CHAPTER 14 Care and Disregard

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Home is where one starts from ...
And the end of all exploring
Will be to arrive where we started
And know the place for the first time.
                    T. S. Eliot, *The Four Quartets*

"Take me home, my little João, take me home." It was the first time I was visiting Vó Manda, my paternal grandmother who, against my long-distance wishes, had been placed in a nursing home in the town of Brochier. I was writing my doctoral dissertation at University of California, Berkeley and was back to visit extended family in southern Brazil in the summer of 1996. Vó Manda, who was in her late seventies, had seen her husband and two children die, including my father two years earlier, and even though she had been in a somewhat fragile state for several years she had managed to live by herself in a working- and lower middle-class district in Novo Hamburgo. She was then cared for by my cousin Tania, her most devoted grandchild who lived next door, and by my widowed mother.

I knew Vó Manda was difficult to care for and to please, but I could not leave her there, I told myself. Her piercing eyes and lucid voice made it clear that the asylum, two hours away from her home and family, was a death sentence. We were all killing her. I couldn't stop crying and feeling guilty as I returned to what had once been home. I pleaded with all parties. While I invoked kin ties and morals – what would our father do if he were alive? – I also had to hear that my being distant in the United States made it easier for me to come up with moral imperatives.

My siblings each had family problems and economic insecurities to deal with and my mother was exhausted. She had cared for my father (who had had both legs amputated due to severe diabetes) for over 10 years and she wanted to move on with life. She did not hide the fact that she disliked Vó Manda. We grew up hearing stories about the immense burden of debt that she and my shrewd grandfather Oscar and their daughter Iva had always placed on our family, earlier in rural life and then after

migration to Novo Hamburgo (then known as the shoemaking capital of Brazil). It was as if Vó Manda had not earned the right to be cared for. But after intense shaming and blaming and careful economic calculations, I succeeded in making the case that our family, meaning my mother, should pay for a full-time caregiver and that Tania and her family would oversee.

Vó Manda came back and for one year she was cared for by Solange, a young woman from the interior who badly wanted a job in the city. But after a year, Solange simply moved on. Vó Manda had become increasingly frail and supposedly difficult, so the story goes, and was sent to a *casa de idosos*, a makeshift geriatric clinic in a nearby town, which my mother paid for. We later learned that Vó Manda had in fact never returned "home": my cousin Tania and her husband had secretly taken her to a notary where she had signed over the house, all she had, to them.

The last time I saw Vó Manda was on a hot summer day in January 1997, crying and begging to leave that place full of TV noise, flies, the smell of urine, and abandoned voices. By now she was being medicated to calm her down, to dampen her voice. "Take me home, my little João, take me home." A few months later, she was transferred to another geriatric business, this time closer so that people could visit her more easily. She died soon after, her body so curled up that her legs had to be broken to fit into the coffin.

When Nothing Can Be Done

Vó Manda and her social destiny were in the forefront of my thinking when, just a few months later, I met a young woman named Catarina who had been abandoned in an asylum called Vita in Porto Alegre, the state's capital (Biehl 2005). Her speech was slurred and she had difficulty walking: "Maybe my family still remembers me, but they don't miss me."

In our first conversation, Catarina said that she was also from Novo Hamburgo and that her ex-husband had given their daughter Ana to the family of Urbano, his boss, for adoption. She said that she had been seen by psychiatrists and that medicines had worsened her condition, making her "always dependent." Catarina continued, "My brothers and my brother-in-law brought me here. I exercise, so that I might walk. I must wait for some time." Something had made it impossible for Catarina to return home. But the desire was still there: "It is not that one does not want to."

Even though Catarina insisted that she had a physiological problem – "My legs don't work well" – and that her presence in Vita was the outcome of various relational, domestic, and medical circumstances outside her control, to Vita's volunteer caregivers she spoke "nonsense." They referred to Catarina as "mad" and knew nothing about her life outside Vita, haphazardly treating her – and the more than 100 people who were also waiting *with* death in Vita – with all kinds of psychiatric drugs (donations that by and large had expired).

As I was to find out, Porto Alegre contained more than 200 such grassroots institutions of last resort, most of which were called "geriatric houses." These precarious places housed those cut off from family life, the mentally ill, and the sick in exchange for their welfare pensions. A good number of these institutions also received state funds or philanthropic donations. I began to think of Vita and the like as *zones of social abandonment*. The existence of these zones was intertwined with the realities of changing households and with local forms of the state, medicine, and the

economy – they absorbed those individuals, young and old, who had no ties or resources left to sustain themselves, whose bodies were not worth governing. Neither the legal authorities nor welfare and medical institutions intervened directly in these zones of abandonment. Here the unwanted were sure to become unknowables, with no human rights and no one accountable to them.

Even though Vó Manda and Catarina had lived in the same city, their everyday worlds had been separated by distinct social and economic boundaries. Yet, seen from the geriatric house and Vita, each also embodied a reality that was more than her own. To some extent, they shared a story of family abandonment, an abandonment that brought the poor and the middle class together in an emergent care enterprise. And, as I traced Catarina ethnographically back to the medical institutions, neighborhoods, households, relations, and crossroads at which her madness and abandonment had taken form, I discovered a moral ambiguity and fatalism similar to what I had found among my own family. In the face of physical and mental deterioration the spoken common sense was "What else could be done?" And the unconsidered reality was that the verb "to kill" was being conjugated. As Catarina wrote in her notebook with an uneven handwriting that betrayed minimal literacy:

> The pen between my fingers is my work
> I am convicted to death
> I never convicted anyone and I have the power to
> This is the major sin
> A sentence without remedy.

In my efforts to verify the sources of this human destiny, I found that the family was increasingly the medical agent of the state, providing and at times triaging care, and that medication had become a key instrument for such deliberate action. I uncovered an intricate domestic moral economy (Fassin 2008), in which illness was the ground on which experimentation with changes and breaks in intimate household relations occurred and that pharmaceutical care both legitimated disregard and sanctioned abandonment, as if Catarina's condition had ultimately been self-generated. As she elliptically wrote: "To want my body as a medication, my body." Or, as she repeatedly stated: "When my thoughts agreed with my ex-husband and his family, everything was fine. But when I disagreed with them, I was mad. It was like a side of me had to be forgotten. The side of wisdom ... Why was it only me who had to be medicated?" The renegotiation over what constituted meaningful social relations and the getting rid of the unsound and undesirable was intimately tied to families operating as proxy psychiatrists, to the dying out of values based on blood ties, and to people's attempts to continue with their own lives amid economic insecurity in wounded cities.

FAMILY COMPLEXES

In one of his earliest texts "Family Complexes in the Formation of the Individual," Jacques Lacan (1938) emphasizes the family as a contingent social phenomenon, always situated in history and in culture. Neither a natural structure that follows from biological instinct nor merely a miniature representation of society, families are plural

and complex – they are caught up in conflicts and inertia of their own and they must be studied with care. Throughout the text, Lacan develops the idea of the "complex," which, he insists, "is dominated by cultural factors" (12). He continues:

> As for the individual integration of objectifying forms, this is the work of a dialectical process that makes each new form arise from the conflicts between the preceding one and the real. In this process we must recognize the character that specifies the human order, namely the subversion of every instinctual fixation from which arise the fundamental and infinitely variable forms of culture. (Lacan 1938: 12)

In reviewing this text, Jacques-Alain Miller (2005) argued that the "complex" was in fact a "prestructure" and that Lacan then lacked "the concept of structure." Yet, I would argue that this theoretical/structuralist lack, so to speak, enables the appearance of something altogether different in this early text. For Lacan's insight here is not merely that reality and the psyche that perceives it are given shape by culture, but that the vehicle of this "dialectical process" is the family, which both transcends the sterile rigidity of structuralist "culture" and escapes a narrow biological, evolutionary, or genetic determinism. The father and the mother are not the coordinates of everything that is invested by the unconscious (see Deleuze 1997: 62); rather, Lacan wants us to consider the cross-cultural and transhistorical shifts in the constitution of the family as well as the family's plasticity (like the "intrusion" that comes with the birth of a sibling: Lacan 1938: 23) and the demands that all this places on specific human conditions. While identifying, for example, the "social decline of the paternal imago" (55), Lacan thus creates a productive space in which we can rethink the forms and roles of the family today.

In this essay, I explore how the domestic encroachment of medical commodities affects care and family ties in resource-poor contexts, as well as how these commodities become interwoven in the very fabric of symptoms and identities. What is the fate of social bonds in today's dominant mode of subjectification at the service of medical science and capitalism? I am particularly interested in how psychiatric drugs become part of economies of care and disregard – the ways they open up and relimit family complexes and moral imagination – and the agency that solitary and chemically submerged subjects such as Catarina express and live by, reduced as they are to a failed medication regimen. In her words:

> Not slave, but housewife
> Wife of the bed
> Wife of the room
> Wife of the bank
> Of the pharmacy
> Of the laboratory.

As institutional care becomes increasingly outsourced to entrepreneurs and local communities, and as powerful medications circulate without even a doctor's visit, human relationships with medical technology are increasingly constituted outside the clinical encounter (Biehl with Moran-Thomas 2009). New therapeutic populations and forms of intimacy are now emerging around technology at community and domestic levels, as in the case of the massive and often unregulated dissemination of

psychiatric drugs worldwide (Luhrman 2000; Ecks 2005; Petryna et al. 2006; Biehl 2007; Martin 2007; Fischer 2009; Biehl and Petryna 2011; Jenkins 2011).

Rationalities play a part in the reality of which they speak, and this dramaturgy of the real becomes integral to how people value life and relationships and enact the possibilities they envision for themselves and others. Psycho-pharmaceuticals seem to have played a key role in altering Catarina's sense of being and her value for others. And through these changes, family ties, interpersonal relations, morality, and social responsibility were also reworked. Her "ex-family," she insisted, thought of her as a failed medication regimen. And in her writing, global pharmaceuticals were not simply taken as new material for old patterns of self-fashioning: "The dance of science, pain broadcasts sick science, the sick study, brain, illness, Buscopan, Haldol, Neozine, invoked spirit." There was a science to Catarina's symptoms and exclusion, a science that was itself sick, a money-making science. The goods of psychiatry, such as Haldol and Neozine, were now as ordinary as Buscopan (an over-the-counter antispasmodic medication) and had become part of familial practices. Ritual-like, they worked on her brain and her illness. "What I was in the past does not matter."

In *The Divided City*, writes Nicole Loraux, one must "expose the city to what it rejects in its ideological discourse yet lives in the time of the event" (2002: 61). Overall, Loraux is concerned with the denial of historicity in Greek classic democracy: "the denial of conflict as a constitutive principle, in order to construct the generality 'city'" (61). Civil war is at the core of civic life. The historian shows how the citizenry's conceal-ment of war generates an affect that works like "the cement of the community." The crime being concealed has been engendered "in a single family" (33). For Loraux, the city is the subject which makes the symptom through the family. Fratricide, she argues, is "ordinary civil war, because the brother is also the paradigm of the citizen" (209). She thus constructs a scenario in which the household is affectively politicized: "hate would be more ancient than love, in which forgetting can be valued only in terms of the unspeakable joy brought by the wrath that does not forget" (66). The restora-tion of familial relations becomes paradigmatic of reconciliation in the city. In the end, a false brotherhood conceals the original reality of division (39).

My encounter with Catarina and the events it precipitated made it possible to retrieve a world deemed to be lost. This essay brings out of thoughtlessness the set of symp-toms, moral sentiments, domestic relations, and practical calculations by which the marketable and those who are left to die are linked to each other and to the political body via pharmaceuticals. As formal institutions either vanish or become nonfunc-tional in the wake of the country's fast-paced neoliberalization, the household is further and distinctively politicized. Amid the "pharmaceuticalization of health care" (Biehl 2007) and in the daily rituals of medication and compliance, alternative conceptions of caregiving, moral experience, and ideas of what life is for begin to take shape.

Ethnographic work can break open totalizing assumptions and capture this active embroilment of reason, life, and ethics as human lives are reshaped and lost. An immense parceling out of the specific ways communities, families, and personal lives are assembled and valued and how they are embedded in larger entrepreneurial processes and institutional rearrangements comes with the on-the-ground study of a singular "other." While entering the density and intensity of a locality, the anthropologist is challenged to think with the theories, however articulate or inarticulate they may be, created by those excluded, like Catarina, concerning both their condition and their

hope. I say hope for, against all odds, Catarina and so many in Vita and other zones of social abandonment keep searching for ways to endure, for ties and a way home.

Catarina resisted the foreclosures that Vita posed, and, in ways that I could not fully grasp at first, she voiced an intricate ontology in which inner and outer space and self and others were affectively laced together, along with the wish to untie it all: "Science is our consciousness, heavy at times, burdened by a knot that you cannot untie. If we don't study it, the illness in the body worsens ... Science ... If you have a guilty conscience, you will not be able to discern things." Catarina's spoken accounts and her writing contained the confused sense of something strange happening in the body: "cerebral spasm, corporal spasm, emotional spasm, scared heart." As she moved from house to hospital to other houses to Vita, experiencing both pharmaceutical care and human disregard, it seemed there was a danger of her becoming too many, strange to herself, all the while cementing an estranged social body. "One needs to preserve oneself. I also know that pleasure in one's life is very important, the body of the Other. I think that people fear their bodies."

Such difficult and multifaceted realities and the fundamentally ambiguous nature of people living them gives the anthropologist the opportunity to develop a human (not abstractly philosophical or merely psychological or economic) critique of contemporary machines of social death. Ethnography, I believe, can help us to resituate and rethink social death within various familial, technological, and political economic circuits and concrete struggles over belonging, voice, and care of others and of self (Foucault 1988; Fassin 2007). In contrast to subjects of statistical studies and the figures of philosophy, our ethnographic subjects have a future – and we are a part of that.

TECHNOLOGIES OF CARE AND DISREGARD

Taking Catarina's spoken and written words at face value led me on a journey into the various medical institutions, communities, and households to which she continually alluded. With her consent, I retrieved her records from psychiatric hospitals and local branches of the universal healthcare system. I was also able to locate her family members – her brothers, ex-husband, in-laws, and children – in nearby Novo Hamburgo. Everything she had told me about the familial and medical pathways that led her into Vita matched the information I found in the archives and in the field.

Catarina was born in 1966, and grew up in a very poor place, in the western region of the state of Rio Grande do Sul. After finishing fourth grade, she was taken out of school and became the housekeeper as her youngest siblings aided their mother in agricultural work. The father had abandoned the family. At the age of 18, Catarina married Nilson Moraes, and a year later she gave birth to her first child. Shady deals, persistent bad harvests, and indebtedness to local vendors forced Nilson and Catarina to sell the land they had inherited to take care of Catarina's ailing mother, and in the mid-1980s the young couple decided to migrate and join two of her brothers who had already migrated and found jobs in the booming shoe industry in Novo Hamburgo. In the coming years, she had two more children and began to have difficulties walking. As her condition progressed, her marriage also disintegrated. Catarina had become too much of a burden for her old and new family, a history tangled by the complications of disease, poverty, and fear, and was frequently hospitalized and overmedicated with

powerful antipsychotics. In 1996 she was sent to Vita. Her eldest two children went to her husband's family, and her youngest daughter was given up for adoption.

Had I stayed only with Catarina's utterances in Vita, the whole field of tensions and associations that existed between her family and medical and state institutions, a field that shaped her existence, would have remained invisible. Catarina did not simply fall through the cracks of these various domestic and public systems. Her abandonment was dramatized and realized in the juxtapositions of several social contexts. Scientific assessments of reality (in the form of biological knowledge and psychiatric diagnostics and treatments) were deeply embedded in changing households and institutions, informing colloquial thoughts and actions, an emerging common sense that led to her terminal exclusion.

Following Catarina's words and plot was a way to delineate the powerful, noninstitutionalized ethnographic space in which a family gets rid of its undesirable members. The social production of deaths such as Catarina's cannot ultimately be assigned to any single intention. The fabric of this domestic activity of valuing and deciding which life is worth living remains largely unreflected upon, not only in everyday life, but also in the social science and theory of caregiving. As this study unfolded, I was challenged to devise ways to approach this unconsidered infrastructure of decision-making, which operates, in Catarina's words "out of justice" – that is, in spite of the bounds of law – and which is close to home. I also uncovered that Catarina actually suffered from a rare neurodegenerative disorder that caused her to lose her ability to walk and, over time, shut her down. Reaching this diagnosis took me through a maze of medical hoops and, as the picture of her disease became clearer, I took her to a geneticist and neurologist who finally made the correct diagnosis and provided the best possible care.

In what follows, I engage core debates on the gendered meanings of care vis-à-vis the psychology of moral experience, hoping to shed light on the relevance of the ethnography of illness and medicine in refiguring commonly held assumptions about the economics and moral dimensions of caregiving. Yes, caregiving is an existential quality and means for the good, but it is also intimately bound to the possibility of disregard and evil. By using the terms "disregard" and "evil" together, I want to emphasize two points: (1) disregard can be sanctioned by assumptions that the suffering of the abandoned person is a form of punishment for evil done; and (2) the ways in which clinical medicine and psychiatry – disciplines that pledge to do no harm, at the very least – are made instrumental in blaming victims for their own suffering and disqualifying them from care and human connection. I hope to open up an analytical space to engage the negative space inhabited by Catarina in which people could excuse themselves from her, a space of disregard at the nexus of market rationality, science, and intimacy that points to the limits of care (Stoler 2009: 256).

Social theorists have struggled to find ways to understand these often troubling novel entanglements of care and the markets of medical technology. Drawing inspiration from feminist critics like Carol Gilligan, whose book *In a Different Voice* (1993) argues for the relevance of care as a separate value excluded by masculine rationalities that do not acknowledge the relational nature of morality, some theorists have identified an absolute opposition between care and the market (Hankivsky 2004; Held 2006).

In *The Ethics of Care*, Held asks: "What kinds of activities should or should not be in the market and governed by market norms? How does marketing an activity change its character and what values are served by this transition? On what moral grounds can we make such decisions and where should the limits (if any) of markets be drawn?" (2006: 108) For Held, there is an aspect of care that cannot be valued in terms of market capitalism. She distinguishes between compensating caregivers for their work and transforming care into a market commodity. Thus the core issue is one of a prioritization of values: "not whether the work is paid or not but the norms under which it is done and whether the values that have priority in its doing are market values or some others" (111). In other words, "What might the moral grounds plausibly be for deciding on the limits or boundaries of the market?" (116). In her book *Social Policy and the Ethic of Care*, Hankivsky (2004) draws from Held and makes similar arguments about a fundamental opposition between care and commodity. For her, experiences and values of care are incommensurable with market values (90; see Tronto 2008). Hankivsky cites a troubling study conducted by Phillip Morris that concluded that "smoking is not costing the Czech government money because government costs in treating smoking-related illnesses are offset by the early death of smokers. In fact, the company reported that, in 1999, smoking produced a net gain of approximately $150 million dollars for the government" (99–100). This logic produces a deeply unsettling moral calculus.

Both Held and Hankivsky are concerned with the ever encroaching market in public institutions and social relations, its logic of commodification, and the erasure of other social and moral values as they are replaced with consumer-capitalist ideology. Yet, the mixing of commodity and care *does* happen, and if we cannot explain the moral gravity of caregiving by merely defining good care as a pure, transcendent value and opposing it to the corrupting force of the market, how can we apprehend the ethics of care in today's consumer-capitalist society?

Sociologist Viviana Zelizer's work is a strong critique of an analytic scheme where the intimate world of caregiving occupies a "separate sphere" from the corrupting economic rationality of the market. Writing against a monolithic notion of economic rationality and against binary oppositions, Zelizer sees intimacy and economics intersecting constantly in a dynamic she terms "connected lives." In *The Purchase of Intimacy* (2005), she rejects essentializing theories of care that distinguish it absolutely from market values or that reduce it to economics, culture, or biology. Zelizer argues for a complex dynamic of intersection: "Economic arrangements for the provision of care do not simply call up considerations of cost, convenience, and efficiency. They involve negotiation of the forms, representations, obligations, and rights attached to meaningful interpersonal ties" (2005: 172).

Yet, what is the moral dimension of this vision of care? The idea of "intimate care" (as in Gilligan, for example) too easily "sentimentalizes," Zelizer would say, calling up all the familiar images of altruism, community, and unstinting, noncommercial commitment: "From there it is only a step to a notion of separate spheres of sentiment and rationality, thence to the hostile worlds supposition that contract between the personal and economic spheres corrupts both of them" (2005: 207). Yet Zelizer contends that a close examination of how people actually speak of experiences and relationships of care and intimacy challenges this argument:

> In fact, personal care incessantly mingles economic transactions with the provision of sustained and/or life-enhancing personal attention. Looking meticulously at caring relations reveals that participants themselves do not contend over whether those relations should involve economic transactions. They contend instead over appropriate matches among relations, media, and transactions, taking great pains to distinguish relations providing similar practical forms of care but having significantly different implications for longer-term connections among the people involved. In negotiating economic conditions of care, participants are also defining meaningful social relations. (Zelizer 2005: 207)

Although Zelizer demonstrates the mutual involvement of intimacy and economics and does not dismiss or deny the ethical challenges posed by care and caregiving, her descriptive work leaves space to ask about the experience of moral uncertainty confronted by caregivers living, as she calls them, "connected lives." For Catarina's abandonment was not merely a process of social definition, but a moral choice, an unwillingness by those in her life to be accountable to her words and needs. If, as Zelizer argues, economic decision-making is neither wholly excluded nor in a position of absolute determinism over relationships of care, what new moral dimensions emerge in the actual practice of caregiving?

Arthur Kleinman (2008, 2011) has written reflectively and provocatively about the human dimensions of care. Drawing from his own practice of caring for his wife Joan Kleinman, he argues for the moral gravity and human significance of care:

> To use the close experiential language of actually doing it, caregiving is also a defining moral practice. It is a practice of empathic imagination, responsibility, witnessing, and solidarity with those in great need. It is a moral practice that makes caregivers, and at times even the care-receivers, more present and thereby fully human ... Caregiving is one of those relationships and practices of self-cultivation that make us, even as we experience our limits and failures, more human. (Kleinman 2009: 293)

Another important perspective on the moral dimensions of care is given by Annemarie Mol (2008), who argues for a "logic of care," problematizing what she calls the "logic of choice" which defines patient choice as its chief value. Mol demonstrates that "autonomy" and "choice" can be euphemisms for social practices of neglect, as responsibility is placed on the individual for her own care. In the logic of choice, she argues, it is not only that autonomy is regarded as an ethical good, but also that, "in the logic of choice making normative judgments is the moral activity *par excellence*, and it is this activity that this logic endorses" (2008: 74). But in the logic of care, it is not decisions but practices that carry moral weight: "For care is not a (small or large) product that changes hands, but a matter of various hands working together (over time) to produce a result" (18).

The logic of care, according to Mol, is not a matter of identifying an essence of care or caregiving that works in opposition to the market or to Enlightenment rationality; on the contrary, the logic of care for Mol is precisely a consequence of the deconstruction of the binary opposition between the moral and the impartial or rational: "The logic of care has no separate moral sphere. Because 'values' intertwine with 'facts,' and caring itself is a moral activity, there is no such thing as an (argumentative) ethics that can be disentangled from (practical) doctoring" (Mol 2008: 79). The logic of choice, on the other hand, "comes with guilt. Everything that follows after a choice

has to be accepted as following from it ... In the logic of choice, having a choice implies that one is responsible for what follows. In the logic of care this is different" (79). This guilt has profound consequences for health care, particularly as we grapple with the place of new technologies in our lives; as Mol writes, "the expectation that technologies subordinate themselves as obedient means to their valuable ends, makes us all too surprised, time and again, when these technologies come with unexpected, undesired effects" (93). In other words, it is a logic of choice which, precisely by attempting to distill the moral from the neutral, rational, and technological, permanently blocks us from approaching the moral dilemmas that are fundamentally linked to those apparently value-neutral objects.

Both Zelizer and Mol argue against a straightforward opposition of idealized care and the market. Zelizer demonstrates that financial transactions are deeply embedded in the social negotiation of caring relationships. Mol argues that the sense of impending doom about market capitalism corrupting the moral good of caregiving is intelligible only in the discursive terms of market capitalism itself; it is a logic of choice that allows us to separate them and then see them as mutually opposed.

While Mol's theoretical framework provides a fresh perspective on the moral consequences of the economies of care, it cannot identify evil or neglect except as discursive functions of neoliberal capitalism. An ethnographic perspective points to a potential new direction for inquiry: how can we put the ethical person or the moral community at the center of our understanding of the intersection between care and capitalism? How can these theoretical debates be refigured by ethnography and by more attention to the social experience of care or lack thereof?

Ethnography has the potential to illuminate how certain technologies that are named or fall under the category of "care" – psychiatric diagnostics, psycho-pharmaceuticals, and institutionalization in geriatric houses, for example – actually create the conditions for the possibility of evil, precisely because they are not care at all in the sense that Mol and Kleinman define it, as practice rather than decision or commodity. The practices I chronicle in the following sections substitute momentary decisions for relational practices that extend indefinitely over time. What makes them so insidious is that they masquerade as what they are not, enabling the parties making the decisions to feel that their behavior is within the bounds of acceptable morality. It is Orwellian in its absurdity: society gives something a name – "health care" – that means precisely the opposite of what the thing actually is (social abandonment/ disregard) – and everybody is off the hook.

In contexts of poverty, the financial and relational aspects of caregiving are often in extreme tension, placing people in very difficult situations in which they feel they have "no choice." As I will show with Catarina's family, people attempt to resolve this tension by substituting drugs and institutionalization for care as relational practice, a strategy made possible by the fact that the former are mistakenly considered forms of caregiving by modern healthcare science. The consequence of conceiving of care as technological intervention rather than relational practice – the abandonment and death of people in great need – is a kind of evil. Detachment and disregard, not purely psychological but socially situated, relational, and economic, are prescribed and practiced, when in fact people's pain calls for the opposite.

These forms of disregard, disguised as caregiving, transform relationships in family and work, reshape community values and priorities, and alter economic prospects and

life chances. Local patterns of caregiving and disregard thus illuminate larger social processes and the fundamental human potential for good and evil. Ethnography can also engage the thinking of those subjected to disregard, and, in so doing, force us to inquire into how such human capacity can be made part and parcel of much-needed efforts to reimagine and redirect both caregiving and the knotty relationship between care of the self and care of others. "Could the activity of thinking," asks Hannah Arendt, "be among the conditions that make men abstain from evil-doing or even actually 'condition' them against it?" (1981:5).

Ex-Home

I followed Catarina's clues into Novo Hamburgo's poorest districts. No, nobody around knew of anyone like Catarina, the Gomes family, or the Moraes family. I had gathered a few addresses from Catarina's medical records. To my surprise, one of them led me into a rich neighborhood. Beyond the dead end of Travessão Street, however, a cluster of wooden shacks sat on a large grassy field – a squatter settlement on city property. A bar connected the cluster of shacks. There was a pink house where (according to hospital records) Catarina had once lived. A neighbor kindly gave me his cell phone number and told me that I could call later. If Catarina's husband came around, he would put me in contact with him.

That night I called. It turned out that the owner of the pink house was not Catarina's husband. "My name is Nilson Maurer. I am the other Nilson," he said, "I am married to Sirlei, Nilson Moraes' sister. You can call me Alemão [German]." He added that Anderson, Catarina's teenage son was visiting them, and that I was welcome to stop by.

A semblance. That was the first thing I heard about Catarina as I entered her former house and the world of her ex-family: "She was so beautiful in the wedding photos," said Catarina's sister-in-law. The first memory was not the person but her apparition: "When Nilson first brought her photo home, I said, 'Father and mother, look, what a beautiful girl he got for himself.' Everybody agreed." Catarina entered the new family unit as an appearance, as the property of a man, and as part of a domestic labor force: "When Nilson brought her home, she helped with everything, and now she is in this situation."

For Sirlei, today's paralysis could not be read in the past: "When I first laid eyes on her, one couldn't see she would have the problem she has today. She was a perfect person like us." Alemão, however, suggested that the Moraes family had known something of Catarina's physical condition early on, recalling that "she was already dragging her legs a bit." This physical sign had not entered the initial recollection of Catarina's sister-in-law: "I didn't know her when she was single, but people say that she limped a bit."

Sirlei associated Catarina with another disintegrating body: "Her mother also lost the legs and the hands." "One had to feed her" – a leftover body at the mercy of an impersonal pronoun and a certain moral obligation. A well-off uncle "is also like this," added Alemão, "I think this is hereditary." The onset of Catarina's limping seemed to be of great relevance, for her sister-in-law returned to it, dating its origin to Anderson's birth. This physiological sign also had an economic side: "She worked in a shoe factory. When she had Alessandra, she was still working, but they fired her

because she began to fall there." Catarina was no longer work-able. Anderson entered the conversation: "My uncles also have this problem. They have the legs like that." Nobody knew what the disease actually was, but Alemão had noticed that "it attacked her stronger than it did the brothers." The 15-year-old said that he was living with his father in the Boa Saúde district, that he was studying at night, in the sixth grade, and was looking for a job. Adriana was still living with their grandmother in the Santo Afonso district. Ana, the youngest sibling, was living "with her godparents." As for his father, "he is remarried, and has a son with his new wife." I asked whether he worked. "Yes, he has always worked in shoe factories."

Sirlei again began to discuss Catarina's frequent hospitalizations, and her husband interrupted once more: "But she was not hospitalized only because of the legs. There were other problems. One day, she burned Nilson's clothings and documents." In local slang, the word *documentos* also connotes male genitals. Anderson said that he had witnessed it: "It happened in this house. Father came home, and she burned his things. That was long ago." As far as he could recall, "before suffering the attacks, she was normal. She cooked, she did everything in the house." Alemão added that she seemed to have intelligence. Anderson recollected a caring mother: "She woke me up at the right time to go to school, she helped me with homework. We had a normal life ... until the problems began." But the child couldn't recall precisely when it all began to fall apart.

"When Anderson was born we began to see that it damaged her head. When Alessandra was born, *it* got worse," stated Sirlei. "It": something in Catarina, a child, an unknown disease, the experience of motherhood? Something worsened. Sirlei was now synchronizing Catarina's mental disturbances with the first expressions of her physical paralysis, and with the experience of motherhood. It was as if these things couldn't be teased apart. And as I listened to the inconsistencies in Sirlei's account of Catarina's deterioration, I thought that perhaps the human actions that had conflated these various occurrences needed to remain veiled. Catarina's condition had been constructed by the ways these various elements were brought together. In the end, Catarina was the equivalent of "it." The neutral pronoun "it" can stand for the contempt one has for a person.

"She went mad. In the middle of the night, she went to the streets and wandered. She had everybody preoccupied with her," recalled Sirlei. Alemão added that "she did not want to know of her husband. No one could talk to her." The attacks "were not that frequent," he said, but when they happened, Catarina did not behave as she should have. She began to flirt with the other Nilson: "She sat next to me, talked to me, said that she liked me, began to say romantic things. But then, next day, she was normal." "She went to the hospital in bad shape, but came back normal," Sirlei rushed to say, as if trying to defuse Alemão's description of a sexuality with the wrong object. Her husband, however, insisted on bringing dissonance into the conversation: "Normal, so to speak – she still had those problems with walking." "Yeah, but normal in her head," rebuked Sirlei.

Alemão was linking Catarina's hospitalization and banishment from family life with her paralysis. He hinted at what should have remained unsaid: "The last time she was hospitalized she couldn't walk anymore, so she had to stay there." Sirlei fixed his account and insisted that Catarina could stand on her own feet: "The last time we saw her, when we were leaving, she stood up from the chair and bid us farewell." In this

image Catarina had let the family go of her own volition. "I thought that it was a family disease, that my grandmother also had it," said Anderson. For the child, "it" was not madness. Sirlei interrupted, saying that Anderson was too little when his grandmother (Catarina's mother) died in 1988, "paralyzed in a wheelchair, here in this house." But Anderson remembered his grandfather, he said, and his mother pregnant: "He slaughtered a pig when we visited Caiçara. My father took us. Mom was pregnant with Ana."

The name Ana brought up a dramatic development in this new family complex. "When Catarina was hospitalized, they took the newborn to Dona Ondina, Nilson's mother. But then there was a fight with Tamara and Urbano, the godparents. They wanted to keep the child. They fought with the grandmother and then Seu Urbano was able to – I don't know, we cannot say exactly how it happened ... But as far as we know, Seu Urbano made a deal with Nilson. Nilson is illiterate; he can only sign his name. They made a shady deal, and took a paper there and forced her to sign, the poor woman." Catarina? "Yes. So that they could keep the child." Did she know what she was signing? "We don't know for sure ... But she was weak ... Now the girl has been legally passed onto them." Sirlei said that Urbano and Tamara did not want the siblings to visit each other. "They didn't let the girl call Catarina 'mom' – only 'auntie.'"

The absent mother had to be praised: "I remember the times Catarina lived alone with the kids, down there, next to my mom's. We could see the love she had for them. The little money she had, it was to go to the market to buy things for them." As the image of a self-sacrificing mother, Catarina still had value. But she had no money of her own, and her body was not working. "She separated from Nilson, she returned from the hospital. Then Nilson left her this house, and she exchanged it with Delvane. Then went to the shack that was set on fire, went to the hospital, and did not return."

"When the house burned down, the family did not provide her with a new place. She lived with my mother. She was getting mad ... So many problems, poor thing, one can only go insane," said Sirlei. There was compassion now, even an understanding that there was a material and historical course to Catarina's condition, though contingent on her madness.

Catarina had said she wanted to know what people had written of her and went with me to retrieve her medical records from psychiatric institutions. She wanted me to find her family. These people had responded with hospitality and information to my attempt to understand what had happened. And in the course of our interaction – amid dissonant recollections, dissimulations, hidden judgments, and moralities that protected their lives and interests – a common sense had been cracked open. Many relational, physiological, medical, and economic factors intersected and gave form to a common sense or belief that it would be impossible for Catarina ever to return.

COMMON MORAL SENSE

That same night Nilson and Anderson took me to see Altamir, Catarina's eldest brother, who lived nearby. Altamir owned a bike repair shop and, according to Nilson, had "married up" as his wife's family owned a small store. I related what I knew of their family history through Catarina and mentioned that she always spoke very highly of her brothers. Her paralysis was the entry point of discussion.

"This comes from the family," said Altamir, using the expression "it is in the trunk of the tree." Their mother, maternal grandfather, and great-grandfather "also had *it*," he said. "My mother had about 10 siblings, and four or five had *it*. Some cousins have *it*, and others don't." His wife Vania, who worked in a shoe factory, linked *its* manifestation in Catarina to her labor: "*It* got to her when she had her last daughter." Altamir didn't follow that line of reasoning and mentioned that "*it* develops slowly." The symptoms are always the same: "The legs get shaky, more and more, and you walk as if you were drunk. Speech also gets slurred."

He then suggested something of a broken taboo as the root of the disorder: "People used to say that the root of this old trunk was marriage among cousins or brothers and sisters. I don't know if this is true; this is what I heard." "It's a mystery," added Vania. No one in the family had ever had a genetic exam. And I wondered about the identity of this disorder, its incidence, and the dynamics and strategies, both familial and medical, that had been developed over time to manage it and that kept it unacknowledged.

"When Catarina lived with us," Vania continued, "she was treated by the mental health people. Because there were times that she was very crazy, right? Crazy to run out, to escape and all these things." I asked again about the time of onset of Catarina's problems. Altamir described her as "normal" during their childhood. Vania then reintroduced the semblance of Catarina: "She was *very* normal. I remember the wedding photos." I wondered about this gradation of normality and what in one's life or interests determined its application to another family member.

"Catarina passed through the health post, the general Hospital, the Caridade ... The truth of her illness nobody knows." Simply put: the outcome of Catarina's passage through medicine and psychiatry has been *nonknowledge*, on several registers. First, Sirlei spoke as if the family had not known of Catarina's physiological deficiency before she entered their household. Second, Catarina was treated and medicated for something else other than "it" – an "it" that remained unknown. Third, Vania, whose husband is beginning to show similar physical signs, looked back and saw Catarina as embodying something they all feared. And, finally, this family (and perhaps others) did not have medical knowledge of their condition and had devised ways to live with the unknown disease.

Vania was dominating the conversation. She commented that Armando was already limping, like the older brothers: "When they walk, you notice a difference. It's not normal." The immediate association was death: "Their mother died in a wheelchair." I wondered what one had to have, own, or be to avoid the certainty of being cast out: "Catarina's children and our son show no signs. Ademar's kids are also normal. I don't know if with time ..." The nonknowledge around this condition was visibly measured and had economic meaning: Vania speculated about whether the brothers would be able to work in a few years from now. Altamir noted that when he stopped doing things, the difficulties with locomotion increased. His mindset, he believed, could help to deter the disease: "One must not lose the will."

Vania brought the conversation back to Catarina, suggesting that some disorder other than the unknown disease had led her away from home: "Do you remember, Altamir, you always told me that she escaped home and that Nilson went after her?" But Altamir refused to attribute Catarina's mental condition to pathology: "This was due to the illness itself," he insisted. "I think that she revolted against the illness. I think that

this provoked unhappiness in her." Her mood disorder was not a mental illness, so to speak, but a way to face the biological signs – or, perhaps, the ways they were handled domestically. That's what Vania now speculated, for theories of causation focused on Catarina continued to change: "You are right, afterwards she got even crazier. I shouldn't say crazy, for she knows what she is saying. Her daughter was given away, and she couldn't take care of the children anymore – all this had an impact on her.

As Catarina's ex-family members reasoned about her condition, they freely assembled a bricolage of its etiology, unconcerned by contradictions. In the process, however, a constant theme crystallized: she was isolated and beyond treatment. Vania recalled Catarina's last hospitalization at the São Paulo Hospital. By then, no one was responsible for her: "It's complicated. I don't understand it well. She was hospitalized at the São Pedro. I think that her husband Nilson did it. She got better and came home, alone. When you least expected, she was coming home. She was discharged, obtained money at the bus station, and came home. She was so good in her head, that she came home alone." It seems that nobody expected her to come back. That nonplace she had in her family's mind and the indiscriminate medicating made Catarina crazy all over again, as she wrote in her notebook: *louca da cabeça, louca da casa* (crazy in the head, crazy in the house).

As the conversation went on, they began to displace moral attention from Catarina to what happened to her youngest daughter. Alemão again made the case that giving up Ana for adoption had been the "wrong thing." Altamir and Vania, however, were adamant that the child was now well taken care of and lived a rich life. Blood ties were not as meaningful: "The child is much better off than if she lived with her mother or grandmother. It couldn't be better. The stepmother likes her a lot. Ana has her own room; she has everything." For Vania, the only problem was that they did not take the girl to visit Catarina: "Tamara told me Ana couldn't go in to Vita, for it is a place for mad people. But I told her, if you think this will traumatize the kid, then take Catarina to spend a weekend with you." The most they will consider are temporary measures to expunge the doubt of their morality.

Then the inevitable: how to speak of Catarina in Vita? Without my asking, Vania mentioned that "the last time we visited her in Vita she was content and asked to see Ana." The phrase "the last time" minimizes how much time had passed since anyone visited Catarina. Vita's oldest volunteers recalled only a few visits to her, around 1996, just after she had been left there. But tonight's conversation, it seemed, had occasioned the thought of a brief return: "It's time for us to bring her here to spend a weekend with us," suggested Vania.

Overall, I felt that Catarina's relatives saw me as a kind of emissary of the country's laws. In other words, they knew that by law they were legally liable to care for Catarina. As I learned from the Public Ministry in Porto Alegre, public attorneys have the power to subpoena family members of abandoned people and negotiate care or financial responsibility. But as Vita's history suggests, this happens in only a few cases, which then become emblematic of a supposed democratic state of human rights.

"You grew up with her," I said to Altamir, "Seeing what has happened to her, what comes to mind?" "It's tough, but what to do? If one brings her home, one also cannot do anything. And we have to work."

In subsequent years, I have continued to engage Catarina's family. I have always been welcomed into their homes. And I have always been taken aback by the ease with

which they spoke of her. For Catarina, there was nothing to be done, I heard over and over again. That was common sense. The impossibility of doing anything to bring her back to social life was assumed rather than analyzed and acted on, I thought. Each one claimed that he or she had done all that was possible, to the limit.

An ordered realm existed in Catarina's exclusion. Who belonged in the house, who was worth medicine, who made money, and the gradation of acceptable normality – these are all key elements of the household's maintenance. The common sense that Catarina was physically unviable and mentally unsustainable had a value and validity for those who possessed it. And as Clifford Geertz has luminously written: "Here, as elsewhere, things [or humans] are what you make of them" (2000: 76). In this context, marked by economic pressure and violence, how does one speak of the "evil" that is done and the "good" one must do? For Altamir and other family members, it was through a rhetorical question to which the unspoken answer is "nothing": "It's tough, but what to do?"

EVILNESS

Like the others, Nilson, Catarina's ex-husband, also spoke openly about her. "It's all past," he stated in an interview in 2001, "It is not even in my mind." He then added, "In Porto Alegre, they gave her medication for the head. She didn't want to take it, though – she threw it into the toilet and flushed it down. All that medication. A person must help herself. It was just a matter of taking the medication, but she didn't help herself." "What has passed is over. One must put a stone over it."

I asked Nilson when Catarina's problems began, to which he replied, "After the premature birth of Ana." I told him that, according to the records, Catarina was first hospitalized in 1988, four years before Ana was born. He agreed and said that he had lost track of time. At any rate, she had been escaping home: "I worked as a security guard at the city hall at night and left her at home. Then, once at midnight, people came, saying 'Your woman is on the road.' One day we found her in the nearby town of Estância Velha. So I decided to hospitalize her." And this became routine: "It was a month at home and a month at the hospital." The day Catarina set his clothes and documents on fire, Nilson told himself "this is no longer madness, it is evil" and "I went to the judge to get a separation." "Finally," said Nilson, "the city hall took up the case, picked her up and took her there." To Vita? "I don't know where. The last time I saw her was many years ago." In the end, Catarina was a stray thing, to be picked up by the city's humane services, banished from one's view to a place one does not name.

Nilson explained that when he married Catarina, half of the family's land was in his name, as the couple assumed the care of her mother and her younger brother. Nilson didn't comment any further on what had happened to the land, but mentioned that he had brought the mother and brother-in-law along to the city. "The old lady was in a wheelchair. She lost her legs. We even had to feed her." He described Catarina's fraternal ties as ineffective: "My brothers-in-law never supported me. There was nobody to help. I had to leave my work and run after her. The city hall then pitched in. But the brothers never came to see whether we needed anything, and we had little children. One begins to lose strength, right? They had their houses and cars, but never came to visit, never said we will help to search for our sister ... that's what happened."

Catarina's family was to be blamed for her destiny, though she herself was not innocent, since she had refused to take medication, he insisted: "They gave her the best medication in Porto Alegre. The problem was that she only took them while there."

Did she tell you what happened in the hospital? "No, she didn't remember." For Nilson, Catarina had no memory, yet it was Nilson who seemed intent on forgetting Catarina's physical conditions. Again, I brought up her difficulties with walking and again the ex-husband spoke as though these things had no clear history or development: "She walked a bit shaky. I don't recall when this began. This comes from the family, from her grandfather, I think. I don't know what this is." He then traced the onset of Catarina's problems not to the mysterious hereditary disease but to Catarina's mistreatment of her disabled mother. In this account, Catarina's mental disturbance was the result of guilt for domestic violence, for her *ruindade* (evilness). "After her mother died, she began saying things that didn't match with reality. She said that her mother appeared to her. She was very bad to her mom. She struck her mom in the face …We said don't do that to the old lady, you don't know what will happen to you someday, what you will have to endure … After her mom died, she began having problems." Are you saying that she should be punished? "Of course, if one does such a thing, it comes back to you. To do this to a sick mother. The spirit comes down. Her mom said that Catarina would pay for her evil."

When I later spoke to Ademar, Catarina's middle brother, he mentioned that their mother had, indeed, been a very strong-willed woman, but he knew nothing of Catarina's violence toward her. He was even more frank than Altamir had been about the economics of the changed family complex: "It was tough. We came to work here. Left everything to Nilson, and then afterwards when Catarina became *ruim* [worse] he left her. I think that when she had things, he was with her – and after she became worse, he abandoned her." Given that Catarina had "'been given away'" to Nilson and that the young couple had squandered the family's land, the brothers felt no obligation to her.

Both the brothers and Nilson referred to Catarina as *ruim*, which means "bad," in the sense of physically degraded or "evil." But the verb used with *ruim* assigns the meaning. For the ex-husband Catarina "was" *ruim*: she was an evil person. For the brothers, she "became" *ruim*: her condition worsened. In the ex-husband's interpretation of Catarina as essentially evil, she was solely responsible for her own abandonment, and not even a utilitarian ethics could be invoked: she was paying for her evil actions (such as hitting her disabled mother and burning her husband's documents), she had failed to adhere to her pharmaceutical regimen, and she was simply outside the domain of rational thought. In the brothers' account of Catarina as gradually becoming worse, there was room for a historicity of the physical signs and for a maternal linkage, though not for ongoing relationships. For instance, the brothers associated mother and sister: "In Catarina, it began earlier than in our mother. We were grown up when our mother stopped walking. But with Catarina, no … Her kids were very small and she was already much worse [*bem ruim*]." It seemed that as Catarina became increasingly like their deceased mother – read: biology – it became possible to leave her behind. This was the economic and gendered fabric of their moral thinking, beyond the domain of the blood tie.

An unspoken order or economically motivated common sense has developed over time around this unknown disease, making possible the unbinding of the family and

informing memory and morality. This was an intricate story. Only by listening to all parties, recurrently and over time, by juxtaposing deceptions with finally revealed thoughts, was it possible to access the underlying plot to cast Catarina out. The fact is that, given certain physical signs, Catarina's husband, her brothers, and their respective families believed that she would become an invalid, as her mother had been. They had no interest in being part of that genetic script. Catarina's "defective" body then became a kind of battlefield in which decisions were made within local family–neighborhood–medical networks about her sanity and, ultimately, about whether "she could or could not behave like a human being," as her mother-in-law put it to me. Depersonalized and overmedicated, something stuck to Catarina's skin – the life determinants she could no longer shed.

"What do you remember of Catarina?" I asked the ex-husband. "Her nonsense." Catarina was outside of familial common sense. The tragedy of her destiny in Vita was not simply the extended family's failure to undertake the necessary work of care-giving; rather, her neglect was achieved through a perversion of the meaning of care itself. People now had a medically legitimated fabulation of the mad or evil woman which stood in place of the family tie. The narrative that formed around Catarina had no evident agents and, after some time, no one was responsible for her any longer. As Clifford Geertz pointed out, "common sense is not what the mind cleared of cant spontaneously apprehends; it is what the mind filled with presuppositions … concludes" (2000: 84). By empirically assessing how common sense is forged and conceptualizing deliberations over it, wrote Geertz, one can see how culture is put together and better understand "the kinds of lives societies support" (93).

Catarina had become a leftover in a domestic world that was disassembling and reassembling in intricate interactions. She was the negative value, the unnecessary component of a migrant and urban poor culture. At the core of common sense are practices and attitudes toward death, real and imaginary. Catarina's abandonment speaks of what ties reality together and the forms of human life that are endorsed these days.

CONCLUSION: WOMEN, ECONOMIC INSECURITY, AND SOCIAL DEATH

In July 2002 I visited the Novo Hamburgo center for psychosocial attention (CAPS) where Catarina was treated between hospitalizations. "We have at least five hundred Catarinas in the service right now," said psychologist Simone Laux, after I told her about Catarina and my work with her. Laux affirmed the ordinariness of the story I was reassembling: "Exclusion always passes through the family." And by "five hundred Catarinas," she meant most of the adult female clientele of the center, which was treating about 1,500 people a month. About half of the clients got free psychiatric medication at the city's community pharmacy.

"When our CAPS began in the late 1980s, it was meant to deal mainly with schizophrenia and psychosis," reported psychologist Wildson Souza, "but this has changed a lot, both diagnostically and numerically. There is an immense growth of mood disorders." He added, "We don't have statistics, but we see that the social field is breaking down and the population is getting sicker and sicker." He cited "unemployment, harsh struggle to survive, no opportunities for social mobility, urban violence" as contributing to this epidemic of mental suffering. The psychologist suggested that the

center had become the vanishing social world, the welfare state, and the social medicine that was no more: "Many factories are closed, people don't have jobs or health plans or family support ... They need some form of recognition and help, and they demand it from SUS [Brazil's universal healthcare system]. Nothing is isolated." "We have three women's groups here," continued Laux. "Most of them are not psychotic. But at some points in their lives, they had a crisis or were at risk of committing suicide. All of them have a story that resembles Catarina's." The other health professionals who had gathered for a group discussion then began to tell tales of "women's historical subjugation," female bodies entangled in realities of migration, poverty, and violence. "Once a woman came with a machete cut in her head. The husband of another one had raped all their children. Many report that, according to their husbands, they are always inadequate." The common pattern was that "he is the owner of her life, in all possible ways."

I was again struck by how historically entrenched power relations in heterosexual households were woven together with social death. And, after I briefed the group on Catarina's trajectory, Daniela Justus, the service's psychiatrist, replied: "Catarina is not searching for a diagnosis, but for life." I mentioned that Catarina used to say: "I am allergic to doctors." "She is right," Dr. Justus added, "That's the minimum attitude she could have developed. It is a must to trust the patient. The ideology and politics of a psychiatric hospital are not to trust. Patients are treated like animals. Minimal medical effort and social control through medication."

Catarina's story shows that the patterning of the mass patient and her dying at the crux between abandonment and overmedication are both public and domestic affairs, I noted. "Indeed," replied psychologist Luisa Rückert, "families organize themselves so that they are no longer part of the treatment and care." The major exception is when cash is involved, stated Andreia Miranda, the center's occupational therapist. "Families keep their mentally ill relatives as long as they can manage their disability income." Folding together the economic and intimate, the family produces a moral common sense and an adroit abdication of responsibility.

"I don't think that diagnostics makes the differentiation." Dr. Justus then expanded on the family's role in fostering illness: "When patients improved – and we saw this quite often at the Caridade – families discontinued treatment, and the person had to be hospitalized again." Crisis situations were constantly induced. The relation between the family and mental illness, I was told, is made explicit in the culture of pharmaceuticals: "In our group sessions, we can see that the fragility of a minimal social integration is revealed in everyone's relation to the medication, the fight over its discontinuation, the lack of money to buy it, or the problems with forgetting to take it."

Families, in fact, come into the service demanding medication, Rückert stated: "When I ask them to tell their story, many times they say, 'No, I came here to get a medication for her.'" The psychologist added that during initial group meetings, people often ask her "'Why is the psychiatrist not here?' As if I were not sufficient for a first treatment. They want to leave with a prescription." Medication has become a family tool and the family crystallizes its way of being in the ways it deals with medication. "Bottom line, the type of ethics the family installs," said Rückert, "serves to guarantee its own physical existence." The exclusion of Catarina served also as a form of self-care for the family. Yet just as what was called care for Catarina was actually abandonment, what seems here to be the self-care of the family is actually its

negation, as kinship ties and relations are disavowed in favor of the exigencies of material survival and novel self-interests. Fabio Moraes, also a psychologist, agreed that "the family caregiver quite often becomes the state that does not care." The family is thus "*a state within the state.*" Sigmund Freud actually used this expression to reiterate the constraining features of neurotic pathologic processes vis-à-vis "external reality" (cited in Loraux 2002: 84).

I take the interplay of political power and individual psychology to be more than analogic: as Veena Das and Renu Addlakha have argued, the domestic sphere "is always on the verge of becoming the political" (2001: 512). The decision to make persons and things work or to let them die is at the center of family life no less than it is at the center of state politics. And in today's local worlds, science, in the form of medication, brings a certain apparent neutrality to this decision-making process – the psychiatric aura of reality. "In the meetings," Rückert continued, "the patient quite often realizes that given the continuing process of exclusion, she has already structured her own schemes of perception and codification of reality." Rather than psychosis, out of all these processes a para-ontology comes into view – a Being beside itself and standing for the destiny of others. The now "irreversible" condition of the mentally afflicted gives consistency to an altered common sense.

In sum, just as care is made through the contribution of many hands (rather than singular choices), so Catarina's destiny shows that intractability and disregard is a shared (if inconsistent and contradictory) process mediated by the indiscriminate use of pharmaceuticals. Families have become psychiatrists by proxy and the abandonment of unproductive and unwanted family members is facilitated and legitimated by drugs, both through the scientific truth value they bestow and through the chemical alterations they occasion. The one who is medicated within the family is, then, in Catarina's words, "on a path without an exit." Pharmaceuticals thus work as moral technologies – they actually make the loss of social ties irreversible.

Here, bodies, inner lives, and new forms of exclusion are entangled with large-scale processes and shifting grounds of knowledge and power, science and money. And the domestic and public display of these entanglements, the reversal of ties and values, the uncertainty of limits, the instability of characters and roles, and the anxieties created indicate the mutation of mental universes and the emergence of new laws of perception and action toward familial others even in the face of an ingrained sameness.

Catarina struggled to transmit her sense of the world and of herself, and in doing so she revealed the paradox and ambiguity of her abandonment and that of others. The human condition in Vita challenges analytical and political attempts to ground ethics and morality in universal terms, in the exceptions that stand outside the system. "People say that it is better to place us here so that we don't have to be left alone at home, in solitude ... that there are more people like us here. And all of us together, we form a society, a society of bodies." And she added: "maybe my family still remembers me, but they don't miss me."

When Simone Laux first opened Catarina's folder, she read aloud an entry by nurse Lilian Mello from December 12, 1994, that left us all speechless:

> I drove Catarina home. But as she now lives alone, I left her at the house of her mother-in-law, called Leonora. Catarina was badly received. The mother-in-law said that Catarina should die, because she was stubborn and aggressive, didn't obey anyone, and

didn't take the medication. The mother-in-law made clear that she would not be responsible for Catarina. I told her that the family should take Catarina to the General Hospital for a clinical evaluation. Ondina told me to call Nilson, Catarina's ex-husband. I went to talk to him. My impression is that he really wants nothing to do with her. He only said that, like other times, Catarina should be taken to Porto Alegre and hospitalized.

No work, be it clinical or anthropological, can do without an entry into the affective tissue of domestic spaces. And there is much to learn from this responsible health professional as she moved through public institutions and households. She disturbed diagnostic certainties and refused to isolate Catarina's body and voice from her surroundings. She followed her behind the scenes of medicine and model health programs, listened to a multiplicity of voices, and registered the modes of affect and social practices that made Catarina a double of sorts and empty of all concrete possibilities. Her work did not veil what was truly happening, the concreteness of "the truth" Catarina embodied. "She died socially," said Laux. "That is the pain that aches in us ... when we realize this: she cannot opt to live."

A machine in which a tie to others and to living are rendered impossible. If it were not for this archival fragment, the explicitness of this medical and domestic operations would remain lost to history. Patricia Barbosa, a psychiatrist, named the line that had been crossed: "She was killed." The ex-human.

ACKNOWLEDGMENTS

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