker's perspective, they would also appear much more relatable to their client. Treating their relationship with clients as a natural, unmediated encounter makes both of them feel as if transgressing their 'official' roles and relation. The social workers first resort to maintaining their identity, *with* and *alongside* their job. The artificial frame in front of them, their condition and employment, is preferably suppressed in exchange for a more 'natural' interaction. One in which their feelings are unimpeded by institutional or moral concerns.

Even when discussing the hostel experience, social workers attempt to be honest about their thoughts and feelings. They will point out a client's validity when expressing a critique they received. They will join him in his laments about the system which the social workers themselves form part of. If a client complains about another resident in the hostel for genuine reasons, the social workers will not play down the issue but rather sympathise and add their own discomfort at the situation, when possible.

However, before dismantling their roles and meeting their clients halfway, the social workers create a certain objective middle ground from which they can rebuild their initial position. This approach acts as a 'pseudo-pressure valve' for the social worker's emotions: they state their real opinions by way of distancing their individual identity from that of the hostel. When problems arise, the social workers will state how they really feel about the issue, subjectively, as ~~the~~ hostel[29], but also what actions and positions they can take as the hostel[30]. Put simply, unofficially and officially.

---

[29] It is worth mentioning that the hostel's liminal position is not entirely negative, and can also be beneficial, allowing it to shift and shape itself as needed. Where some embrace the hostel as a safety net for their emotional investment and futility, others find it alienating and opt to adopt a more subjective, individual, and 'human' approach, despite the emotional turmoil that often ensues. In other words, the hostel is beneficial both when it is explicit and implicit, uttered and implied, as the hostel and ~~the~~ hostel.

[30] The important role of empathy can be understood, after all, as a 'decentering of self' (Rumsey 2011). The only difference is that here, in addition, the social workers present their own self to the client. The client, himself decentered, is then invited to follow the guidelines he contested for the hostel or foundation as opposed to the individual social worker or whomever he might have a qualm with. Both achieve closure by de-personalizing the entire conflict: the social worker as a vehicle of the foundation (and perhaps a genuinely caring person at a legal impasse) and the client as obedient to the hostel as a whole instead of a particular individual.

The latter is, of course, only possible as long as the explicit code of conduct is maintained. If a client complains about his medication and threatens to terminate his prescription, the social worker is bound to communicate the established message of the hostel. In one scenario, Mattheus wanted to alter his prescription slightly, avoiding a particular pill because it made him sleepy. He preferred to take it later and, after checking, the social worker accepted his decision, although the support worker strongly advised him to settle it there and then. “But you know the rules, I can’t force you to take it” he says to Michael after trying to persuade him. Afterwards, in private, he stated that he could perfectly understand the client’s concern and action; that he himself would not want to take the particular medication at all but could not in any way express his opinion in front of him.

As mentioned, emotional labour is not all about creating feelings, but also withholding and re-shaping them (Hochschild 2012). Although less common at the hostel, this is still present. It is usually performed by referring to the hostel’s guidelines as to how one should feel. Embarking on the hostel's perspective, as opposed to one’s own, is a way in which the social worker protects his or her fatalism and, perhaps, burnout. As a safeguard against direct responsibility, ‘following orders’ ensures the social workers cannot feel remorse in their actions. If things go wrong or remain unchanged it is the hostel’s (not the individual’s) fault. But social work allows very few opportunities to distance oneself from one’s actions.

One social worker expressed her profound disagreement with some prescriptions. For Agatha, medications are given without any sensitivity or consideration for the clients “time in life” and “circumstances”. She disagreed with fluctuating doses and additional drug trials. Agatha adamantly suggested that doctors need to keep in mind what one is going through when one relapses, which might not be related to biological changes at all. Perhaps the loss of a loved one, some financial inconvenience, global events or even seasonal weather could be held responsible for the client's erratic behaviour. Out of an inadequate understanding of the very cure she is providing (Vassallo 2008), or in recognition of the commodification of health and healthcare (Whyte et al. 2002; Rylko-Bauer & Farmer 2002), despite her intense sense of futility, she had to administer the same drugs she felt were completely unnecessary, if not harmful, in terms of quantity and kind. The way she dealt with it was precisely by positioning herself as a vehicle for the hostel’s intentions, rather than directly administering the pills: *administering prescriptions* rather than *giving medication*.

Unlike pharmaceutical prescriptions, there is no comprehensive rule book for each and every situation. As aforementioned, there is no overarching and structural practice for the social worker. On a day-to-day basis, social workers have to formulate their own idea of what's right and wrong in every situation. Similar to other studies of mental health systems (Myers 2015, pp. 141-155), staff dealing with clients directly often feel that they are filling in the gaps in the official but flawed rules; that they themselves have to represent and enforce their idea of what the hostel should support. Consequently, investing one's own feelings and opinions entails reaping a very personal-as opposed to structural and institutional-disappointment[31].

More so, the emotional support and counselling they do provide does not originate in a conceptually endemic or contained field within social work itself. They constantly get re-trained on the latest psychological techniques (such as 'mindfulness'), research and medical management skills. They have to learn the types of drugs, what they do and how they can be harmful. They have to know how to approach and speak to an individual with acute mental illness, how to alleviate the burden of his condition through basic counselling and short-term plans. The social workers do not provide a highly-specialised or unique service. They do not always embody any idea of themselves as offering a private service to clients, nor public servants tasked with using tax money effectively to accelerate cures.

If anything, they are more likely to construct themselves as guides to the client through already available professionals, services and products as a form of charity or public service[32]. Their existence within the formal hostel structure is entirely reactionary to a society in distress and, perhaps, a severe lack of people with the simple vocation to care for one another.

---

[31] If they cannot come to terms with their own actions, social workers will defend themselves against the sinking feeling of futility by consulting the hostel's texts and writings, guidelines and instructions from administration. It would not be far-fetched to say that how the social workers 'instrumentalize' their identity is identical to the transcendental relation the clients take to their illness; their roles work 'through' them, not from them. Both conceive of their current status or rather their identity within the hostel as temporary and inherited. For both, their jobs and illnesses are identities contained within them, but also external to them. Where the social workers/employees internalise the foundation that employs him, the client (unfortunately and for reasons beyond his control) carries a 'disease' inside him which is specific but not particular to him.

[32] The hostel is assisting, learning, and consuming alongside the individual who is navigating the mental health system, trying to rid himself of his status as a client, as ill. As Floersch (2002) argues for the medical world, increasingly, the distinctive dynamic between doctor and patient is fading. Like social workers and clients, both of which fall into the 'category of the consumer' which 'challenges Foucault's dividing practice; because we are all consumers, no professional language can easily distinguish the practitioner from the service recipient'. (p. 57)

If a somewhat clear fault-line can be pointed out between invested and uninvested social workers, it is precisely which stance they take on their relation to their client. On the one hand social workers attempt to shed their distinction, adopting a more situational approach, human-to-human. They are more likely to empathise with their clients and see their actions as authentic, resting responsibility on themselves rather than the hostel. In addition, they situate their role as assisting the client to consume the right services, such as the more affordable or closest pharmacies or the cheapest taxis to their appointments, rather than offering a service of their own.

On the other end, the rest of the staff mediate their emotions through an image of themselves in the hostel's image. They only allow what the hostel wants them to feel, trimming the excess or manufacturing their lack of emotion. Consequently, they are less susceptible to feel responsible for doing what they were only required to do.

The social and support workers may stick to one side of this conceptual fault. However, on a daily basis, they jump from one side to the other and back. Standing behind the hostel, the social workers may punish a client for disobeying the rules. But putting themselves in front of the hostel, they may, perhaps regrettably, care for the client outside of the hostel’s boundaries of concern.

Where social workers present themselves through the hostel, as an emotional screen that restricts the emotional interaction between client and staff, they might feel that there are too many rules for a fundamentally human profession. Other social workers attempt to “be honest” to dispel precisely that alienation, but they might find themselves too invested in an unrecoverable client. One sacrifices emotional investment at the expense of disinterestedness. However, one also sacrifices emotional distance at the expense of ‘burnout’.

5.5 Locating Social Work

What social work is, its definition, varies across the staff at the hostel. From a ‘vocation’ to a mere job, a disposition of character and even talent are used to describe it. It is a skill

set, trait, or ability resistant to simple explanations, and barely possible to be taught as text. In fact, the social workers suggested that it cannot be taught in formal educational institutions. Only as a practice can 'real' social work be taught. In addition, it is not a dedicated space of knowledge, but the science of being human: how people are flawed, sensitive and prone to misjudgement or misfortune. The staff would often describe the work involved in social work as 'life skills'. For them, what they help others do is learn life; the good and bad of it. For this reason it is said by the social workers that it can only be learned through actually being human, caring for others, with time. "What I know cannot be taught at University or written in textbooks", Sarah stated. If the staff acknowledge some sort of profession, it is "life" itself.

Social work is conceptually and practically dependent on neighbouring professions such as psychiatry and medicine. Even within itself, it is an unbounded discipline, unable to locate a concrete set of practices, rules, or coherent *modus operandi.* For this reason Flexner (2001) argues that social work is intimately related with several professions, but it cannot be said to be one on its own. However, he does suggest that the ultimate criteria should be whether or not the practitioners themselves view themselves as a profession, emically, rather than through any external and quasi-objective judgement. The social workers at the hostel, despite practising a warranted profession, still struggle to define a coherent and common understanding of their role.

Apart from social work, the hostel on its own is a relatively new concept, originating in the wake of de-institutionalization and privatisation of mental health. As a model for the long-term care of mentally-ill clients it can be said to be still in its early and experimental days. This is certainly the case for Malta where such hostels started appearing 6 years ago. Consequently, the concept of the hostel is still developing. How its unique conundrums are overcome is still unresolved. Although a concrete 'rule book' exists (but has since taken up a digital form and scattered across email communiques and updated pdfs), and is the most crucial material for any aspiring or current social worker working in the hostel, the exact approach for any situation is never clear. The variety of techniques and methods used to get results for the hostel are varied and constantly changing. This is because no solution exists for increasingly nuanced situations.

The staff however adhere to certain constant principles rather than regulations. These principles could range from to never shout or to assist rather than doing things for the client whenever possible. The official management of the hostel constantly generates a more complete form of structure for the social workers to follow. Whilst the younger and

freshly hired social workers attempt to adhere to it strictly in its entirety, the older and more experienced social workers understand it as a mandatory declaration of their boundaries, rather than the official routes they are to take towards solutions to the problems they face. The hostel has a clear idea of what should constitute social work. The experienced social worker, sceptical, maintains an open mind informed by experience.

To cite a particular case, one social worker raised her voice at a resident that refused to share the television with the rest. Upon request for his cooperation, wishing to keep on watching the music channel instead of a football match the rest of the clients wanted to follow, he started to shout and threaten everyone in his immediate surroundings. The official guidelines of the hostel clearly state that the social workers cannot raise their voices nor stress any of the clients in any way to any extent. They cannot use too much assertiveness or outrightly command the clients. However, it is well known that this particular client is completely and overtly indifferent to such approaches. If he is quietly approached and it is suggested to him that he amend his actions he simply carries on as if the social worker's request was never communicated.

More so, in such situations, he becomes a threat to the safety of the hostel if he retaliates (which he usually does) by verbally abusing his co-residents and the staff, unless it is made clear that he has no choice but to obey. This is exactly what the social worker did, raising her voice to her utmost limits and asserting her authority, going against the hostel's rules. She directed the client towards the appropriate behaviour or the requested amendment through obligation, wielding her remnants of institutional power. "Had she not done so" said Judith, reflecting on the incident, "he [the resident] could have hurt someone. It was the right way to handle it".

The social worker utilises the hostel's regulations as a cartographic instrument: mapping the trajectory of the hostel's moral project. It is important that the social worker does no harm, cares for the clients and gives them her undivided attention at any given time. However, the regulations do not always provide solutions for all the day-to-day encounters in the hostel. Navigating their way through their daily encounters requires the social workers to deploy what Brodwin calls 'everyday ethics' (2013): every situation *enacts* and *produces* new knowledge, requiring and creating different ethical positions.

Unlike other medical/care establishments (Webster 2020), the hostel is not an 'objective organisation', whose technologies of change are set in stone with supporting evidence. The social workers constantly build up their particular knowledge of each hostel like a

microcosm of individuals with specific rules. As in other healthcare systems (Howard and Hoffman 2018; Miles & Asbridge 2014), the hostel adopts a person-centred and person-specific approach. The needs of the patients are analysed and services are tailored to them. In addition, every individual is understood to be a unique case which might require unique approaches. However, although one method or technique may not be applicable to another client, it does not render it false or non-transferrable. As Haraway (1988) puts it, 'situated knowledge' is not set in opposition to scientific, objective facts. Rather, it is the object of knowledge in its entirety; a living and ongoing process of locating 'knowledge'. 'Like poems' Haraway argues:

> which are sites of literary production where language too is an actor independent of intentions and authors, bodies of objects of knowledge are material-semiotic generative nodes. Their *boundaries* materialize in social interaction. (p. 595)

In this way the hostel is a centre of knowledge, shared by the social workers that inhabit it. They do not have a unified series of techniques to alter selves. However, they can certainly demonstrate the specific body of knowledge (or 'literature') produced in each hostel. More so, dividing it further into particular clients, not as archetypes but as further particular loci of knowledge, one can state that there is no 'situated knowledge' at the level of the hostel itself but in the unique relationship and interactions every social worker has with her client.

Being and becoming a social worker exposes this inherent incompleteness in the hostel's seemingly regulated structure. In terms of a coherent body of knowledge, there is no such thing as the hostel (a complete and transferable structural model), or even hostel (an overarching system of concepts sharing a particular trajectory among staff and clients). Only by including both of these negations can we begin to refer to ~~the~~ hostel.

Chapter 6: Dancing in the Rain: Becoming Cured

The residents are certainly not referred to as patients, and surely not perfectly healthy individuals either. They are *clients*: an individual with the agency to request the services of the hostel him/herself. The hostel only accepts as clients the individuals that can take care of themselves to a certain extent. Put simply, only candidates that can be guided as opposed to 'nursed', can be accepted. As clients, the residents are deemed to possess the ability to *choose* the *services* offered by the hostel. However, at the same time, the social workers accept that this is only partially true. Here, we can begin to look into the specific understandings of illness and cure as practised by the hostel.

Across multiple works concerning transcultural psychiatry and psychological anthropology, Kleinman (1978, 1981) developed the concept of *clinical reality*. Every society, culture, or context has a different definition of patient and healers, a differing dynamic and situation to be studied and compared with others. When looking into the hostel and the way it is said to 'treat' its clients, it is crucial to understand the specific roles and their relations. In our case, the defining nodes of the hostel's reality are the hostel, social worker, client and patient.

Once the client becomes a resident at the hostel he loses some of his agency, only for it to be reacquired through the hostel. The role of the social worker is to return to the client his freedom and capacity to choose for himself: the possibility to live without mental illness and related afflictions depriving him of total independence (which he had to possess to become a client in the first place). The client is at once in possession of and lacking agency, a patient. Tracing back this dilemma, a conceptual crossroad can be located in a dialectical understanding of illness concerning 'circumstances' and 'character'. The notion of client is attached to the conception of mental illness as a circumstantial event, to some extent curable with service-oriented self-alteration. On the other hand, 'building' character is a process requiring alteration of the self.

6.1 Illness and Clients?

On a sunny afternoon, the hostel is still. Time passes slowly as the residents try to keep themselves busy. The social workers, still on duty, attend to their reports. The resident's

routine is set, along with the week's exceptions; perhaps a doctor's appointment or a family visit. There is no other reason to expect a client to leave the hostel.

That day, Richard, a client, walked into the office stating that he had to collect his medicine from a pharmacy nearby. The social workers, Julie and Sarah, looked at him and acknowledged his statement. However, the moment he stepped outside of the hostel, Sarah leapt towards the window. "Where is he going? He never picks up his pills at this time" she exclaims, thinking out loud. Her face looks unmistakably worried. She looks at me and asks if I would be willing to follow Richard. "What do you think?", she says with hesitation.

I was willing to accept her request. I felt that I would be genuinely helping out a client who could be heading towards harm. Perhaps he was heading to purchase alcohol or pick up other harmful things, as other clients have done in the past. However, another social worker in the room replied before I could: "But obviously we can't do that". To which Sarah, increasingly preoccupied, had to agree. Almost as if coming to realise the implications of the hostel's 'client-based' approach, she shrugged off the suggestion to follow the client as total nonsense.

Pursuing her request, following the client, would cost the hostel's entire understanding of care; of residents as independent clients. And yet, she took back her request with disappointment. She wanted to know where Richard was going.

She couldn't possibly send me to follow the client because, no matter what happens to him, he is still understood to be an individual, an agent[33]. However, the individual is a client at all because he has lost some capacity for agency; perhaps, also some part of himself.

The clients subscribe to the hostel in order to undergo some process of self-alteration. They feel that their mental illness, for a variety of reasons, is preventing them from being themselves. Their identity is tainted, damaged by their malady and/or its consequences. Their illness could be seen as the cause of their unemployment for example due to a lack of motivation caused by depression. It could also be presented as having a direct effect limiting their potential. Perhaps, that schizophrenia obfuscates one's ability to coherently articulate one's identity, or depression prevents one from waking up on time for work.

[33] This is both for the constitution of the client as capable of practising free will and as an entity within society.

When a client recounts his symptomatic history he will present his illness as an event in which he was, quite literally, captured. He will articulate it as 'meta qabditni l-marda' which literally translates to 'when I was caught by the illness'. Although the residents understand their 'marda' to be, at least partly, stemming from social-turmoil or trauma, and is therefore closer to Klienman's use of the term 'sickness' (1981), their symptoms are not understood to be completely psychological. As clients, they suffer from an illness: a combination of mental problems manifesting in physical shortcomings.

The hostel, to transform its clients, constantly faces this impasse of freedom. On the one hand, there is the client as a person *with* an illness, whose capacity to be an individual, to possess a self, is only diminished by his illness[34]. On the other hand, but for the same reason, the client is incapable of agency; the client is precisely at the hostel due to his very lack of self.

For the social workers what the illness took away from the client is not so clear. If it is a question of biological capacity, then medication and counselling should be sufficient. The client would be free to care for himself beyond his illness which is only afflicting him. The self remains preserved although burdened by the illness. With this understanding, he is completely free to utilise or neglect the hostel's services. He can opt to partake in its 'cures' much like he can choose whether or not to attend a doctor's appointment or follow his prescription strictly.

The client, by possessing the capacity to be a self, an individual, has the utmost liberty on his own illness, and body. He is made responsible for his illness and himself. On one occasion Albert (after a lengthy meeting with a social worker in his support) set out to buy a bottle of whiskey and consume it in one sitting. He passed out on a pavement not a hundred metres away from the hostel. An ambulance was called (due to severe dehydration) and his consent was sought to take him to the hospital. Although the social worker (and the paramedics) wanted to carry him into the ambulance they could not lay a finger on him without his consent. Neither could the social worker give consent on his behalf. In spite of his condition the agency of the client, as agreed when he signed himself to the hostel, was still sustained. There was Albert, lying on the floor, unable to articulate a single sentence and yet the paramedics were waiting to receive verbal consent in order to provide him with assistance.

[34] This is, of course, an extension of the fundamental reaction on which the hostel and community care in general was created in the first place, as a reaction to the encapsulating nature of institutional care. The ill individual is only entrapped in a repressive institution which contains him rather than cures him.

He alone can choose. As a client, alteration occurs *with* the social workers. Thus, as in other instances of agency in healthcare settings (Myers 2015; Brodwin 2013), the issue of responsibility over the client is resolved through extracting formal permission, evading moral dilemmas in the process. The client's signature justifies a text which makes explicit, or even constructs the client's will. Choosing whether or not to follow a prescription, visit a family member or live at the hostel at all is up to the client. He cannot be obligated to accept the hostels decisions, the social workers advice on how to manage his depression or anxiety. As a client, he is not forcibly steered away from possibly harmful scenarios and situations[35].

The affliction *belongs* to-and is not identical to-the client. Therefore, he has the final say on what occurs to himself as a free individual *with* an illness. Only when there is nothing to distinguish himself from the illness, he enters a different dimension of care.

6.2 Pills and Patients?

To start my fieldwork I spoke with several administrators within the Rain organisation. One of which was the overarching manager for all the hostels. I explained my fieldwork and topic. When I asked about the patients of the organisation she immediately stopped me, stating that their clients are definitely not patients. Their 'clients' are people that are treated as individuals. 'Patient' is a word too closely connected to the outdated asylum: Mount Carmel. More so, she explained how their clients are trying to distance themselves from their previous identity as patients.

The client is an individual 'released' from Mount Carmel after two, three to even twenty-two years. As opposed to being a patient at Mount Carmel, they have to actively permit medical intervention on themselves and manage their health, their pills, and therapy. Consequently, they have to adopt a stance on their illness; what exactly is it, and to what extent are they capable of becoming 'cured' from it.

On the other hand, the staff knows that oftentimes the client cannot be separated from his illness, he is overwhelmed by its symptoms. Almost a patient, the client's self cannot

[35] Sometimes the social workers, despite their best efforts, can only watch their clients succumb to their illnesses. In addition, they cannot intervene on related side effects. Oftentimes, they can only watch alcoholic clients leave the hostel to go drinking, or nervously wait for the return of a usually regimented client that suspiciously went for a walk outside of his regular schedule.

possibly be altered by the same self. Instead of assisting the client to become better, through medication, counselling, and emotional support, sometimes, the social workers adopt a more direct approach.

The clients 'choose' to follow calculated prescriptions, arguably inaugurating another 'self' which anthropologists have addressed through numerous terms. Rose (2003) refers to this as the 'neurochemical self', where the patient's mind is increasingly conceptualised in terms of chemical processes. Another term employed is the 'pharmaceutical person' (Martin 2006) through which the individual builds up his self-understanding through medication and its effects. In the meantime, whichever transitional conception the clients adopt is just one of many 'selves' they develop or inherit in the road to recovery, if not to navigate contemporary existence in general (Rose 2007).

Separating himself from his illness, the self from its symptoms or, perhaps, acquiring an addition if not replacement to it, medicine does its part. Early morning and late at night the residents queue next to the office door half an hour before they are supposed to receive their medicine. Even if it's 5 minutes until 9 p.m. they begin to state 'it's 9 o'clock, just give them to us'. If they manage to get their medication a few minutes before they are supposed to, it is still worth the wait. Why all this rush?

Boredom becomes intolerable and sleep is often the only recourse. They cannot go to bed before they take their medication at 9. Otherwise, they would have to interrupt their sleep to get their medication. Consequently, the residents' sleep schedule is synchronised to medication, they go straight to their rooms just after taking it. At 8 pm, dinner has finished and the residents finish up their chores. They take a seat and watch the clock eagerly as the minutes tick past. It was not uncommon to hear residents exclaim that they will soon be able to end their day soon enough during this liminal hour. The majority of the residents, especially in winter, unless there is a reason to stay awake, will head straight to bed immediately after. In this regard, medication dictates their life; they start to look more like patients towards a cure.

Despite their worrying side effects, medication is an integral part of recovery. Specific pharmaceutical types or brands are deemed to work wonders by the staff and residents alike. At the very least, it allows the residents to fall in the category of clients, medication being one of the essential services or products provided. As consumers, they find it easier to find their coordinates as an individual involved in a process of healing. If no drugs

were involved in one's recovery, besides the counselling and supervision of the social workers, no form of 'treatment' or 'cure' would be as easily perceptible.

Although the client experiences healthcare as a service, the experience of his illness renders him a patient. As discussed before, symptoms and conditions range from diarrhoea, constipation, impotence, head-aches, nausea, anorexia, megarexia, hallucinations, and depression. It would be futile to decipher what is caused by the actual illness and what are symptoms caused by the medication itself. Likewise, which are strictly somatic as opposed to psychological. The clients understand their experience of illness as a combination of 'big' and 'small' problems with themselves; largely their body. Even if they understand their inability to have an appetite as a direct cause of their new prescription, it is still said to be a problem with the brain as an organ; as an integral and inseparable part of the body. If a material pill caused the symptom, the symptom itself is understood to be a physical problem.

The term '*marda*[36]', located between 'illness' and 'disease' is ubiquitously employed to express and understand each other's condition. It is fundamentally a malfunction in some part of their corporeal existence. However, as opposed to clients, as patients and particularly due to medication, they decisively suffer from a disease: a psycho-somatic, but mostly biological problem. Like a neutral virus possibly affecting anyone, beyond their comprehension and ability to cure without being a patient to a professional. As opposed to illness, which Klienman (1981) describes as a culturally-specific articulation of symptoms, the term 'marda', when employed in the context of the residents as patients, is closest to the term disease. This is because, despite not always manifesting itself physically, the disease or 'marda' is an external force that descended upon the client.

'Qabditni marda' entails being caught *by* the disease, as opposed to *catching* the disease. The disease captures the individual, he becomes entangled in its symptoms. The way the illness alters the self is clear for the client. His biological faculties are impeded by it. He feels sleepy, exhausted, and dissatisfied because of his illness or the medication he has to

[36] "Marda" or 'disease', is the common term for any serious affliction in Maltese. It is commonly used to refer to series and infectious ailments such as bronchitis, diabetes or cancer. It cannot be adequately used to articulate lesser and non-contagious bodily issues such as muscle ache and flesh wounds, unless directly caused by a disease. During the recent pandemic, getting *the* 'marda' automatically referred to contracting Covid-19. It was regarded as *the* disease. Likewise, getting a mental "marda" is understood to be an unfortunate and unpreventable event- one that, usually, exposes human fragility to death despite all modern medical advances.

take because of it. The disease took something away from him; altered his self directly or indirectly[37].

Unlike emotional support, for the clients, pills are meant to directly eliminate the disease within them, including its symptoms (albeit seemingly not very effectively), rather than to help manage them. At the very least, to suppress its effects until they are no longer felt, or at a level wherein one can cope with them. The majority of the clients adhere to their prescriptions and associated temporality. They diligently sign their consent forms for medications every day and pick up their prescriptions on time. Apart from demonstrating their co-operation to the hostel by signing, and attending their appointments punctually as a way of possessing evidence for their independence to their doctors and social workers, they also do so because it gives them a sense of managing their illness.

Speaking to Mattheus, he shares with me how proud he was of attending all of his visits to Mount Carmel. He, like many others at the hostel, knows his prescription list of some fifteen different pills by heart and has a vague idea of what they're for. For Matthew it's the only way he actually feels he is trying (*nipprova*) to cure himself. Managing their medication, the clients can harness a sense of efficacious labour towards suppressing their condition, despite their side-effects.

“These pills are destroying me”, says Julian, one of the oldest residents, as we chat on a bench close to the hostel. He spent 5 years at Mount Carmel in his early fifties, spending the rest at the Hostel, still on medication. “Every time they [the doctors] say let’s try this, let’s try that”. For Julian, the constantly changing prescriptions were confusing him physically and mentally. His body reacted to new medicine with new side effects which he had to constantly get used to. On the other hand, he also had to keep track of new

[37] The most common term for madness is miġnun. One can describe someone as miġnun, which is to say that he is mad. It also carries with it the ironic connotation of a strange individual, not related to any negative remark. In any case, it refers to incoherent or illogical behaviour, actions or thought. Etymologically, one can trace miġnun to the arabic word for madness, *majnūn* (مَجْنُون), which itself derives from *jinn* (جِنّ) , colloquially known in English as ‘Genie’. However it can be more accurately translated as demon or spirit. It is meant to imply that madness is the state of being possessed by such a supernatural being. From its earliest roots, the term *miġnun* tends to imply spirit possession. In its contemporary usage, although completely removed of its demonological connotations, one can still see its implications towards possession by an external force; the individual dispossessed of himself. In fact, it is not uncommon to follow *miġnun* with *ma jafx x’qed jaghmel* meaning (‘he doesn't know what he is doing’). In the hostel, the client’s themselves explain their illness (especially the trouble they found themselves in as its by-product) as a state in which they are unsure of themselves (‘ma nafx x’kont qed naghmel’). In every sense of the word, *miġnun* implies the loss of self.

names and doses[38] all the while trusting his doctor's knowledge on his condition. Any feelings of mistrust or outright 'pharmaceutical burnout' - a lack of emotional energy to constantly build up the trust necessary to take up new medicines - had to be suppressed.

Where some build up their critique on their own and others' experiences, the rest harness an attitude of acceptance by re-articulating their trust in their carers and doctors. For the latter, self-alteration is a process that is fully entrusted to the care of doctors and social workers. Like the 'choice' of following one's prescriptions, it is only a partly informed choice[39]. The residents see their move from hospital to the hostel as an improvement when it comes to their medication and care: a later stage in the life cycle of a mentally ill individual. A point in time that still features drugs but may include less of them, alongside other cures and treatments, such as the 'community' itself.

One can even argue that community-care has resulted in a return to the containment of asylums in the form of stabilisation or maintenance made possible in the notion of the community as the embracing *milieu* or protective, 'normalising' environment itself (Fox 2003). Some have even suggested community care is only a 'progressive' and 'neo-liberal' cover for what is essentially an extension of age-old faults and practices under new disguises (Cummins 2020). At the hostel, although the clients receive all sorts of professional support, the clients still perceived their 'treatment' as pharmaceutical.

Although temporary, pills are considered by the residents to be the necessary sacrifice in light of the exceptional circumstances of the mental illness they find themselves in. Where the social workers see medicine as a step towards another and 'real cure', the clients see their mental wellbeing as an effect of their biological state. Self-alteration is only physical, where the hostel sees it as (essentially) mental. When clients conceptualise their disease in entirely biological terms, medical cures are always deemed most effective.

[38] Prescriptions may change from time to time, and each client is given a carefully studied combination of drugs; a variation in both type and quantity. For example, certain drugs are given instead of others to slowly ease out of another addicting type of drug. Others might be newer generation drugs that they try to introduce into the clients' prescriptions. Experimental and/or emergency drugs may also feature on a client's list. In the hostel, only one resident, Marco, is entirely off medication. The rest take between 20 to 50 pills each day. Every resident has his list to keep track of, every client has his pills to try out or slowly reduce from time to time.

[39] Despite its ambiguity, medication retains a central role in the hostel's daily routine. It is also a crucial function of the hostel itself, if not the essential development in psychiatric care that created the conditions of its existence (Brown 1985; Floersch 2002). Medicine allows care beyond the hospital walls, allowing case management to occur through smaller professional teams.

Sitting down on an old-fashioned sofa in the evening, I chat with the residents on their medicine. Medication, new and old pills are always a pertinent topic. February 2021 was a time in which the residents were articulating their opinion on yet another medicine to take: the Covid jab. To live in the hostel, it was obligatory to take it. Where some felt apprehension, the hostel reassured them that it was only an additional medication to prevent the worst of Covid. Maurice explained to me that he's gotten used to injections, citing one particular jab he takes once a month for his schizophrenia. “But we have to take it” he says, “otherwise we will be more sick”. Within this understanding, the Covid jab was only another medicine to take for yet another illness. The fact that they must attend counselling and receive ample moral support from the hostel is deemed irrelevant toward a ‘cure’ from their condition. For the residents, one cannot ‘speak’ one’s way out of Covid and certainly not schizophrenia.

Nevertheless, social workers tend to see medication as only a superficial mode of self-alteration; addressing the effects rather than the cause. The healthy client is not one without symptoms but an independent one according to a specific construction of independence. The client remains a *patient* not because of his symptoms, or prescriptions, but so long as he refuses to understand the role his *character* plays in his affliction, and counselling towards some ‘cure’. In a very neo-liberal, and, in Scharff’s (2016) terms, ‘entrepreneurial’ spirit, the hostel wants its clients to become the best version of themselves; employable individuals with the required skills to, at the very least, sustain themselves. As long as the creation of a renewed, independent self is not recognised as fundamental to recovery, the client remains a ‘patient’: an ill individual lacking agency. If the ‘patient’ does not adopt the hostel’s perspective voluntarily the social workers resort to ulterior, but perhaps equally voluntary means.

6.3 Circumstances and Character

There is a certain paradox in the hostel’s aim to support clients. The hostel takes on clients on the principle that they freely consent to their services, that they are already capable of exercising their autonomy. However, the client subscribes to the hostel to gain the very same ability, to choose things out of his own will: the very precondition for being at the hostel. He arrives at the hostel because he possesses and wishes to attain

agency. The client however is at once free to pursue his own desires and forced to adhere to rules, both a client and a patient.

Though the client can refuse to follow his prescription, he cannot sleep late or quarrel with his roommates without consequences. He can use facebook and other social media but he cannot befriend his social workers on such sites, keeping them at a distance[40]. The resident can, although strongly advised not to, consume all sorts of unhealthy food and uptake (or re-uptake) any self-damaging habits such as smoking or alcohol abuse. C*uring symptoms* is related but different from *being cured* in a more holistic sense. In the office, a quote is painted in large letters, the central decor piece, which states that:

'Life isn't about waiting for the storm to pass...it's learning to dance in the rain'

The hostel is actively trying to create new individuals capable of living in these new socio-economic circumstances. The question is what is this individual the hostel is trying to change and improve?

The social workers accept that mental illness is an unfortunate 'wound' that, with 'time and love', can be healed. However a scar remains on the resident, and he never truly exists in the category of client as the hostel understands it to be. Individuals that went on to live independently, in completely different circumstances such as flats and independent living, still have contact with a case manager, they still undergo some form of counselling and follow prescriptions. For the social workers, being cured does not mean an end to one's symptoms but a more independent state in relation to the management of the illness: a *resilient character*. That one can never be completely rid of schizophrenia does not mean he cannot ever be 'cured'. Health depends on the notion of 'capacity' which is variable and depends on its subjective effect on the individual. For the hostel, being cured, just like being sick, is often a question of how much of one's capacities the affected person feels are re-gained or gained. The gravity of an illness is often not defined by its capacity to be cured but rather one's ability to manage it. Thus, illness for the hostel is detached from its in/terminability. As Parsons (1975) notes:

[40] In hindsight, during my fieldwork I wrongly assumed I could keep in touch with my informants, clients or social workers, through facebook. Especially due to recurring Covid lockdowns, I felt that establishing an online relationship could give me a backup 'connection' to my fieldsite. The clients enjoyed keeping touch but the social workers would not allow it and asked me to remove them from my friends list. Looking back, it was the right thing to do since they were growing too attached through it. Albeit, it allowed them to stay in touch with me in their exceptionally lonely world. The hostel wants them to be as sociable as possible with whomever and through whatever way they please but only with their consent. This sort of confusion was commonplace.

> The fact then, that diabetes is not, in the sense of pneumonia, ‘curable’, does not put it in a totally different category from that of acute illness. (p. 259)

For the hostel, Schizophrenia or depression are only acute or mild in terms of one’s capacity to control it, not to be cured from it. Ill clients are not so much seen as individuals on a trajectory towards becoming healthy individuals. Rather, the client’s illness is accepted as a complete and valid way of being. To a certain extent, it is simply who he is. This asymmetry between the client’s and the hostel’s goals makes ‘being cured’ an impossible possibility: a state that one can and cannot ever reach. Rather than a goal, it is an activity largely occupied with preventing things from getting worse before attempting to make them better. Thus, in this regard, it is closer to contemporary models of care based on conservation. As Mol (2008) puts it:

> What characterises good care is a calm, persistent but forgiving effort to improve the situation of a patient, or to keep this from deteriorating. (Mol 2008, p. 20)

At the same time, the hostel is actively trying to care through actively creating new individuals. Encouraging their clients to reach a practically unreachable state can, at the very least, yield some form of improvement. Social workers push the client to get better, while acknowledging the impossibility of being ‘cured’ and ‘free’ of symptoms.

As is also noted in Estroff’s (1981) account, although curing is not deemed to be entirely within the capacity of the hostel, they do their utmost to assist it. Countering the common assumptions of stigma and shame associated with the word ‘crazy’, Estroff notes how instead clients can form new identities based on their new-found illnesses. Through the gruesome side-effects from prescriptions, their mutual struggle against loneliness and homelessness the residents could, as a narrative and cultural strategy, embrace their suspended identity. Being mentally ill was not a deficiency but a ‘lifeway’ possibly as valid as being Yanomamo or Dinka, only called ‘crazy’. As Estroff puts it:

> Clients who are told constantly in multiple ways that they need meds, probably for the rest of their lives, are also being told that they will never "get well." They cannot persuade themselves that, with perseverance and care, they will be cured. Rather, they come to see themselves caught between a non-medicated world that is out of reach, and a medicated world that identifies them as crazy people with problems in their heads and in their lives. [..] Long-term psychiatric patients are entwined in the paradoxes of constructing and living with a crazy identity and with

> uncertain illness in a sociocultural environment that communicates and denies, enhances and devalues who they are and how they are. This is what "making it crazy" means. (Estroff 1981, p. 109-244)

At the hostel, to an extent, the clients do identify with their illness: that they can never be cured or return to their old self completely. However, they continuously retrace their steps to specific mishaps and poor healthcare. This is denied by the hostel and the social workers who do their utmost to get their clients to move on from the past by accepting and managing illness in the present. Nevertheless, for some cases, the social workers come to terms with the fact that the client would not be in the condition he is now had he not been admitted to Mount Carmel in the first place. What was an ordinary case of depression or anxiety disorder was, in some cases with malicious intent,[41] exacerbated to merit hospitalisation. The social workers and the hostel are adamant that, motivated by greed or personal animosity, patients who could have gotten better with minimal medical intervention ended up with worsened conditions once admitted to the hospital. If their condition was not acute, the social workers assert, it certainly became so once inside Mount Carmel. The hospital acted on them, as Goffman notes, 'like a thick and faulted prism' (Goffman 1961. p 360), which traps the individual by rendering any reaction contrary to hospitalisation as an indication of its necessity.

Put simply, the social workers see the clients as the residual outcome of the inherent repression of life and the healthcare system, the tattered adults emerging from their neglected, and sometimes unnecessary years at Mount Carmel. Perhaps, for the general public, as Martinez (2017) argues, as some sort of 'excess' which should not exist, but at the same time the outside that defines the inside so well. However, for the hostel, the fact that the client exists does not mean that he is a problem. Rather, that there is a fundamental problem in society and the mental healthcare system alike. Each client is a constellation of factors or 'circumstances' that unknowingly led him to his condition outside of his control.

For this reason, beyond *circumstances*; moving to the 'safety' of the hostel away from Mount Carmel, *character* is the second crucial factor in the hostel's understanding of the genesis of mental illness. The social workers state that to be mentally ill does not

[41] One social worker confided that in the past one could get away with false declarations about a patient's condition in order to warrant an involuntary admission. It has been suggested to me several times that some cases at Mount Carmel have been admitted even without any medical consultation. In several exemplary cases, a wife wanting divorce presented her husband's criminal record as a sign of acute mental illness, requiring admission. Nowadays, through extensive reforms and improvements in mental health care, such practices are no longer possible.

necessarily mean that one becomes a patient or a client. One can be in a far worse state than people in the hostel. The only difference is one's ability, and therefore *character*, to recognize and deal with life's random *circumstances*.

6.4 Persuasion

With their conception of mental illness in mind the social workers set out to reverse the effects of its original cause. Before discussing the important role of 'character' in cure, we must first deal with 'circumstances'. What this translates to is the endeavour to assist their clients with a careful study of their initial miss-step. Knowing this, the social workers can walk the client backward through his 'downfall'. If a client went from a drink on the weekend to a few drinks in the morning, he does not immediately return to the former, but gradually decreases his daily consumption. Likewise, if the same client has depression due to sudden and unexpected trauma, he is not immediately expected to do things with the same enthusiasm as before.

If a client's unhealthy social environment instigated his illness, he is brought into a healthier one. The approach, put simply, is to give back to the client what he, for one reason or another, lost or did not possess at the time he started to become ill. For example a supportive network of friends, the courage to stand up for one's self, or the determination to push through misfortune. The way forward is to slowly move back towards the original self, altered by symptoms and, perhaps, get to a new improved version.

In the process, a client's trajectory from 'healthy' to 'ill' is clearly mapped so that a goal and path towards 'normality' can be outlined. Sitting outside on a particularly hot night with Philip, he chose that moment to explain his illness to me. After a long history of drug and alcohol abuse, parties, and all sorts of experimentations (some of which I could not understand) he narrows down the day and moment he got ill to a night in Amsterdam. On that day, Philip took a potent blend of drugs, the effects of which he never recovered from. He explained how he had been suffering from hallucinations long before that night but they became incessant and intense after a particular dose. He also explains how his doctors and the social workers helped him understand that his alcohol abuse was already an illness he was suffering from, caused by his previously unidentified depression.

Clearly, the hostel works with the client to understand where he came from. Through a clear story, the plot can be followed back to its beginning and, hopefully, an even better one from now on. If the hostel is trying to do anything it is to provide the setting and circumstances in which an individual could live; one of the crucial elements missing when the client originally became ill. More so, through socialisation and other means, the social workers attempt to start another 'chapter' in the client's story with an even stronger character better immune to illness.

This is parallel to other accounts where illness is approached as a question of truth and discourse (Good 1994). For Davis (2012), illness is a 'truth-game' which is played by the patient or client and staff. Illness is subject to certain knowledge claims and ways to maintain or demolish them. Davis' account provides a novel approach to mental illness as a question of mutually constructed realities. Similarly, the hostel constantly creates medical truths with or against the individual client's. It constantly creates and articulates the client and his illness.

Through persuasion, the hostel is oriented towards the client's becoming rather than being. To do this, the hostel encourages interaction with the local community, living in a household with supportive individuals, and being supervised by people who *care*, albeit in two different understandings. At the hostel, the residents are cared for and '*cared with'* (Floersch 2002). They, quite literally, help them have a choice on what to wear, find out what they like to do, assist them to articulate their future, and how to get themselves there. But only to the extent that they are able to make the right choices. As a client, circumstances become something one can control. It suddenly becomes possible to select which places one spends time in, which people to befriend and how and when to terminate relationships. The self is given the capacity to alter itself through the emphasis on independence. The client works *with* the staff to alter himself.

However, as a client, there is no prescription for social work, no obligation to follow its guidance. Since it cannot command its clients, even if it deems them unable to make entirely 'rational' choices, the hostel resorts to a very subtle art of persuasion. By suggesting alternative courses of action, even joking with the clients, the social workers directly influence them towards the appropriate choices. Instead of directly stating what needs to be altered, the staff suggests it through calculated interactions.

In such cases the social worker positions herself as a guide to the client's freedom. She shows the client what she (and the hostel) want for him, *how* they want him to be free. However, they can never force the client towards their goals, only towards his own. Even before doing so they have to convince the client that he is free, but only in a particular manner. Put simply, they have to give the client the coordinates from which he *must* be free, and manufacture the client's compliance toward independence. Although this is all superficial to the client, who prefers to target his biological symptoms alone, it is the 'independence cure' that is the deciding factor for the hostel. Intended to radically change the client, such techniques function as modes of self-alteration from the social worker to the client.

6.41 Rationalising the cure

For the hostel, beyond his symptoms what needs to be eradicated in the client are unfounded claims. These are deep-seated pre-dispositions that the client reiterates from time to time. The most common being the belief that one is better off as a patient in an institution. When a client encounters an altercation, falls out with a friend or a social worker, or becomes upset with the hostel for whatever reason, he may ask to be transferred back to Mount Carmel. Upon receiving such a request the social workers cannot express any judgement.

However, social workers can begin to persuade the client away from such an idea by exposing paradoxes in his argument. If the client states that he wants to go back to Mount Carmel because he is not treated right at the hostel, he is asked about his time at the hospital. Usually, the client recalls his negative experiences if not downright lack of treatment. In other words, the social workers rationalise the hostel's position on the client's request. Slowly, the client's position is weakened, and he comes to accept the rationalisation presented to him.

The client's decisions are always accepted even if their premises are not. It is not the client who is wrong, but the position he has placed himself in. However, since they are, in effect, altering a client's decisions and redirecting his desire, they are inherently engaging in self-alteration. This process can even occur without any form of deconstruction. By simply affirming a client's position he can be made to reject it. Oftentimes, proposing to be transferred back to the hospital is only a way of inciting the social worker's reaction;

forcing them to heighten their caring roles. Rejecting this ploy and simply affirming the client's request, quite literally stating that one can go to Mount Carmel, the client withdraws his request in due course.

Rationalisation also involves the process of presenting the hostel's point of view consistently and incessantly. Anything put forward against it is impersonally dismantled as inconsistent and irrational. When a client asks to withdraw an abnormally large sum of money from his account to purchase something 'unnecessary', under no condition can his request be rejected. The social worker simply asks him to explain the rationality behind his request. Subscribing to the wish to be independent, explaining how his current action goes against his own intentions generally dissuades the client from proceeding with his purchase.

On one occasion, George, a client, wanted to buy a new bicycle, which he didn't know how to ride, costing him hundreds of euros. The social worker on duty did not reject his request (which she cannot do in any case, unless a client or his family/friends ask for such an agreement) but managed to talk him out of it. The key moment being the moment he realised he could use the money to purchase a gift for his niece instead. Hence, his desire was successfully diverted towards a 'better' goal, at least, in a moral sense. Ideally, the client internalises the hostel's rationality. His desires become synonymous with that of his social worker's; it fits within their understanding, their range of what a normal healthy adult should do with his life and his money.

Explaining how he came to terms with his condition Maurice affirmed his deep admiration for Stephen Hawking. Maurice suffered from intense visions wherein god showed him the pain of hell. The fear he felt during such episodes was indistinguishable from reality. They are experiences that still affect him to this day and remind him of his late father who was deeply Catholic[42]. Coming to terms with his abject traumatization, he attempted to reconcile his religious life. Now, he rejects such an attempt as a misguided, irrational endeavour that furthered him from his cure. Speaking as a proud atheist, he states that he overcame his illness through learning about Stephen Hawking's theories on the nature of the universe. Adopting a radically materialist understanding of the universe, a total rationalisation of its deepest mysteries helped him see his condition as yet another aspect of the cosmos. Much like the fascinating behaviour of electrons and the

[42] The death of his father instigated his visions. He would also state that he felt guilty for disappointing his religious father, which could be a reason why he experienced the Catholic guilt of eternal damnation. His first hallucination also occurred at a time when the client was using copious amounts of recreational drugs.

incomprehensible, paradoxical nature of black holes, he was determined that his illness too could be explained through a similar 'scientific' endeavour.

Although such an interpretation does not fall within the appropriate understanding of an independent self, seeking a 'scientific' backdrop to the world is deemed to be one way of developing a sense of independent thinking, hopefully leading to action. More so, such a 'scientific' approach, attaining knowledge of the world, could lead the client to adopt a 'teaching' role in relation to the others. He would share his 'findings' with the others to dispel what he thought of as unsubstantiated 'rumours' about their conditions and causes. On several instances, I watched him explain the chemical process of depression to his roommates, who had stated that their illness was inherited. The hostel allows its residents to influence one another so long as it is deemed positive and conducive to independence, such as the 'quest' for 'scientific' knowledge.

One way of realising this is the development of 'insight' into one's condition. As Maurice put it: "tal-inqas għandi *insight*, naf xgħandi" ('at least I have *insight*, I know what I have). The client is, for his psychologists and, partly, the social workers, said to possess this new perspective on oneself when he adopts the clinical understanding of one's symptoms. He is deemed to be capable of articulating his condition like an outsider looking onto him, and is therefore independent from his personal, possibly flawed understanding. This is the hostel's aim, and if the client does not adopt the hostel's 'insight'[43] on his condition, at the very least, he is allowed to take up a similar one. Ideally, one that serves the same aim of helping the client cope with his illness. Once his symptoms 'make sense', the moment they fit into a larger and total explanation of his current state, he attempts to guide others towards their own 'insight'.

On one occasion, Matthew wanted to leave the hostel immediately. With tears in his eyes, he felt that he didn't belong here. To him, his symptoms were too much to live in the independent state of the hostel. His roommate, Shafiq, walked up to him to console him. Trying to convince his friend to stay, he proposed his argument alongside the hostel's: "here it is better, you can go out, you can do anything. They [the staff] told you this; *hawnekk mhux* hotel [were not in a hotel]". He presented the freedom of the hostel as superior to Mount Carmel. At the hostel one can quite literally "do anything"; one can be the ideal independent self. At the same time, he presented the burden of responsibility, they have to wash their own bedsheets and cook their own meals. This radical freedom at

[43] It should be noted that 'insight' was always mentioned in relation to Doctor's appointments. Maurice also stated that the doctor told him he has acquired "insight" and now stands a better chance of becoming healthy again.

the hostel also entailed caring for oneself. However, Shafiq was adamant that the responsibility at the hostel is a small burden in relation to the freedom it provides. This is the hostel's argument perfectly embodied by one client and rationalised to another.

The logic of the hostel is made clear to all the residents every Monday. During these weekly meetings, important notices and amendments to the hostel are announced and discussed. Here, the staff takes the opportunity to explain how the hostel works. Doing so, they direct the clients as to how they should see and use the hostel. As a tool, it is presented alongside its application: making independent individuals. When a neighbour complained about loud music being played in the courtyard at night the staff took swift action. At the next meeting, they introduced the new rule: 'nobody is allowed into the courtyard past 9 pm.' However, they didn't present it as a direct instruction but as the only rational decision. "Remember", they say to the residents, "this is your home. *You* have to take care of it." The decision to close the courtyard is given to the residents as one which they themselves should have done, one partly made on their behalf. Presenting the hostel as their home, it is also their responsibility to ensure the neighbours complaints do not lead to its demise; as many other circumstances have threatened to do.

Introducing the new rule, as all other instances of rationalisation, is presented as the only thing that 'makes sense'. Therefore, instead of a direct imposition, it becomes an accepted emergency measure for a problem which the residents failed to address. Persuasion gives the client a necessary understanding of his world which he takes up as a rationality he should have internalised beforehand, as an independently minded individual. For the hostel, there is no such thing as a healthy *and* irrational self.

6.42 Artificial Consequences

There are multiple ways of persuading a free client towards the image of the hostel. The social workers cannot remove the client's total freedom directly. However, to live in the hostel, one has to abide by its explicit and implicit rules.

If the client does not carry out the chores they are assigned they are given extra duties. Likewise, if they disobey a rule set out by the hostel, they are assigned additional tasks and responsibilities. If a client chooses to stay outside the courtyard past 9 pm, he can expect extra tasks the following day.

That being said, if a client uses bad language, sleeps late, purchases alcohol or hard drugs he is not punished for such behaviour. The social worker will, instead, console him. He is given adequate advice and care so that the motivation behind his actions is understood and eliminated. Bad habits, wrong actions, and outright addiction is beyond the self; the client has no control. Here, it is his symptoms that made him pursue such behaviour. The client is only penalised for actions which originate from his own decisions. Mental illness is not said to directly cause his drinking addiction. It is the primary cause for a certain negative feeling he has and its subsequent effects. The variety of methods with which such a feeling is managed is beyond his illness.

Every day, the social workers have to watch Mattheus go outside to purchase all kinds of energy drinks knowing that they are extremely damaging to his already obese state. The social worker can do everything except stop him from purchasing his drinks or punish him for it. When asked if she could do anything about the severe issue, Beatrice, one of the social workers on duty replied: “What can I do? Tell him to stop? It's something he cannot control!”

Beyond a source of emotional turmoil (as discussed before) this situation sheds light on the actual limits of care. For this social worker, his addiction was not part of himself but something external to him, therefore unpunishable. The same social worker would personally explain to the client the damaging effects of his habits and provide ample alternatives. She even went as far as to show him how to make fruit smoothies and gave him a selection of less sugary drinks as alternatives. However, even after accepting her help, he immediately goes out to buy another pack of energy drinks. “You come to a point”, Judith says, “where you have to give up”.

Mattheus also disclosed that he used sugar to get back the energy he ‘loses’ from his medication. For him, it is a necessary addition to his diet to counter the impact of his pills. For both the hostel and the client, his addiction was an indirect effect of his illness. Since it is not a decision made by the ‘pure’ self it is unpunishable by the hostel. The sugary drinks are seen to give back the ‘energy’ he lost, giving him access to his ‘true’ self.

We can see the awkward relationship that exists between unwanted behaviour and punishment. For the hostel, the validity of giving an extra duty depends on the cause of an action: to what extent it originated in the client’s uninhibited ‘self’ as opposed to the

illness. Through penalties, what the patient attributes to his symptoms is instead reframed as the result of the actions of 'self'. This turns what the patient might readily correlate to the effects of symptoms into a manageable aspect of one's *character*.

The more the client becomes who the hostel wants him to be, the more he is left alone. After all, independence is the sought-after goal. That being said, the social worker can partially redirect a client's request to get what she wants from the client. . If a client asks for his weekly allowance but he has not picked up his medicine yet, the social workers will not reject his request but reply to it differently. They might suggest that he go pick up his prescription whilst they fetch his money from the safe. If a client has not completed his daily chores and requests some time alone with a social worker he might be suggested to do both at once (the staff members often talk and help their clients clean at the same time).

In Paul Brodwin's (2013) account of community psychiatry in the US mental health system, persuasion features a dedicated reward system. Through 'voluntary care contracts', people subscribed to an all-encompassing service. Once signed, care becomes involuntary to withdraw from. The clients then become the responsibility of their assigned care-worker who manages their income, habits and finances. However, they must uphold their obligation only until the clients decide they no longer need their service. The trouble begins when one has to determine whether the client's request is genuine or part of the illness, or even a symptom. Even if a client accepts a phone call after 6 months of neglecting contact the 'case' re-starts. In Brodwin's account and the hostel this has all sorts of consequences for the social workers: how they manage futility, make sense of their efforts and relations they form with clients.

One way of circumventing such a dilemma is to maintain a client's contributions towards his own progress. The client cannot be denied any money, medicine, or other necessary items. However, carefully manoeuvring one's services can be a way of keeping clients 'engaged'. On one occasion, Maurice had to clean the steps on the front door, a task which he kept postponing. A meeting he requested with Judith was promptly held while both cleaned the steps. In the end, Mourice thanked the social worker for helping him doubly: getting him motivated to finish his chores and tackling his emotional rut. The hostel never rejects a client, but rather presents him with an alternative proposition that satisfies both sides of the relationship. What results in a successful transaction for the social worker is experienced as a mere alternative, or even better sequence of events for the client.

6.43 Joking

Humour and jokes are also used to reorient the client's self. Jokes however also serve to alleviate the severe tensions between what the social workers *want* to say and what they *have* to say.

Occasionally the clients ask a staff member on duty for help with very basic tasks which they can certainly do alone. When Edmont, a Covid 'refugee' from an affected hostel, asked for his meal to be brought to his room the request was rejected. Edmont explained that he was afraid to use the stairs as they had recently been cleaned and he could easily slip. After explaining the reality that his chances of slipping were very low and that he had climbed the same wet stairs many times, such a rationalisation of the situation fell short. As a way of making light of the situation, Judith told him: "What do you want me to do, carry you? I can barely lift my bag!" Edmont smiled, realising his attempt to get room service had no chance of materialising. He slowly made his way up the stairs from the basement to his meal.

In this situation, the social worker was able to express the absurdity of the client's demands. In addition, the ulterior motive (which in this case is to spare him getting out of bed to eat) is unveiled. The client then has no option but to laugh off his request and proceed along with the hostel's guidelines. This is not to say that the client is ridiculed. Only that he is exposed to the inherent conundrum in the social worker's perspective. In this sense, he is made to feel inconsistent with his ideal self, with how he should be.

On a separate occasion, Matthew was upset since a particular request could not be accepted by Catherine, a support worker. He sat down in the office, sulking, looked up, exclaiming how he hated living in the hostel. Catherine, realising I had noticed the unusual gesture from a usually joyful client, looked at me and said "Have you ever heard the song 'She is like the wind' by Patrick Swayze? That's Matthew", now looking at him, "*he* is like the wind. Sometimes sad, sometimes happy". The social worker spoke to me but addressed the client who was listening, and now almost smiling.

The client is made to perceive himself, his current action as wrong through such subtle remarks. Through humour, in a friendly and fun manner, the client's self is transformed: realising his predispositions for sensitivity, scapegoating, excuses and all other sorts of negative traits in oneself helps to overcome them. Realising his faults, in himself or his symptoms; in his *character* or *illness*, is the very step towards transcending them.

….

These three methods and techniques towards alteration are used by the hostel in order to persuade its clients. Through *joking*, *creating consequences* and *rationalisation* character is built and moulded indirectly through arranging circumstances at the hostel. Nevertheless, the social workers are constantly on the brink of directly shaping character themselves. These techniques expose the contradiction inherent in trying to be free in a constrained way: the conflicting reality of being at once a client with agency, and an individual in need of care. Perceiving his current self as incompatible with the hostel's demand, the client sets out to alter himself accordingly. It is not enough to be cured of one's illness, to simply live in the hostel and follow its rules as an autonomous adult. One has to be independent in the right way: possess the right 'character'.

6.5 The Moral Patient

For the hostel a flawed character is one of the two main causes of mental illness. But what exactly does this mean? This is not to say that the client's particular character was flawed, because everyone's character is understood to be imperfect in its own way. The social workers understand their client's shortcomings to be particular and wrong since they are *specifically* susceptible to the circumstances they found themselves in. The social workers are adamant that two people can go through the same trauma, the loss of a loved one or a failed marriage, but are affected in completely different ways. After a few months, one of them may move on with his life whilst the other develops schizophrenia and has to be hospitalised.

In terms of prognosis, the client is deemed to be 'cured' not insofar as his flaws are eliminated but to the extent that he can manage and limit them. As in other employments of 'resilience' (Foster et al. 2019) the social workers position themselves as 'character builders', designing and nurturing characters fit to withstand any circumstance, or as much as possible.

Judith expressed her very own theory of madness. Life is a 'constant battle' and, for her, the difference between the sane and the insane is their ability to fight back. "Life is war, don't you think? There's always something new to fight. Life is just a recurring battle". Put simply, the ill person is the one that raises a white flag, that lays down his arms, and forfeits the battle that is life. To be sane is to be capable of fighting back against whatever life throws at you: to process misfortune and embody resilience towards every challenge. Refusing to do so inevitably dwindles the mind down to madness.[44] Being healthy entails a certain attitude that is attained through the process of learning to become an adult, or participating in civilization. The moment one no longer possesses such a 'character' mental illness sets in. Stasis is said to be deadly and continual fighting is the only way to survive. Like a military stratagem, Judith nurtures this perspective and plan to her clients indirectly, giving them the essential apparatus to fight the battle that life intrinsically is.

A new and improved character leads the patient towards an ideal self. This includes what are for the Hostel universally accepted moral principles. By 'moral principles' I imply the things one must do towards being deemed 'cured'. They can be understood as things one 'ought' to pursue (Beldo 2014). Arguably, they are inseparable from the 'cure' itself: one possess agency by practising the right morals. To this end, they can also be seen as an invisible lens through which independence is enforced onto the client, as does any 'cultural system' through its codes and symbols (Csordas 2013), such as waking up before 10 am (and sleeping before midnight), keeping a healthy diet, being kind to others, and maintaining an acceptable level of hygiene. This includes the hostel's staff as well. They have to keep their appearance tidy and hygienic and pay careful attention to their manners (the please and thank you's, conversation etiquette, respecting people's boundaries, etc). Such qualities are part and parcel of being a healthy adult, and are therefore morally correct in light of the independent individual the hostel wants its clients to be. Consequently, social workers have to be kind and patient, not only because their job requires such qualities to be possible at all, but also because that is how the hostel wants the client's 'character' to be.

As in other community mental health services (Anderson et al. 2016), some rules, although unwritten, are incontestable, such as (at least trying) to keep oneself busy with hobbies or a job, or even staying organised (Hansson 1993); physically through hygiene and temporally through calendars and their events. Clients are expected to emulate and,

[44] What Foucault, speaking of Renaissance Classicism, would call the conception of illness as the natural state of man, uncivilised and raw; 'the animality that rages in madness dispossess man of what is specifically human in him; not in order to deliver him to other powers, but simply to establish him at the degree zero of his own nature' (Foucault 1967, p. 74).

eventually, incorporate such traits into themselves. Staff are presented as ‘role models’, as Brodwin (2013) also finds, and certain clients as well are encouraged to be role models to others.

The hostel functions as a pool of characters that strengthen each other. A shy client is encouraged to be more outspoken by a confident client and in turn the same client may be encouraged to maintain good hygiene by the former. Matthew struggles to build up an appetite. If he does not eat, fellow residents would encourage him to eat a sandwich, try something different or drink some water. He, in turn, would encourage them to be more active, perhaps join him for a game of pool in the basement or head out to a snack shop nearby. Managing one’s faults and encouraging others towards their own independence from symptoms is presented and understood to be, as Sarah calls it, ‘what normal people do’.

Ideally, the afflicted client attains a sense of duty towards his circumstances, and more so his character. The client must learn to withhold his ‘wrong desires’, to discipline himself. Akin to Foucault's (1977) notion of discipline as one way through which power is manifested in the individual, and perpetuated through self-repression, the client is taught how to contain and subdue himself. However, in a distinct neo-liberal tinge, he is more expected to discipline himself not in regards to withholding his desires but forcing himself to possess them.

He must attain motivation, a reason to wake up in the morning. He must do so himself, but the social workers will assist him and almost change him themselves. By assigning jobs, eliciting vocations or re-igniting passions the staff assist the client to foster his new self. To cite one instance, Albert, returning from Mount Carmel, discussed his short-term future just as much as how he felt in the present and about his past. As the youngest client, staff are especially worried about his life’s plan and strategy as much as his prescription and medical reports. Actively nurturing this ‘disciplined’ will or agentive ‘character’ is all part of the social worker’s role. Breaking away from the idea of the client, the resident almost becomes a patient again in a moral sense. Doing so, the social worker (discreetly) maintains her role of caring *for* her clients as opposed to solely providing a consensual ‘client’ service. Character becomes the fundamental project of the social worker *for* the client.

In fact, the social workers go a step further: they understand mental illness to be a ubiquitous and universal way of being. Not reaching for a cure, no matter how

impossible, inevitably entails settling deeper into one's illness. One does not ‘become’ mentally ill, as the clients conceive of it: like an external malady that invades their body. The social workers accept that mental illness is always already in the individual. Anyone can become just as ill as their clients. Although they recognize that genetics plays an important part, a general consensus exists among the staff that it is the particular combination of *social circumstances* and *individual character* that lead to mental illness.

During a particular interview with Judith, the topic of ‘causes’ came about. I was trying to understand the typical trajectory of the foundation’s clients, how they become ill, and at which point they become clients. The social worker stayed silent for a few seconds. “Listen”, she says; “nobody *becomes* ill: it is only a question of how capable you are of coping”. She then added that there is no biologically or clinically distinguishing feature between individuals within and outside of the hostel, clients, and so-called ‘normal' people. What distinguishes the person living at or outside of the hostel is one’s capacity and “character” to deal with existence as a war against ‘life’.

In other words, the mentally ill are those that simply cannot ‘manage’ or ‘hold back’ the constant onset of illness. For her, everyone could and might be just as ill as her clients. More so, there are people suffering from all sorts of illnesses who have never sought professional help. It was almost as if the social worker had just finished reading Eric Fromm’s *The Sane Society*, in which he states ‘That millions of people share the same forms of mental pathology does not make these people sane’ (Fromm 1991, p.15). Beyond the barriers of stigma or financial support, she affirmed that some people can perfectly manage their conditions. In fact, that is exactly what sane people are at best: people that can manage their illness, winning whatever mental ‘battle’ they are fighting, not free from it. The fact that most ‘normal’ people can do that does not eliminate the fact that they are ill. Since illness cannot be eliminated and its effect only minimised by building a stronger character or self, the hostel is presented as a place where clients can do just that.

However, paradoxically, the notion of being ill, for the social workers also entails the complete loss of self, the loss of agency, and the ability to alter one’s self, to be ‘healed’. Therefore, the client is treated as a ‘patient’ when in need of a direct alteration of self. He must follow certain standards that ‘normal people do’. ‘Control’ and ‘Care’ become interfused. As Singleton (2010) describes concerning farmers and their livestock, caring is usually enough to guide in the right direction. However, a certain amount of control enters the scene to do so efficiently, in terms of monitoring . What this translates to at the

hostel is concise rules the social workers enforce to ‘care’, with the added difference that the clients consent to them.

The social workers do so despite the indelible feeling that some part of them remains unconvinced it is possible at all. A client that picks up a few skills and a more resilient ‘character’ is the realistic goal. If a client easily gives up when facing a complicated problem he will be taught how to separate his issues into manageable steps. If a client breaks down at the thought of social interaction he will slowly learn to express himself and take hints from other people during conversation. Learning new skills and applying them to one’s character, is the primary task in the eyes of the social workers.

At least initially, until the client learns to do it himself, the social workers shape and construct the client's character. It is one thing to offer a service and watch how someone uses it, and another to actively ensure one is being shaped, or radically affected by it correctly. Building up character, or its resilience is another way of manufacturing agency. For this process to take place the individual cannot be perceived as a client. Ensuring that the residents benefit and thrive at the hostel the social workers take up an immensely active role towards a *moral patient*.

Caring *for* the client the social workers start to adopt a sense of responsibility beyond that which is required. They care where a client goes, notice odd behaviour, and constantly counsel their clients on their daily lives. Returning to the aspect of emotional labour, the social workers draw upon their roles as mothers and wives in providing care for the client. They are not there to do what is required of them alone but to see their client’s recovery occurring. Besides protecting their clients they actively help him build up their *character* every step of the way.

“I can’t help but see them as my children”, Judith explains, “even though we’re not supposed to”. In her eyes, care could never be completely professional and distanced; simply a service provided. The individual in front of her required total assistance. He is incomplete and needs, like one’s child, to grow into a fully independent adult. The social workers position themselves as experienced adults if not parents raising individuals to their level of independence. Likewise, the clients understand the additional care they receive as ‘motherly’, if not a direct substitute for a mother. A local study of a psychiatric half-way house (Vassallo 2008) noted an explicit identification of the staff as an ersatz family. This identification with familial roles is something which the residents express. George explained to me that a particular social worker cares for him much more than his

mother ever did. He likened the attention to the qualities he would like in a spouse. Being the same age as one support worker he placed himself as a possible candidate were it not for his condition. Frequently he would tell me: “If I wasn’t ill I would ask her to marry me!”.

Beyond all the procedures and counselling, Judith suggests that what the residents “need most is love”. The human connection missing in their lives is the best form of care they can provide, albeit not quite in consonance with the official hostel approach. The active alteration of selves entails going beyond the hostel, beyond the understanding of caring as is stated explicitly. The moral patient is the client whose character is actively being built up by social workers; the ‘loved individual’.

The ‘client approach’ is quite simple to practice and outline. The other form of care, one based on ‘love’ and the direct alteration of selves sometimes feels, for the social workers, more ‘natural’ to employ but harder to sustain. It is the cultural model of care taken for granted by the social worker. Although it is quite simple to follow guidelines but much more intuitive to provide the cultural forms of care they are acquainted with. The ‘client’ approach is one acquired through formal learning. The ‘moral patient’ approach is, as the social workers themselves put it, the residual outcome of life experience. As such this is seen to be a more ‘real’ form of care because, as Judith also puts it, “one cannot learn how to live from a textbook”. For the social workers, being the effective form of care, it is the only hope for the client to be free of his symptoms and their effects and, therefore, the only ‘real cure’ the hostel can offer.

The ‘maternal’ role constantly threatens to overflow and spill over every aspect of the hostel. However, this perspective can never fully emerge. They cannot say to the client that they ‘love’ them, nor can they explicitly express consolation or affection. At most, they can do so cryptically by scheduling an extra meeting or giving extra attention to a client who needs it. Whatever happens the individual in front of the social worker remains a client. Nevertheless, the caring approach still tries to underlie every decision at the hostel. Seemingly client-conceptualised decisions are maternally or familially motivated. The social workers still manage to express such a caring role in the guise of a service-oriented hostel. Culturally supported forms of caring are masqueraded as part of the hostel structure.

Describing her experience of supporting a grieving client, Judith expressed her intense will, at the time, to express herself to the client beyond formal etiquette. She could not

express her affection beyond those allowed by her face as a social worker. However, in the extreme cases where will turns into a necessity (and therefore becomes part of the obligations as a service provider), the social worker hugs a client, assures him that he is loved, consoles him with the fact that all will be fine. At the risk of her professional identity and, more so, her emotional investment, the social worker may posit the extraordinary as necessary, the caring *for* as a matter of saving caring *alongside* the client, helping him help himself.

A client at the verge of total emotional collapse, the complete breakdown of character, becomes a 'moral patient' so long as his status as a client is restored in the process. Perhaps, only to save someone's capacity for self-alteration is the direct alteration of themselves justified.

Chapter 7: Unravelling the Paradoxes

There are several points to make from the previous discussions on the hostel as the latest iteration of mental health in Malta (Chapter 1) and as a rendition of ongoing deinstitutionalization, the adoption of community care (Chapter 2). Firstly, the enduring legacy of 'the hospital', as a paradoxical source of both trauma and nostalgia (Chapter 4). Although the hostel tries its best to distance itself from Mount Carmel, it must constantly address its remnants within the clients: among other things, trauma, stigma, social neglect, and the lingering longing for institutionalisation.

It also struggles to define itself as a separate concept (Chapter 1 & 5). The hostel often ends up accepting itself as the counterpart to the hospital; an extension with the hope of detachment. This sentiment is also present in its operation, wherein the hostel tries its utmost to create concise and universal guidelines for its client-based project. However, the social workers often adapt and operate on a case-by-case basis, deciding how best to understand each resident (Chapter 5).

The relationship between the social workers and the residents oscillates between the 'logic of choice' and 'the logic of care' (Mol, 2008). On the one hand, the individual is treated as a person capable of making the right choices, consenting to the right services, consuming the needed products, and accepting the appropriate interventions. However, the 'logic of care' does not assume such things about the individual. Rather, given the clients' or patients' inability to choose, the correct choices are made *for* them, returning to the understanding of the individual as a patient as if at Mount Carmel, but also distinctively as a 'moral patient' (Chapter 4 & 6). Disregarding agency is justified under this 'logic' precisely because the hostel does not understand it to exist while the individual is ill or sick, or perhaps only inhibiting it from the client. How can two radically different articulations of the hostel's residents co-exist?

Both logics are utilised by the hostel to achieve its ultimate goal: to care for mentally ill individuals. However, they are different conceptions of care and the caring role that occur simultaneously. This contradiction can be easily followed back to the hostel's duality in

the origins of mental illness itself; between *circumstances* and *character*, a social or private aetiology.

The client's character is deemed total and incomplete at the same time. Therefore, two notions of caring emerge to cater to each conception of illness. On the one hand, there is the service-oriented model in which the hostel is an entirely transactional experience. In opposition to it is the caring role: an all-encompassing approach to care; caring *for* (Floersch 2002) the client.

For the hostel, the client is a liberated patient; he decides what is best for him or whom to ask what would be the right course of action. As opposed to the patient in the asylum, the individual in the hostel is there because he *chose* its services. The hostel is a temporary 'product', meant to allow the client's mind and character to regenerate and build up resilience. For the client, the hostel acts as a semipermeable membrane through which the individual can re-integrate with society in the correct *circumstances*.

The client makes use of the safety of the hostel. He may request aid to schedule an appointment, to assist in his interactions. He may, and is indeed expected to ask for advice in understanding himself; going through his daily routine, his speech, behaviour and coming to terms with any possible inadequacy of his experience as a client. The hostel presents itself as a locus of such services: a collection of products one can use to alter oneself. Put simply, it wants its clients to see themselves as choosing to, rather than forced to stay there.

But the hostel is only half the story, there is also ~~the~~ hostel (Chapter 5). In the latter, rules and regulations are only tools and reference points to use depending on the situation or case. In some instances, the social workers cannot wait for the client to ask for their help. When it comes to 'building character', the social workers take up a more active role beyond the hostel (Chapter 6). They motivate and persuade such clients to make the correct decisions until they are capable of choosing them by themselves.

To 'cure' the client to any extent, he has to undergo some form of drastic self-alteration towards independence. Removing symptoms through medicine and counselling is one superficial dimension of his treatment related to *circumstances*. It is also, for the hostel, the short-term form of cure, which is closer to an alleviation of one's symptoms rather than their elimination: a form of 'fast-relief' (Vuckovic 1999). Without a new *independent* and *resilient* self and *character*, there is no such thing as being cured, no

such thing as finding ‘home’, no such thing as self-management, no such thing as caring for one’s symptoms.

To ‘build character’, social workers often have to transgress their own boundaries of care. As illustrated through the case for love in social work, the staff adopt this approach only when all else fails (Chapter 6). It is the type of care they would like to employ but consistently withhold. As moral patients, through love, *character* is the only ‘cure’ the clients can hope for, not the total elimination of their illness. For the hostel, one must acquire the necessary *character* to prevent such symptoms from returning. In other words, a permanent client, constantly altering and repairing oneself for any circumstances.

The hostel wants its clients to understand that one is never far or completely free from depression, schizophrenia, anxiety, etc. One can only be less susceptible to their acute state; in possession of a character with fewer or differently located imperfections. Everyone's character deemed complete is in fact subjectively weak; it has unique vulnerabilities constantly exploited by life, the ‘constant battle’. Everyone deals with mental illness, as opposed to managing his/her odds of contracting it. Put simply, for the social workers, everyone is mentally ill; everyone has his faults and mental struggles. The difference is to what extent.

Illness is understood to be a fault in the process of being (Chapter 6). Crucially, it is not related to a qualitative transition from healthy to ill. It is only a lack of health, a question of degradation of character caused by circumstances, as opposed to a completely new kind of experiential reality for the individual. This approach and understanding allows us to think of mental illness, and the culturally specific criteria for being ‘cured’, as a social and personal struggle manifested in physical symptoms, or vice versa. Either way, being cured is not just about terminating one's current symptoms but also obtaining the necessary qualities and ‘character’ to prevent it. Only then can the individual become ‘resilient’, fully ‘cured’. Even so, ‘cured’ has nothing to do with forever eradicating illness and its symptoms, and mostly concerned with learning to expect and manage it recurrently.

In this sense, the client is only ‘cured’ when he replaces the hostel in relation to himself: allows his self, to constantly achieve its potentials but also subdue its defects. Rather than strictly becoming normal, the client experience is about coming to terms with an always becoming ‘self’. Those who have enough ‘insight’ to mould their character in such a way

as to live in a world like the rest, capable of protecting themselves from the outside and inside, ‘dance’ their way through life's ‘rain’, are deemed no longer ill. Or, rather, as ‘cured’ or ‘resilient’ as anyone possibly can be. That being said, the question left unanswered is what exactly constitutes the necessary ‘agency’ and ‘resilience’.

Connecting this point with the previous chapters on how the hostel understands and creates agency, in contrast to Mount Carmel and, sometimes, diverting from its guidelines; there are multiple dimensions to agency (Chapter 1 & 4). Throughout this text, I have considered the hostel as an organisation as its own agent and separate from the social workers. The way in which the organisation and the hostel diverged from the individual staff member and vice versa points towards agency beyond the individual. The hostel, as a collection of equally valid opinions by staff members and a subsidiary organisation of the Rain organisation, produces its own ideas on illness and cure, such as the concept of client and ‘agency’ as ‘cure’.

Taking it a step further, even when ‘agency’ is used by the hostel synonymously with resilience and ‘independent character’ as the ultimate goal, what exactly it wants to produce in the client resists simplification. Agency and resilience, the quality or ‘character’ the hostel wants its clients to possess to be sufficiently ‘cured’ can be further split into various understandings. The client has to be able to understand and decipher his emotions, he must be able to support himself financially and find a new home. However, he must also be able to communicate with his peers and strangers without assistance, and be able to move around Malta on his own.

At the hostel, possessing one or a few capacities does not entail possessing agency. Only by achieving all kinds of independent capabilities is one deemed an agent, resilient, capable of being ‘cured’. If one sustains such forms of agency, he graduates from a client to a cured and ‘resilient’ individual. However, he must also learn to practise his agency toward living in the community. Living alone is not the hostel’s plan for the client (and even forms part of its aetiology). Agency is not a singular quality but a multitude of capacities towards independence and ultimate integration into the community of ‘agents’.

This multi-faceted employment of agency raises all sorts of questions. Can the concepts truly be separated and discussed individually? Is agency a fragmented collection of capacities? Is individuality a cause or effect of mental illness, or both? Such questions can open up an analysis of deinstitutionalization in Malta; the endeavour to break up Mount Carmel and replace it with small scale hostels (working with a new and much

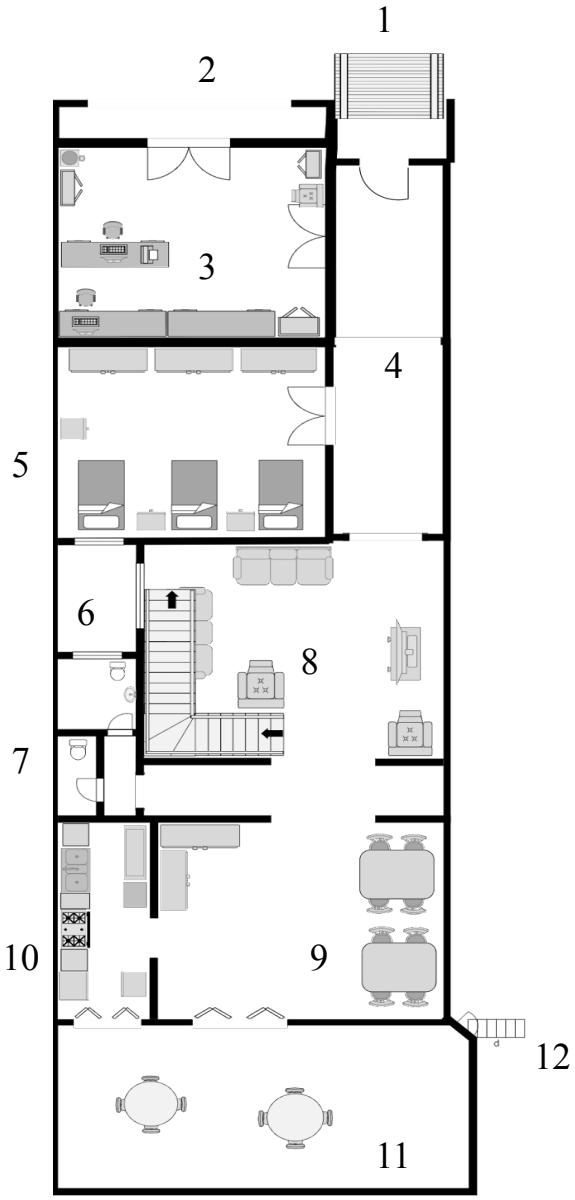
smaller mental hospital). In addition, at least in terms of mental health systems, there is space to suggest a strong connection to the idea of resilience. This tenant, 'resilience', is understood to be an essential quality ideally found in every individual doing his best to live. The lack of resilience in the general population is understood to be the cause of Mount Carmel's prolonged existence, and the need to deinstitutionalize mental health. Perhaps even deconstruct it, to transfer the capacity to resist and recover from illness towards the individual rather than a professional institution.

As an example of anthropology's contribution to mental health, this ethnographic study of a specific fragment of current developments in Malta can provide new and more holistic perspectives. Perhaps, it can also facilitate future research methods into the unique field of mental health in some way. Most pertinently, but often discarded, the long-term & qualitative approach. Specifically, what this text can comment on is the aspect of deinstitutionalization as taken up by the Rain organisation and the hostel. Therefore, what the hostel and the social workers understand to be their task toward helping people live 'fulfilling lives'. But what does the hostel understand to be a 'good life' after learning to manage illness? What does the mental health system in Malta, beyond (but also including) the hostel, understand by a normal 'resilient' individual?

We can only begin to answer the how and why the hostel hopes to communicate its own answers to these questions: that being in the world at all presupposes being an agent in all forms and understandings. However, the range of qualities constituting agency as utilised by the hostel point also towards its cultural enactment. Being an 'agent' entails specific 'moral' capacities as delineated by the hostel, but also the overlapping quality of being 'resilient' as current trends in psychiatry promote and the local mental health system adopts. 'Agency', as being 'cured', is created and lived through such paradigms and within particular environments laden with situated understandings.

Appendix I

Plan of the Hostel's first floor.



1. Main Entrance
2. Balcony
3. Office & staff room
4. Hallway
5. Bedroom
6. Shaft
7. Bathrooms
8. Living room
9. Dining room
10. Kitchen
11. Courtyard
12. Access to garden

Appendix II

The Clients

Name[45]	Age	Length of Hospitalisation	Hostel stay	Condition[46]	Brief description
Albert	28	3 years	2 years	Depression (Brain-tumour)	The youngest resident, struggling to cope with his illness and past. He loves to joke and learn new things.
Shafiq	36	unknown	6 months	unknown	A refugee, he left everything behind to come to Malta. He speaks softly and is very kind.
Maurice	39	unknown	1 year	Schizophrenia	Very loud and confrontational, but also extremely smart and caring.
Mattheus	40	6 years	2 years	Schizophrenia, Depression	Full of life; he could enjoy most things. Unfortunately, he suffered from severe addiction.
Philip	41	22 years	6 years	Depression,	Unpredictable with a good sense

[45] None of the clients are or will be referred to with their real name to protect their anonymity. Since they were all men, 'he' will often be used to refer to clients. I will also use the term 'resident' when discussing the clients, as the hostel does outside of the more 'clinical' office space in the less formal hostel.

[46] I wasn't allowed to ask the clients their official diagnosis, and it wasn't important for me to know either. The ones mentioned here are only diagnoses the clients themselves wanted to share with me, without ever asking about it. To some extent, disclosing their condition/s was inevitable since they felt a need to explain certain 'strange' actions out of embarrassment or even as a way of confirming intimacy.

					of humour.
Eric	48	20 years	6 years	Schizoaffective disorder, depression	Calm and contained. He often said he saw me as family, like a nephew.
Richard	45	Approx 20 years	6 years	Schizophrenia	A man of big stature and an even bigger heart.
Marco	46	Approx 15 years	6 years	Unknown	A chatty, amicable person. The only resident not on any form of medication.
Matthew	49	Approx 20 years	6 years	Depression	The easiest resident to talk to. Friendly and cheerful, most of the time.
George	50	Approx 10 years	6 years	Depression	Did not spend much time with George. I can only comment on his impeccable cleanliness.
Edmont	52	Approx 15 years	6 years	Unknown (Brain-tumour)	A very quiet man, soft spoken. He is always keen to know how others are doing.
Julian	54	Unknown	1 year	Unknown	Despite his age, he speaks coherently and always puts others needs before his own.

Appendix III

The Social and Support Workers

Name[47]	Age (approx)	Job title	Work experience	Brief description
Mary	20s	Social worker	1 year	A recent graduate, just starting her career in mental health.
Sarah	20s	Social worker & Manager	4 years	One of the younger social workers, highly motivated to do well.
Beatrice	20s	Social Worker	4 years	Young, but full of ambition. She was eventually promoted to manager at another hostel.
Judith	40s	Social Worker	5+ years	One of the older, more experienced social workers.
Catherine	40s	Social worker	5+ years	Experienced social worker. Has a history in related careers.
Agatha	50s	Support Worker	2 years	Newly employed at the hostel. She has an extensive background in supported

[47] It should be noted that all social workers at the hostel were female, with the exception of 1 male employee for a month. I will therefore use 'she' to refer to the social workers. Support workers were both Male and Female. There were social and support workers whom I didn't meet since I wasn't there during their shift. This list is not complete but reflects the staff members with whom I spent the most time with or interviewed.

				learning.
Adam	20s	Support worker	2 years	One of two male staff members.

Appendix IV

Ethics form approved by the University of Malta

UNIQUE FORM ID: 7840_18022021_Nikolai Debono
Ticked one or more self-assessment issues. Submitting to FREC for review.

L-Università ta' Malta

ETHICS & DATA PROTECTION

PART 1: APPLICANT AND PROJECT DETAILS

1. Name and surname: Nikolai Debono
Email Address: nikolai.debono.17@um.edu.mt
2. Applicant status: UM student
3. Faculty: Arts
4. Department: Anthropological Sciences

If applicable

5. Principal supervisor's name: Dr. Jean-Paul Baldacchino
6. Co-supervisor's name:
7. Name of Degree and Study-unit code: M.A in Anthropology
8. Student number: 328599M

9. Title of research project: The De-institutionalization of Mental Health in Malta: An Ethnographic Case Study
10. Research question/statement & method: This research is focused on the experience of de-institutionalization of chronic and recovering mental health patients. The primary research question will centre on the community residencies as a social environment, to create an ethnographic account of the environment. It will mostly focus on work in residential facilities in the community through participant observation.
11. Collection of primary data from human participants?
Yes/Unsure (PLEASE ANSWER NEXT QUESTION)
12. If applicable, explain: Data will be collected from male and female residents and staff members of community hostels. The research will focus on one residency in particular that caters for male clients. Besides the principle methodology concerning participant observation, information may also be collected through semi-structured and structured interviews.

PART 2: SELF-ASSESSMENT

Human Participants

1. Risk of harm to participants: Yes or Unsure
2. Physical intervention:
3. Vulnerable participants: Yes or Unsure
4. Identifiable participants:
5. Special Categories of Personal Data (SCPD):
6. Human tissue/samples:

7. Withheld info assent/consent:
UNIQUE FORM ID: 7840_18022021_Nikolai Debono
Ticked one or more self-assessment issues. Submitting to FREC for review.

8. Opt-out consent/assent:
9. Deception in data generation:
10. Incidental findings:

Unpublished secondary data

11. Was the data collected from human participants?
12. Was the data collected from animals?
13. Is written permission from the data controller still to be obtained?

Animals

14. Live animals out of habitat:
15. Live animals, risk of harm:
16. Dead animals, illegal:

General considerations

17. Cooperating institution:
18. Risk to researcher/s:
19. Risk to environment:
20. Commercial sensitivity
21. Other potential risks:

Self-assessment outcome: Ticked one or more self-assessment issues. Submitting to FREC for review.

PART 3: DETAILED ASSESSMENT

1. Risk of harm to participants: Since participants include people who may be recovering from a mental illness it is also possible that the participants may be experiencing distress during the course of my interactions with them and not necessarily as a result of my interaction. I have undergone basic training in mental health first aid and should any participant experience distress I will terminate and/or refer the matter to my field-supervisor for follow-up as necessary. In addition the research will be further supervised on site by the pertinent professional ensuring appropriate and harmless conduct. 2. Physical intervention on participants:
3. Vulnerable participants: This study will take place in a hostel set up for persons recovering from mental illnesses or requiring additional care for the same reason. The people located in the hostel are temporary residents unable or waiting to find suitable accommodation. The study will be concerned with one of many hostels administered by the Richmond Foundation. Staff members from the same institution provide care and support to the residencies. The informants or interviewees are staff members, professionals, and people recovering or recovered from mental distress. Permission from the Richmond Foundation has

been acquired regarding my research intentions.

In addition to consent, safeguards will be implemented so that this research will not obstruct their
UNIQUE FORM ID: 7840_18022021_Nikolai Debono
Ticked one or more self-assessment issues. Submitting to FREC for review.

process of recovery. My presence will be under supervision, both academically and on-site by staff members of the aforementioned institution. On their recommendation, I have completed a course in mental health first aid to navigate with better ease the delicate nature of the environment. The field-site supervisor will guide the selection of participants to ensure that particularly vulnerable individuals are not exposed to any form of distress. Particular attention will be given to the methodology to cater for and prevent any difficulties; such as by refraining from using tape recorders. All the data collected will be pseudonymised at the point of collection. If participants are unable or unwilling to give their consent, I will not actively pursue them for the purposes of this research.

4. Identifiable participants:
5. Special Categories of Personal Data (sensitive personal data):
6. Collection of human tissue/samples:
7. Withholding information at consent/assent:
8. Opt-out consent/assent:
9. Deception in data generation:
10. Incidental findings:
11. Unpublished secondary data - human participants :
12. Unpublished secondary data - animals:
13. Unpublished secondary data - no written permission from data controller:
14. Lasting harm to animals out of natural habitat:
15. Risk of harm to live animals :
16. Use of non legal animals/tissue:
17. Permission from cooperating institution:
18. Risk to researcher/team:
19. Risk of harm to environment:
20. Commercial sensitivity:
21. Other issues
    - 21a. Dual use and/or misuse:
    - 21b. Conflict of Interest:
    - 21c. Dual role:
    - 21d. Use research tools:
    - 21e. Collaboration/data/material collection in low/lower-middle income country:
    - 21f. Import/export of records/data/materials/specimens:
    - 21g. Harvest of data from social media:
    - 21h. Other considerations:

PART 4: SUBMISSION

1. Which FREC are you submitting to? : Arts
2. Attachments: Information and recruitment letter*, Consent forms (adult participants)*, Data collection tools (interview questions, questionnaire etc.), Letter granting institutional approval for access to participants

3. Cover note for FREC : The information has been amended as per FREC recommendation. This is my second submission for the same proposal.
4. Declarations: I hereby confirm having read the University of Malta Research Code of Practice and the University of Malta Research Ethics Review Procedures., I hereby confirm that the answers to the questions above reflect the contents of the research proposal and that the information provided above is
UNIQUE FORM ID: 7840_18022021_Nikolai Debono
Ticked one or more self-assessment issues. Submitting to FREC for review.

truthful., I hereby give consent to the University Research Ethics Committee to process my personal data for the purpose of evaluating my request, audit and other matters related to this application. I understand that I have a right of access to my personal data and to obtain the rectification, erasure or restriction of processing in accordance with data protection law and in particular the General Data Protection Regulation (EU 2016/679, repealing Directive 95/46/EC) and national legislation that implements and further specifies the relevant provisions of said Regulation.
5. Applicant Signature: Nikolai Debono
6. Date of submission: 18022021
7. If applicable data collection start date: 01032021
8. E-mail address (Applicant): nikolai.debono.17@um.edu.mt
9. E-mail address (Principal supervisor): Jean-Paul.Baldacchino@um.edu.mt
10. Conclude: Proceed to Submission

Appendix V

Participant's Consent Form

L-Università ta' Malta

Participant's Consent Form

I, the undersigned, give my consent to take part in the study conducted by Nikolai Debono. This consent form specifies the terms of my participation in this research study.

I have been given written and/or verbal information about the purpose of the study; I have had the opportunity to ask questions and any questions that I had were answered fully and to my satisfaction.

I also understand that I am free to accept to participate or to refuse or stop participation at any time without giving any reason and without any penalty. Should I choose to participate, I may choose to decline to answer any questions asked. In the event that I choose to withdraw from the study, any data collected from me will be stored anonymously or deleted.

I understand that I have been invited to participate in Anthropological research in which the researcher will interview, converse, or simply participate in daily events to observe and record observations as part of ethnographic fieldwork. I am aware that participant observation (fieldwork) will take approximately six to eight months. I understand that the formal interview or conversation is to be conducted in a place and at a time that is convenient for me and will last from 1-3 hours.

I understand that my participation does not entail any known or anticipated risks.
I understand that there are no direct benefits to me from participating in this study. I also understand that this research may benefit others by improving psychiatric intervention and rehabilitation, patient inclusion, and care as well as contributing to academic research on relevant areas.

I am aware that my identity and personal information will not be revealed in any publications, reports, or presentations arising from this research.

I understand that, under the General Data Protection Regulation (GDPR) and national legislation, I have the right to access, rectify, and where applicable, ask for the data concerning me to be erased or pseudonymized.

I have read and understood the above statements and agree to participate in this study.

Bibliography

Abela, A, Farrugia, R, Vella, A. M, & DeGiovanni, K 2016, 'Familistic countries need a family-inclusive service when caring for people with mental health problems - the case of Malta', *Families, Relationships and Societies*, vol. 5, no. 2, pp. 313-331.

Abela, M 2003, 'History of social work in Malta: 1980-2001', B.A dissertation, University of Malta, Malta.

Allan, H.T, & Arber, A 2018, *Emotions and Reflexivity in Health & Social Care Field Research*, Palgrave Macmillan, London.

Andersen, A.J.W, Larsen, I.B, Topor, A 2016, 'Caring through discipline? Analyzing house rules in community mental health services in Norway', *Scandinavian Psychologist*, vol. 3, no. 1.

Anderson, E.R 2021, 'Positionality, Privilege, and Possibility: The Ethnographer "at Home" as an Uncomfortable Insider', *Anthropology and humanism*, vol. 46, no. 2, pp. 212–225.

Anderson, K, and Priebe, S 2021, 'Concepts of Resilience in Adolescent Mental Health Research', *Journal of Adolescent Health*, vol. 69, no. 5, pp. 689–695.

Anderson, L 2006, 'Analytic Autoethnography', *Journal of Contemporary Ethnography*, vol. 35, no. 4, pp. 373-395.

Aviram, U 1990, 'Community care of the seriously mentally ill: Continuing problems and current issues', *Community Mental Health*, vol. 26, no. 1, pp. 69–88.

Azzopardi, G 2019, *Malta: the nurse of the Mediterranean: a study on hospitals and medical activities in Malta during the Great War,* Bachelor's dissertation, University of Malta, Malta.

Bachelard, G 2014, *The Poetics of Space*, Penguin Classics, United Kingdom.

Balbuena, F 2021, ‘Laing Versus Szasz: Antagonists, Kindred Spirits, or a Misconstrued Rivalry?’, *The Journal of humanistic psychology*, September 2021, pp. 1-20.

Balzan, J 2021, ‘Watch: New ward at Mount Carmel Hospital is first to meet mental health standards’, *Newsbook* , viewed 10 May 2022. <https://newsbook.com.mt/en/watch-new-ward-at-mount-carmel-hospital-is-first-to-meet-mental-health-standards/>.

Ben-Arl, E 1995, *Conflict in the Military World-View: An Ethnography of an Israeli Infantry Battalion*, U.S. Army Research Institute for the Behavioural and Social Sciences.

Barbara, G 2022, ‘‘It Still Haunts Me Today’: A Harrowing Journey Within Mount Carmel’s Walls From A Man Who Almost Committed Suicide’, *Lovin Malta*, viewed 10 May 2022, <https://lovinmalta.com/lifestyle/health/mental-health/it-still-haunts-me-today-harrowing-journey-mount-carmel/>

Barg, F. K, Keddem, S, Cohen, W. S, & Henderson, R 2014, ‘An anthropology of caregiving’, Talley,C. & Travis, S, (Eds.), *Multidisciplinary coordinated caregiving: Research, practice, policy*, Springer, New York.

Barnard, S, & Fink, B 2002, *Reading Seminar XX Lacan's major work on love, knowledge, and feminine sexuality*, SUNY series in psychoanalysis and culture, University of New York Press, Albany State.

Barrett, R 1996, *The Psychiatric Team and the Social Definition of Schizophrenia: An Anthropological Study of Person and Illness*, Studies in Social and Community Psychiatry, Cambridge University Press, Cambridge.

Beldo, L 2014, ‘The unconditional ‘ought’: A theoretical model for the anthropology of morality’, *Anthropological Theory*, vol. 14, no. 3, pp. 263-279.

Berg, A & Mol, A 1998, *Unraveling Practices, Techniques, and Bodies*, Duke University press, United States of America.

Bateson, G 1972, *Steps to an Ecology of Mind: Collected Essays in Anthropology, Psychiatry, Evolution, and Epistemology*, Chandler Publishing Company, San Francisco.

Biehl, J & Locke, P (eds) 2017, *Unfinished: The Anthropology of Becoming*, Duke University Press, United States of America.

Boas, F 1911, *The Mind of Primitive Man*. The Macmillan Company, Germany.

Borg, A, et al. 2022, 'Developing the 2020-2030 mental health strategy for Malta: Addressing the needs of a small island state undergoing rapid socioeconomic transition', *Health policy (Amsterdam)*, vol. 126, no. 8, p.744-748.

Borg, J 2000, *A comparison of organisational culture in two mental health rehabilitation facilities in Malta*, M.A dissertation, University of Malta, Malta.

Borg, J 2021, 'Take your COVID-19 booster jab, PM urges', *Times of Malta*, Viewed 12 March 2022.<https://timesofmalta.com/articles/view/take-your-covid-19-booster-jab-pm-urges.917914>
.

Bourdieu, P and Nice, R 1984. *Distinction: a social critique of the judgement of taste*, Harvard University Press, United States of America.

Bourdieu, P 1977, *Outline of a Theory of Practice*. Cambridge University Press, Cambridge.

Boyer, D, Faubion, J.D. & Marcus, G.E 2015, *Theory Can Be More than It Used to Be*, Cornell University Press, Ithaca.

Bosk, C. L 2003, *Forgive and remember: Managing medical failure*, University of Chicago Press, Chicago.

Brady, A.M 2022, 'Mental Health, Resilience and Existential Literature', *Journal of Philosophy of Education*, vol. 56, no. 1, pp. 78–87.

Brettell, C.B 2002, 'The Individual/Agent and Culture/Structure in the History of the Social Sciences', *Social Science History*, vol. 26, no. 3, pp. 429–45.

Brodwin, P 2013, *Everyday Ethics: Voices from the Front Line of Community Psychiatry*, University of California Press, United States of America.

Brown, P 1985, *The Transfer of Care: Psychiatric Deinstitutionalization and Its Aftermath*, Routledge & Kegan Paul Books, United States of America.

Bruun, M 2019, *Scientific Persuasions: Ethnographic Reflections on Evidence-Based Psychological Therapy*. Phd thesis, University of Cambridge, Cambridge.

Camilleri, A 2012, *Acute Mental Health Settings in Malta : Nurses' Perceptions of Stressors and Coping Mechanisms*, B.Sc. dissertation, University of Malta, Malta.

Camilleri, M, Sammut, A, & Cachia, J. M 2019, 'The development of public mental health in Malta', Azzopardi, N, Muscat, D. Cauchi & Fenech, T (Eds.), *Public Health in Malta*: *1999 - 2019*, Malta: Malta Association of Public Health Medicine, pp. 29-34.

Camilleri, N, and Zahra, A 2014, 'A commentary on the new mental health act for the Maltese Islands', *Malta College of Family Doctors*, vol. 3, no. 2, p. 7-9.

Campbell, C 2009, 'Distinguishing the Power of Agency from Agentic Power: A Note on Weber and the "Black Box" of Personal Agency', *Sociological Theory*, vol. *27*, no. 4, pp. 407–418.

Candeam, M 2018, *Comparison in Anthropology: The Impossible Method* (New Departures in Anthropology), Cambridge University Press, Cambridge,

Carrithers M, Collins S, & Lukes S (eds) 1985, *The Category of the Person: Anthropology, Philosophy, History*, Cambridge University Press, Cambridge.

Carabott, S 2022, 'Surge in calls for mental help, suicide, as experts warn it's just the beginning', *Times of Malta*, viewed 10 May 2022. <https://timesofmalta.com/articles/view/surge-in-calls-for-mental-help-suicide-as-experts-warn-its-just-the.950401>.

Cassar, P 1964, *Medical history of Malta (Publications of the Wellcome Historical Medical library new series, 6)*, Wellcome Historical Medical library, London.

Cassar, P 1986, *The availability of medical records in Malta: an historical retrospect*, Proceedings of the 6th European Conference on Health Records, Malta.

Cassar, P, Adami, A, & Vassallo, V 1949, *The institutional treatment of the insane in Malta : (up to the end of the nineteenth century)*, Government Printing Office, Malta.

Chapman, T, Hockey, J & Wood, M 2002, 'Daring to be different? Choosing an alternative to the ideal home', Chapman, T & Hockney J (eds), *Ideal homes? Social change and domestic Life,* Routledge, London & New York, pp.198-200.

Chircop, J 2013, 'Management and Therapeutic Regime in Two Asylums in Corfu and Malta, 1837-1870', Lang, P, *Hospital Life; Theory and Practice from the Medieval to the Modern*, New York.

Chua, J.L 2013, 'Reaching Out to the People: The Cultural Production of Mental Health Professionalism in the South Indian Public Sphere', *Ethos*, vol. 41, pp. 341-359.

Clemmensen, MB, Køppe, S 2021, 'Normality, subjectivity and mental health: A genealogy of Danish psychiatry, 1938–2017', *Health*, vol. 25, no. 2, pp. 231-249.

Clifford, J, Marcus, G.E, & School of American Research, 1986,'Writing culture : the poetics and politics of ethnography', *School of American Research advanced seminar*, University of California Press.

Clough, P 2020, 'Agency, Time and Morality: An Argument from Social and Economic Anthropology', *Agency and Causal Explanation in Economics*, Virtues and Economics, Róna, P, Zsolnai, L. (eds), vol 5, Springer Cham, Switzerland.

Cohen, H 2015, *Eating Soup without a Spoon*, University of Texas Press, New York.

Cooper, A 2014, 'Time Seizures and the Self: Institutional Temporalities and Self-Preservation Among Homeless Women', *Culture, Medicine and Psychiatry*, vol. 39, no. 1, pp. 162–185

Cooper, B & Brown, A. C 1967, 'Psychiatric practice in Great Britain and America: A comparative study', *The British Journal of Psychiatry,* vol. 113, no. 499, pp. 625–636.

Cordina, J 2021, Psychiatric facility to be leased until new one is built, *Newsbook*, viewed 10 May 2022.
<https://newsbook.com.mt/en/budget-2022-psychiatric-facility-to-be-leased-until-new-one-is-built/>.

Cordina, J 2021, 'Watch: Mix-up sees Somali youth detained for 4 months after release date', *Newsbook*, viewed 10 May 2022.
<https://newsbook.com.mt/en/watch-mix-up-sees-somali-youth-detained-for-4-months-after-release-date/>.

Costello, L, McDermott, M & Wallace, R 2017, 'Netnography', *International journal of qualitative methods*, vol.16, pp. 1-12.

Cromley, E 2012, 'Mapping Spacial Data', Schensul, J and LeCompte, M, *Specialized Ethnographic Methods: A Mixed Methods Approach*, AltaMira Press, United States of America.

Csordas, J.T 2013, 'Morality as a Cultural System?', *Current Anthropology*, vol. 54, no. 5, pp. 523-546.

Cumming, J 1990, 'The community as milieu-a memoir', *Community mental health journal*, vol. 26, no. 1, pp. 15–25.

Cummins, I 2020, 'Using Fraser's model of 'progressive neoliberalism' to analyse deinstitutionalization and community care', *Critical and Radical Social Work*, vol. 8, no. 1, pp. 77-93.

Davis, A 2012, *Bad Souls: Madness and Responsibility in Modern Greece*, Duke University Press, United States of America.

Deleuze, G, Guattari, F 1983, *Anti-Oedipus: capitalism and schizophrenia*. University of Minnesota Press, United States of America.

De Jong, B 2021, 'I Spent 8 Days in Mount Carmel: This Is What I Saw', *Side Street Malta*, viewed 10 May 2022, <https://www.sidestreetmalta.com/post/i-spent-8-days-in-mount-carmel-this-is-what-i-saw>.

DiGiacomo, S.M 1992, 'Metaphor as illness: Postmodern dilemmas in the representation of body, mind and disorder', *Medical Anthropology: Cross-Cultural Studies in Health and Illness*, vol. 14, no. 1, pp. 109-137

D.O.I 2022, 'Post of Social Worker in the Ministry for Health', *Malta Government Gazette*, Viewed 6 June 2022. <https://www.gov.mt/en/Government/DOI/Government%20Gazette/Employment%20Opportunities/Pages/Post-of-Social-Worker-in-the-Ministry-for-Health.aspx>.

Dowling, E 2021, *The Care Crisis: What Caused It and How Can We End It?,* Verso, United States of America.

Drew, G, Skinner, W. & Bardsley, D.K 2022, The 'drive and talk' as ethnographic method. *Anthropology today*, vol. 38, no. 3, pp, 5–8.

Durkheim, E 1951, *Suicide, a study in sociology,* Translated by Spaulding, J, & Simpson, G, Routledge, London.

Duyvendak, A 2011, *The Politics of Home. Nostalgia and Belonging in Western Europe and the United States*, Palgrave Macmillan, London.

Ellis, C, Adams, T.E & Bochner, A.P. 2011, 'Autoethnography: An Overview. *Forum, qualitative social research*' , vol. 12, no. 1, art. 10.

Ellul, S 2015, *From exclusion to inclusion : the way forward under the new mental health act*, LL.D. dissertation, University of Malta, Malta.

Estroff, S 1981, *Making it crazy an ethnography of psychiatric clients in an American community*, University of California Press, United States of America.

Fainzang, S 2012, 'Medical anthropology at home', *Anthropology & medicine*, vol. 19, no. 1, p, 16.

Farahani, F 2015, 'Home and homelessness and everything in between: A route from one uncomfortable zone to another', *European Journal of Women's Studies*, vol. 22, no. 2, pp. 241–247.

Farrugia, C 2019, 'Close down Mount Carmel for all psychiatric conditions - Richmond Foundation', *Times of Malta*, viewed 10 May 2022.

<https://timesofmalta.com/articles/view/close-down-mount-carmel-for-all-psychiatric-conditions-richmond.712990>.

Farrugia, C 2021, 'New 10-bed ward at Mount Carmel Hospital set to open', *Times of Malta*, viewed 10 May 2022.
<https://timesofmalta.com/articles/view/new-10-bed-ward-at-mount-carmel-hospital-unveiled.869491#cta_comments>.

Farrugia, C 2021, 'Requests for mental health support jump 500% since COVID', *Times of Malta*, viewed 10 May 2022.
<https://timesofmalta.com/articles/view/requests-for-mental-health-support-jump-500-since-covid.917191>.

Farrugia, C 2021, 'More wards closing down at Mount Carmel Hospital – MUMN', *Newsbook*, viewed 10 May 2022.
<https://newsbook.com.mt/en/more-wards-closing-down-at-mount-carmel-hospital-mumn/>.

Farrugia, L 2016, *Mental illness and hospitalisation in Malta 1920s- 1960s*, M.A dissertation, University of Malta, Malta.

Faubion, J.D. & Marcus, G.E 2009, *Fieldwork is not what it used to be: learning anthropology's method in a time of transition*, Cornell University press, United States of America.

Fenech, M, Scerri, J 2014, 'The impact of providing care to the relatives with a severe illness: the caregivers' experience', *Malta Journal of Health Services*, vol. 1, no. 1, pp. 19-23.

Ferret, N 2021, 'Game is to Space as Narrative is to Time. A Ricœurian Anthropology of Play and Game as Spatial Mimesis', *Études Ricoeuriennes*, vol. 12, no. 2, pp.44–56.

Fino, A, & University of Malta 1989, *Society and the mentally disordered*, Foundation Studies Course.

Fisher, M 2009, *Capitalist Realism: Is there no Alternative?*, Zero Books, United Kingdom.

Fisher, M 2012 'Why mental health is a political issue', *The Guardian*, viewed May 21 2021. <https://www.theguardian.com/commentisfree/2012/jul/16/mental-health-political-issue>.

Flexner, A 2001, 'Is social work a profession?', *Research on Social Work Practice*, vol. 11, no. 2, 152–165.

Floersch, J 2002, *Meds, money, and manners: The case management of severe mental illness*, Columbia University Press, United Stated of America.

Foot, J 2015, *The Man Who Closed the Asylums: Franco Basaglia and the Revolution in Mental Health Care,* Verso, United States of Americaa.

Foster, K, et al. 2019, 'Resilience and Mental Health Nursing: An Integrative Review of International Literature', *International Journal of Mental Health Nursing*, vol. 28, no. 1, pp. 71–85.

Foucault, M 2013, *Madness and Civilization*, 1963, Random House, United States of America.

Foucault, M 1977, *Discipline and Punish: the Birth of the Prison*, Pantheon Books, New York.

Foucault, M 1980, Power/knowledge, Selected Interviews 1972-1977, Colin Gordin et al. ed., Pantheon Books, New York.

Fox, C 2003, 'Debating Deinstitutionalisation: The Fire at Kew Cottages in 1996 and the Idea of Community', *Health and History*, vol. 5, no. 2, pp. 37-59.

FRA 2011, *The legal protection of persons with mental health problems under non-discrimination law: Understanding disability as defined by law and the duty to provide*

reasonable accommodation in European Union Member States, European Union Agency for Fundamental Rights.

Frankenberg, R.J 1989, 'Village on the Border: a Text Revisited', *Village on the Border*, 2nd edn, Waveland Press, United Kingdom.

Friedman, R 2009, 'The "Social Case": Illness, Psychiatry, and Deinstitutionalization in Postsocialist Romania', *Medical Anthropology Quarterly*, vol. 23, no. 4, pp. 375–396.

Freud, S 1938, *Totem and Taboo: Resemblances between the Psychic Lives of Savages and Neurotics*, Penguin Books, United Kingdom.

Freud, S 1955, 'A Difficulty in the Path of Psycho-Analysis', *The Standard Edition of the Complete Psychological Works of Sigmund Freud, (1917-1919): "An Infantile Neurosis" and Other Works, Vol. XVII*. The Hogarth Press and The Institute of Psycho-Analysis, London: pp. 135-144

Freud, S 1965, *The Interpretation of Dreams*, Strachey, J, 1913, Trans, Avon Books, New York.

Freud, S 2014 , *Civilization and its discontents,* 1930*,* Penguin Classics, United kingdom.

Fromm, E 1991, *The sane society*, (2nd ed.), Routledge, United Kingdom.

Fromm, E 1941, *Escape from freedom*, Farrar & Rinehart, New York.

Galea, ART, 2016, 'Report of the Comptroller of Charitable Institutions, for 1922- 23', *Malta Government Gazette Supplement, XIII (1924)*, p. 108, Quoted in Farrugia, L. *Mental illness and hospitalisation in Malta 1920s- 1960s*, M.A dissertation, University of Malta, Malta.

Galea, M 2009, *The experience of growing up with a parent who has a mental health problem,* M.A dissertation, University of Malta, Malta.

Galea, O 2021, ‘Made her vulnerable husband live in a boxroom, later in an Iklin farm, so that she and her partner could live comfortably off him’, *Times of Malta*, viewed 2 July 2022. <https://www.tvm.com.mt/en/news/made-her-vulnerable-husband-live-in-a-boxroom-later-in-an-iklin-farm-so-that-she-and-her-partner-could-live-comfortably-off-him/>.

Galea, S, and Mifsud, J 2004, ‘The mental health care system in Malta’. *International Psychiatry: Bulletin of the Board of International Affairs of the Royal College of Psychiatrists*, vol. 1, no. 5, 11-13.

Gell, A 1998, *Art and Agency: an Anthropological Theory*, Clarendon Press, United Kingdom.

Gellner, E 2003, *The Psychoanalytic Movement: The Cunning of Unreason*, Wiley-Blackwell, United States of America.

Gennep, A 1960, *The Rites of Passage*, University of Chicago Press, Chicago.

Geertz, C 2002, ‘An Inconstant Profession: The Anthropological Life in Interesting Times’, *Annual Review of Anthropology*, vol. 31, pp. 1-19

Geschiere, P 2010, ‘The Self-Reflective Turn in Ethnography: From Dialogue to Narcissism?’, *Etnofoor*, vol. 22, no. 1, pp.137–146.

Goffman, E 1961, *Asylums : Essays on the social situation of mental patients and other inmates*, Penguin, United Kingdom.

Good, B.J 1994, ‘How Medicine Constructs its Objects’, *Medicine Rationality and Experience*, Cambridge University Press, Cambridge.

Gouder, D 2013, *From student to practitioner : a grounded theory exploration of transition to practice of newly qualified mental health nurses in Malta*, M.Sc University of Malta Dissertation, Malta.

Graham, E 2022, 'The Ethnographer Unbared: Honoring Hatred in Uncomfortable Terrains, *Qualitative Social Research,* vol. 23, no. 1, Art. 9.

Green House, C.J 1985, 'Anthropology at Home: Whose Home?', *Human organization*, vol. 44, no. 3, pp.261–264.

Greenland, F 2018, 'Material Culture and the Problem of Agency', *American Journal of Cultural Sociology*, vol. 7, no. 3, pp. 412–420.

Grech, M 2003, *The impact of schizophrenia on family members acting as caregivers*, B.A dissertation, University of Malta, Malta.

Gregor, C 2010, 'Unconscious Aspects of Statutory Mental Health Social Work: Emotional Labour and the Approved Mental Health Professional', *Journal of Social Work Practice*, vol. 24, no. 4, pp. 429–443.

Grob, N 1994, *The mad among us: A history of the care of America's mentally ill,* Free Press, Washington.

Grob, N 2014, *From Asylum to Community: Mental Health Policy in Modern America,* Princeton Legacy Library, United States of America.

Günel, G, Varma, S & Watanabe, C 2020, 'A Manifesto for Patchwork Ethnography', Member Voices, *Fieldsights*, June 9, Available online at: https://culanth.org/fieldsights/a-manifesto-for-patchwork-ethnography

Haas, B.M 2020, 'Asylum Is the Most Powerful Medicine': Navigating Therapeutic Interventions in Limbo' , *Culture, Medicine and Psychiatry*, vol. 45, no. 2, pp. 193–217.

Hancock, B 2018, 'Michel Foucault and the Problematics of Power: Theorizing DTCA and Medicalized Subjectivity', *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*, vol. 43, no. 4, August, pp. 439–468.

Hansson, J.H 1993, *Organizing normality: essays on organizing day activities for people with severe mental disturbances*, Phd thesis, Linköping University, Sweden.

Haraway, D 1988, 'Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective', *Feminist Studies*, vol. 14, no. 3, p. 575-99.

Hayano, D. M 1979, 'Auto-Ethnography: Paradigms, Problems, and Prospects', *Human Organization*, vol. 38, no. 1, 99–104.

Healy, D 2012, *Pharmageddon*, University of California Press, United States of America.

Hecht, A 2011, 'Home Sweet Home: Tangible Memories of an Uprooted Childhood', *Home Possessions: Material Culture behind Closed Doors*, Palgrave Macmillan, United States of America, p. 141.

Heiss J.P., Piette A 2015, 'Individuals in anthropology', *Zeitschrift fuer Ethnologie*, 140(1), pp. 5-17.

Hochschild, R 2012, *The Managed Heart*, 1st ed, University of California Press, United States of America.

High, H 2011, ‘Melancholia and anthropology’, *American ethnologist*, vol. 38, no. 2, pp. 217–233.

Hochschild, A.R 2012, *The Managed Heart*, 1st ed., University of California Press, Berkeley.

Howard, C, and Hoffman, M 2018, ‘Variable-Centered, Person-Centered, and Person-Specific Approaches’, *Organizational Research Methods*, vol. 21, no. 4, pp. 846–876.

Hsu, F 1969, *The study of literate civilizations*, Holt, Rinehart, and Winston, New York.

Hutten, R and Bruun, M 2022, *Towards an Anthropology of Psychology: Ethnographies of mental health and psychotherapy*, Call for Book Chapters for an edited volume.

Illich, I, & Illich, I 1977, *Limits to medicine: Medical nemesis : the expropriation of health*, Penguin, United Kingdom.

Illouz, E 2007, *Cold intimacies: The making of emotional capitalism*. Polity Press, Cambridge, United Kingdom.

Illouz, E 2008, *Saving the Modern Soul: Therapy, Emotions, and the Culture of Self-Help,* The University of California Press, United States of America.

Incorvaja, J 1999, *A Comparative study of educational attitudes between First, Second and Third level Nurses working in Psychiatric Practice in Malta*, M.Sc. dissertation, University of Malta, Malta.

Ingold, T 1995, ‘Building, dwelling, living: how animals and people make themselves at home in the world’, Strathern, M & Association of Social Anthropologists of the Commonwealth, *Shifting contexts : Transformations in anthropological knowledge*, Taylor & Francis Group, United Kingdom, pp. 57-80.

Jain, S, & Jadhav, S 2008, 'A cultural critique of community psychiatry in India' , *International journal of health services : planning, administration, evaluation*, vol. 38, no. 3, pp. 561–584.

Jauregui, B 2013, 'Dirty Anthropology: Epistemologies of Violence and Ethical Entanglements in Police Ethnography', Garriott, W. (eds) Policing and Contemporary Governance, Palgrave Macmillan, New York.

Jenkins, J. H 2011, *Pharmaceutical Self: The Global Shaping of Experience in an Age of Psychopharmacology*, School for Advanced Research Press, United States of America.

Johnson, T.M & Sargent, C.F 1990, *Medical anthropology: contemporary theory and method*, Praege, United States of America.

Karp, I 1986, Agency and Social Theory: A Review of Anthony Giddens, *American Ethnologist*, vol. 13, no. 1, pp. 131–137.

Keane, Webb 2003, 'Self- Interpretation, Agency, and the Objects of Anthropology: Reflections on a Genealogy' , *Comparative Studies in Society and History*, vol. 45, no. 2, p. 224.

Khosravi, S 2016, 'Engaging Anthropology: An Auto-Ethnographic Approach', Bringa, T, and Bendixsen, S, (eds), *Engaged Anthropology: Approaches to Social Inequality and Difference*. Palgrave Macmillan, United States of America.

Kidd, S, Frederick, T, Tarasoff, L.A, Virdee, G, Lurie, S, Davidson K, Morris, D, & McKenzie, K 2016, 'Locating community among people with schizophrenia living in a diverse urban environment', *American Journal of Psychiatric Rehabilitation*, vol. 12, no. 2, pp. 103-121.

Kitanaka, J 2012, *Depression in Japan: Psychiatric Cures for a Society in Distress*, Princeton University Press, United States of America.

Kleinman, A 1978, Culture, Illness, and Care. *Annals of Internal Medicine*, vol. 88, no. 2, pp. 250-2.

Kleinman, A 1981, *Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine, and Psychiatry*, University of California Press, United States of America.

Kleinman, S, & Copp, M.A 1993, *Emotions and Fieldwork*, SAGE Publications, Los Angeles.

Knowles, C 2000, 'Burger King, Dunkin Donuts and community health care', *Health Place*, vol. 6, pp. 213-224

Laing, R.D 1969, *The Divided Self: An Existential Study in Sanity and Madness*, Tavistock Publications. London, England.

Lacan, L 2007, *Ecrits*, Trans. Fink, B, W.W. Norton and Company, New York.

Lacan, J, Miller, J.A. & Fink, B 1999, *The Seminar of Jacques Lacan: On Feminine Sexuality, the Limits of Love and Knowledge,* Book XX: Encore 1972-73, W.W. Norton and Company, United States of America.

Lakoff, A 2003, 'The Lacan Ward: Pharmacology and Subjectivity in Buenos Aires' , *Social Analysis: The International Journal of Social and Cultural Practice* 47, vol. 1, no. 2, pp. 82–101.

Larsen, I.B, & Topor, A 2017, 'A place for the heart: A journey in the post-asylum landscape. Metaphors and materiality', *Health & place*, vol. 45, pp.145–151.

Latour, B 2005, *Reassembling the Social: An Introduction to Actor-Network-Theory*, Oxford University Press, Oxford.

Latour, B, & Woolgar, S 1979, *Laboratory life : the social construction of scientific facts*, Sage Publications, California.

Law, J 2004, *After Method: Mess in Social Science Research*, Routledge, London.

Lester, R 2013*,* Back from the edge of existence: A critical anthropology of trauma*, Transcultural Psychiatry,* vol. 50, no. 5, pp. *753–762.*

Lemelson, R, & Tucker, A 2017, Afflictions: Steps toward a visual psychological anthropology, Springer International Publishing, New York.

Lavee, E, and Strier, R 2018, 'Social Workers' Emotional Labour with Families in Poverty: Neoliberal Fatigue', *Child & Family Social Work*, vol. 23, no. 3, pp. 504–512.

Lévi-Strauss, C 1963, *Structural Anthropology*, Basic Books, New York.

Levi, P 1959, *If This is a Man*, Orion Press, United Kingdom.

Lewis, M 2021, *Pandora's Box: Ethnography and the Comparison of Medical Beliefs* (The 1979 Lewis Henry Morgan Lectures), p. 170.

Longhofer, J, Floersch, J, & Jenkins, J. H 2003, 'The social grid of community medication management', *American Journal of Orthopsychiatry*, vol. 73, no. 1, pp. 24–34.

Magri, G 2021, 'Are you paid above or below the average? Increase in full-time employment registered', *Times of Malta*, viewed 10th August, 2022, <https://timesofmalta.com/articles/view/women-earn-3000-less-than-men-in-annual-basic-salary.878582>.

Malaby, T. M 2009, ‘Anthropology and Play: The Contours of Playful Experience’, *New Literary History*, vol. 40, no. 1, pp. 205–218.

Mallia, R 2009, ‘The beliefs of nurses about patients with a psychiatric history admitted to an acute area setting’, B.A dissertation, University of Malta, Malta.

McBride, D 1994, ‘Black America: from community health care to crisis medicine’, Morone, J, and Belkin, G, *The politics of health care reform : lessons from the past, prospects for the future*, Duke University Press, United States of America.

McWade, B 2015, ‘Temporalities of Mental Health Recovery’, *Subjectivity*, vol. 8, no. 3, 2015, pp. 243–260.

Magalhães-Goulart, D 2019, *Subjectivity and Critical Mental Health: Lessons from Brazil*, Routledge, United Kingdom.

Malinowski, B 1939, ‘The Group and the Individual in Functional Analysis’, *American Journal of Sociology*, vol. 44, no. 6, pp. 938–964.

Mallett, S 2004, ‘Understanding Home: A Critical Review of the Literature’, *The Sociological Review*, vol. 52, no. 1, pp. 62–89.

Makari, G 2008, *Revolution in Mind – The Creation of Psychoanalysis*, Harper Collins Publishers Inc, United States of America.

Marcuse, H 1965, *One Dimensional Man; Studies in the Ideology of Advanced Industrial Society*, Beacon Press, Boston.

Marcuse, H 1962, *Eros and Civilization: A Philosophical Inquiry into Freud*, Vintage Books, New York.

Marsella, A. J, et al 1981, 'Depression and Body Image Satisfaction', *Journal of Cross-Cultural Psychology*, vol. 12, no. 3, pp. 360–371.

Martin, E 2006, 'The Pharmaceutical Person', *BioSocieties*, vol. 1, pp. 273–287.

Martinez, F 2017, 'Waste is not the end. For an anthropology of care, maintenance and repair', *Social Anthropology*, vol. 25, no. 3, pp. 346-350.

Mauss, M 1985, 'A Category of the Human Mind: The Notion of Person; the Notion of Self' , translated by W.D. Halls, In *The Category of the Person: Anthropology, Philosophy, History,* edited by Carrithers, M, Collins S, & Lukes, S, Cambridge University Press, U.K, pp. 1–25.

Mazzarella, W 2017, *The Mana of Mass Society*, University of Chicago Press, Chicago.

Mental Health Act 2012, p. 3-4. Caps, 9. P. 3, 464, P. 2. (e), viewed May 10 2022. <https://deputyprimeminister.gov.mt/en/CommMentalHealth/Pages/Mental-Health-Act.aspx>.

Metzl, J 2003, *Prozac on the couch: prescribing gender in the era of wonder drugs*, Duke University Press, United States of America.

Miles, A and Asbridge, J 2014, 'The European Society for Person Centered Healthcare (ESPCH) - Raising the Bar of Health Care Quality in the Century of the Patient', *Journal of Evaluation in Clinical Practice*, vol. 20, no. 6, pp. 729–733.

Moesby-Jensen, K and Schjellerup-Nielsen, H 2015, 'Emotional Labor in Social Workers' Practice', *European Journal of Social Work*, vol. 18, no. 5, pp. 690–702.

Mol, A 2008, *The Logic of Care: Health and the Problem of Patient Choice*, Routledge, London, pp. 1-29.

Montigny, G 2015, *Social Working: An Ethnography of Front-line Practice*, University of Toronto Press, Toronto, pp. 40-60, 217-224.

Moore, H 1995, 'The changing nature of anthropological knowledge: an introduction', Moore, H, *The Future of Anthropological Knowledge*, Routledge, London.

Mula, R 2010, *Hospitalisation of the insane, in Malta: 1850-1880*, B.A dissertation, University of Malta, Malta.

Murphy, M 1992, 'On Jogging With Fascists and Strolling With Reds: Ethnoethnography and Political Polarization in an Andalusian Town', *The Naked Anthropologist: Accounts From Around the World*, Wadsworth Press, Belmont, pp. 173-183.

Munn, N.D 1992, 'The Cultural Anthropology of Time: A Critical Essay', *Annual Review of Anthropology*, vol. 21, pp. 93–123.

Myers, N 2015, *Recovery's edge : An ethnography of mental health care and moral agency*, Vanderbilt University Press, United States of America.

Newton, L, Rosen, A, Tennant, C, Hobbs, C, Lapsley, H. M, & Tribe, K 2000, 'Deinstitutionalisation for long-term mental illness: an ethnographic study', *Australian and New Zealand journal of psychiatry*, vol. 34, no. 3, pp.484–490.

Newton, L, Rosen, A, Tennant, C, & Hobbs, C 2001, 'Moving Out and Moving On: Some Ethnographic Observations of Deinstitutionalization in an Australian Community', *Psychiatric rehabilitation journal*, vol. 25, no. 2, pp.152–162.

Newton, L 2001, 'Self and illness: Changing relationships in response to life in the community following prolonged institutionalisation', *The Australian Journal of Anthropology*, vol. 12, no. 2, pp. 166-181.

NHS 2019, *Overview - Cognitive behavioural therapy (CBT)*, viewed 5th August, 2022, <https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/talking-therapies-and-counselling/cognitive-behavioural-therapy-cbt/overview/>.

ODPMMH 2019, *Building Resilience Transforming Services A Mental Health Strategy for* Malta 2020-2030, viewed 10 May 2022. <https://deputyprimeminister.gov.mt/en/Documents/National-Health-Strategies/Mental_Health_Strategy_EN.pdf>.

Orland, K 2021, 'Mental health support requests continue to rise substantially', *The Malta Independent*, viewed 22 May 2022. < https://www.independent.com.mt/articles/2021-11-25/local-news/Mental-health-support-requests-continue-to-rise-6736238576>.

Orr, D, et al. 2019, 'Meaning in Hoarding: Perspectives of People Who Hoard on Clutter, Culture and Agency' , *Anthropology & Medicine*, vol. 26, no. 3, pp. 263–279.

Otake, Y, and Teisi, T 2021, 'Sociality and Temporality in Local Experiences of Distress and Healing: Ethnographic Research in Northern Rwanda'*Transcultural Psychiatry*, vol. 58, no. 4, pp. 546–560.

Parr, H 2011, *Mental health and social space: Towards inclusionary geographies?*, John Wiley & Sons, United States of America.

Parsons, T 1975, 'The Sick Role and the Role of the Physician Reconsidered', The Milbank Memorial Fund Quarterly, *Health and Society*, vol. 53, no. 3, pp. 257–278.

Pilkey, B, Scicluna, R, & Gorman-Murray, A 2015, Alternative Domesticities, *Home Cultures*, 12(2), pp. 130-32.

Pisani-Scalpello, D 2019, *A healthy worker is a productive worker : a study on mental health policy at the workplace in the Maltese islands*, B.A dissertation, University of Malta, Malta.

Pfeilstetter, R 2017, Anthropology and social work, *European journal of social work*, vol. 20, no. 2, pp.167–178.

Racine, C 2021, *Beyond Clinical Dehumanisation towards the Other in Community Mental Health Care: Levinas, Wonder and Autoethnography*, Routledge, London.

Raghavan, R, et al 2019, 'Reflections on the Use of Mental Health Resilience Concepts in Migration and Global Mental Health', *International Journal of Mental Health*, vol. 48, no. 4, pp. 299–308.

Rapport, N 2002. *Transcendent Individual*. Taylor and Francis, United Kingdom.

Rapport N, Overing, J 2000, *Social and Cultural Anthropology: The Key Concepts*, Routledge, London.

Reyes-Foster, B.M 2019, *Psychiatric encounters : madness and modernity in Yucatan, Mexico,* Rutgers University Press, New Jersey.

Richaud, L, and Ash, A 2019, 'Mental Health, Subjectivity and the City: an Ethnography of Migrant Stress in Shanghai' , *International Health*, vol. 11, no. 1, pp. S7–S13.

Roberts, N 2016, *To Be Cared For: The Power of Conversion and Foreignness of Belonging in an Indian Slum*, The University of California press, United States of America.

Roberts, R & Ittens, T 2006, 'Laing and Szasz : Anti-psychiatry, capitalism, and therapy', *The Psychoanalytic review (1963)*, vol. 93, no. 5, pp.781–799.

Rogachevsky, R 2001, 'David Stoll vs. Rigoberta Menchú: Indigenous Victims or Protagonists?', *Delaware Review of Latin American Studies*, vol. 2, no. 2.

Romakkaniemi, M, and Järvikoski, A 2012, 'Service Users' Perceptions of Shared Agency in Mental Health Services', *European Journal of Psychotherapy & Counselling*, vol. 14, no. 4, 2012, pp. 381–394.

Rose, N 2003, 'Neurochemical Selves', *Society (New Brunswick)*, vol 41, no. 1, pp. 46-59.

Rose, N 2007, *Politics of life itself: Biomedicine, power, and subjectivity in the twenty-first century,* Princeton University Press, Princeton, pp. 187-224.

Rosen, G 1968, *Madness in Society: Chapters in the Historical Sociology of Mental Illness*, University of Chicago Press, Chicago.

Rumsey, A 2011, 'Empathy and Anthropology: An Afterward', Holland, D.W & Throop, C.J. , *The Anthropology of empathy: Experiencing the life of others in Pacific Societies*, Berghahn Books, New York, p. 217.

Rylko-Bauer, B, & Farmer, P 2002, 'Managed Care or Managed Inequality? A Call for Critiques of Market-Based Medicine', *Medical Anthropology Quarterly*, vol. 16, p. 4, pp. 476–502.

Sahlins, M 2013, *What kinship is - and is not*, University of Chicago Press, Chicago.

Salzmann‐Erikson, M 2018, 'Using focused ethnography to explore and describe the process of nurses' shift reports in a psychiatric intensive care unit', *Journal of clinical nursing*, vol. 27, no. 15-16, pp. 3104–3114.

Saris, A. J 1996, 'Mad Kings, Proper Houses, and an Asylum in Rural Ireland', *American Anthropologist*, vol. 98, no. 3, pp. 539–554.

Sartre, J 1943, *Being and Nothingness*, 2003, translated by Hazel Estella Barnes, 2nd ed., Routledge, London.

Savona-Ventura, C 1999, 'Civil hospitals in Malta in the last two hundred years', *Historia Hospitalium*, vol. 21, pp. 45-63

Savona-Ventura, C 2004, *Mental Disease in Malta*, Association for the Study of Maltese Medical History for The Management Board, Our Lady of Mount Carmel Hospital, Malta.

Savona-Ventura, C 1997, *Outlines of Maltese Medical History*, Midsea Books Ltd, Malta
Scerri, A. M 2010, 'Tommaso Chetcuti : the man in the light of his times', *Malta Medical Journal*, vol. 22, no. 4, p. 40-42.

Scarry, E 1985, *The body in pain: the making and unmaking of the world*, Oxford University Press, Oxford.

Scharff, Christina 2016, 'The Psychic Life of Neoliberalism: Mapping the Contours of Entrepreneurial Subjectivity', *Theory, Culture and Society*, vol. 33, no. 6, pp. 107-122.

Scheper-Hughes, N 1979, *Saints, scholars, and schizophrenics: Mental illness in rural Ireland*, University of California Press, Berkeley.

Scull, A 2015, *Madness in civilization: A cultural history of insanity, from the Bible to Freud, from the madhouse to modern medicine*, Princeton University Press, Princeton.

Sidenius, Anne, et al 2020, 'Temporality and Timework: Danish Endometrial Cancer Patients: Experiences of an Accelerated Cancer Patient Pathway', *Time & Society*, vol. 29, no. 3, pp. 866–891.

Singleton, V 2010, 'Good Farming: Control or Care?', In Mol, A. Moser, I. Pols J. *Care in Practice: On tinkering in Clinics, Homes and Farms*, Transcript Publishing, Bielefeld, pp. 248-49.

Soler, J 2021, 'An evidence-based COVID-19 response', *Times of Malta*, viewed 30 June 2022. <https://timesofmalta.com/articles/view/an-evidence-based-covid-19-response-jean-karl-soler.915561>.

Smardon, R 2008, 'I'd rather not take Prozac': stigma and commodification in antidepressant consumer narratives', *Health*, vol. 12, no. 1, pp. 67–86.

Spivak, C 1988, 'Can the Subaltern Speak?', Nelson, C and Grossberg, L, (eds.), *Marxism and the Interpretation of Culture*, Macmillan, Basingstoke.

Stark, A 2006, *The Limits of Medicine*, University of Toronto Press, Canada.

Stewart, C (ed) 2014, *Colonizing the Greek Mind? The Reception of Western Psychotherapeutics in Greece*, The American College of Greece, Athens.

Strathern, M 1995, ‘The nice thing about culture is that everyone has it’, Strathern, M, *Shifting Contexts: Transformations in Anthropological Knowledge*, Routledge, London, pp. 153-176.

Strava, C 2017, ‘At home on the margins: caregiving and the ‘un-homely’ among Casablanca's working poor’, *City & Society,* vol. 29, no. 2, pp . 335-37.

Szasz, T 1974, *The myth of mental illness : foundations of a theory of personal conduct,*. Harper & Row, New York.

Taussig, M 1980, ‘Reification and the consciousness of the patient’, *Social Science and Medicine*, Part B: Medical Anthropology, vol. 14, no. 1, pp. 3-13.

Tanner, T, Bahadur, A., & Moench, M 2017, *Challenges for resilience policy and practice: Working Paper 519*, Overseas Development Institute, London.

Taylor-East, R 2019, ‘Working in psychiatry in malta: A personal view’, *BJPsych International*, vol. 16, no. 3, 56-57.

Taylor-East, R, Rossi, A, Caruana, J, & Grech, A 2016, ‘The mental health services for detained asylum seekers in Malta’, *BJPsych international*, vol. 13, no. 2, 32–35

The Independent 2019, ‘Richmond Foundation demands Mount Carmel be closed for all psychiatric conditions’, *The Independent*, viewed 10 May 2022. <https://www.independent.com.mt/articles/2019-06-12/local-news/Richmond-Foundation-demands-Mount-Carmel-be-closed-for-all-psychiatric-conditions-6736209460>.

Thelen, T 2015, ‘Care as social organization: Creating, maintaining and dissolving significant relations’, *Anthropological Theory*, vol. 15, no. 4, pp. 497–515.

Times of Malta 2006, ‘Mount Carmel patients to live in hostels’, *Times of Malta*, viewed 30 July 2022. <https://timesofmalta.com/articles/view/mount-carmel-patients-to-live-in-hostels.45614>.

Times of Malta 2021, ‘Lack of investment in Mt Carmel Hospital cannot be allowed to continue - union’, *Times of Malta*, viewed 10 May 2022, <https://timesofmalta.com/articles/view/lack-of-investment-in-mt-carmel-hospital-cannot-be-allowed-to-continue.861205>.

Times of Malta 2021, ‘Useful protection or not warranted? Third jab debate rages’, *Times of Malta*, viewed 10 May 2022. <https://timesofmalta.com/articles/view/useful-protection-or-not-warranted-third-jab-debate-rages.899464>.

Trundle, C 2018, ‘Uncomfortable Collaborations: The Ethics of Complicity, Collusion, and Detachment in Ethnographic Fieldwork’, *Collaborative anthropologies*, vol. 11, no. 1, pp.89–110.

Turner, V 1969, *The Ritual Process: Structure and Anti-Structure,* Aldine Publishing Company, Chicago.

Turner, V 1967, *The Forest of Symbols: Aspects of Ndembu Ritual,* Cornell University Press, New York.

Underberg, M & Zorn, E 2013, *Digital ethnography: anthropology, narrative, and new media*, University of Texas Press, Austin.

Vaness, A 1993, ‘Neither homed nor homeless: Contested definitions and the personal worlds of the poor’, *Political Geography*, vol. 12, no. 4, pp. 319-340.

Varley, E 2008, ‘Enmities and introspection: fieldwork entanglements and ethnographic reflexivity’, Chua, L, High, L, Lau T, *How do we know? Evidence, Ethnography and the making of Anthropological knowledge*, Cambridge Scholars Publishing, pp. 133-156.

Vassallo, J 2008, *(Re)ordering disorder?: analysis of a rehabilitative psychiatric halfway-house*, B.A dissertation, University of Malta, Malta, p 35, 38, 72.

Vella, M 2021, 'Mosta 'cat killer' challenges seven-year detention inside mental health facility', *Malta Today*, viewed 10 May 2022. <https://www.maltatoday.com.mt/news/court_and_police/111414/mosta_cat_killer_challenges_sevenyear_detention_inside_mental_health_facility#.YnBRIdrP16k>.

Vella, M 2022, 'I'm no cat killer': Mount Carmel patient protests seven-year committal on website', *Malta Today*, viewed 10 May 2022. <https://www.maltatoday.com.mt/news/national/111428/im_no_cat_killer_mount_carmel_patient_protests_sevenyear_committal_on_website#.YnBUrtrP16k>.

Vuckovic, N 1999, 'Fast Relief: Buying Time with Medications', *Medical Anthropology Quarterly*, 13(1), pp. 51–68.

Windle, G 2011, 'What is resilience? A review and concept analysis', *Reviews in Clinical Gerontology*, 21(2), pp. 152–169.

Webster, F 2020, *The Social Organization of Best Practice: An Institutional Ethnography of Physicians' Work*, Palgrave Macmillan, pp. 62-66.

Weber, M 2001, *The Protestant Ethic and the Spirit of Capitalism (1905),* Routledge, London.

Whyte, G, Hardon, G, Sjaak, V, & Hardon, A 2002, 'Drug Vendors and their market: the commodification of health', *Social lives of medicines* (Cambridge studies in medical anthropology), Cambridge University Press, United Kingdom.

Whitaker, E.M 2019, '"Bring yourself to work": rewriting the feeling rules in "personalized" social work', *Journal of Organizational Ethnography,* vol. 8, no. 3, pp. 325-338.

Wulff, K, Donato, D, & Lurie, N 2015, 'What is health resilience and how can we build it?', *Annual Review of Public Health*, vol. 36, pp. 361–374.

Xuereb, M 2019, 'Watch: 'Dangerous ceilings' in most Mount Carmel Hospital wards', *Times of Malta*, viewed 10 May 2022. <https://timesofmalta.com/articles/view/watch-dangerous-ceilings-in-most-mount-carmel-hospital-wards.707754>.

Young, A 1982, 'The Anthropologies of Illness and Sickness', *Annual Review of Anthropology*, vol. 11, no.1, pp. 257-285

Young, M 1987, 'The Ethnographer As Hero: the imponderabilia of Malinowski's everyday life in Mailu', *The Asia Pacific Journal of Anthropology*, vol. 10, no. 2, pp, 32-50.

Žižek, S 2014, *Event: philosophy in transit,* Penguin, London.

Word count: 48, 750 words