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Erratum: The photograph that appeared on the cover of *AE* 31(2) was taken by Lucinda Broadbent and was courtesy of Florence E. Babb.

On the cover: Power Wall three-dimensional computer simulation of meteor impact (photograph courtesy of Los Alamos National Laboratory).

Life of the mind:

The interface of psychopharmaceuticals, domestic economies, and social abandonment

ABSTRACT

In this article, I address the embroilment of medical science in the lifeworlds of the urban poor in Brazil, particularly the place of psychopharmaceuticals within households. I explore how psychiatric diagnostics and treatments are integrated into a domestic "dramaturgy of the real" and how family members use them to assess human value and to mediate the disposal of persons considered unproductive or unsound. I focus on the life of Catarina, who was deemed mad and left by her family in an asylum in southern Brazil. Disabled and abandoned, Catarina began to compile a "dictionary" of words that have meaning for her. By tracing Catarina's words back to the people, households, and medical institutions that she had once been a part of, I illuminate the complex network in which her abandonment and pathology took form as well as the edges of human imagination that she keeps expanding. From this examination, one comes to understand how economic globalization, state and medical reform, and acceleration of claims over human rights and citizenship coincide with and impinge on a local production of social death. One also sees how mental disorders gain form at the juncture between the subject, her biology, and the technical and political coding of her sense of being alive. Hers is not just bare life, though: Thinking through her condition, Catarina anticipates social ties and one more chance. This is also a story of the methodological and ethical challenges I faced as I supported Catarina's search for consistency and her demands for continuity. [*networks of family, medicine, state and economy in Brazil, mental health, social death, biology and environment, ethics*]

As Brazil transforms itself into a more viable market in the inescapable context of economic globalization (Cardoso 1998, 1999; Lamounier and Figueiredo 2002), how are Brazilian citizens, particularly the urban poor, struggling to survive and even prosper? What happens in the process to polity and social relations on the ground? Scholars of contemporary Brazil argue that the dramatic rise in urban violence and the partial privatization of health care and public security have deepened the divisions between the marketable and the socially excluded (Caldeira 2000, 2002; Escorel 1999; Fonseca 2000, 2002; Goldstein 2003; Hecht 1998; Ribeiro 2000). All the while, newly mobilized patient groups continue to demand that the state fulfill its biopolitical obligations (Biehl in press a; Galvão 2000). As economic indebtedness, ever present, transforms communities and revives paternalistic politics (Raffles 2002), for larger segments of the population, citizenship is increasingly articulated in the sphere of consumer culture (Edmonds 2002; O'Dougherty 2002). Overburdened families are suffused with the materials, patterns, and paradoxes of these processes, which they are, by and large, left alone to negotiate (Scheper-Hughes and Bourgois 2004:3; see also Comaroff and Comaroff 2000 and Lamont 2000).

I find in this ethnography that the family is increasingly the medical agent of the state, providing and at times triaging care, and that medication has become a key instrument for such deliberate action. Free drug distribution (including psychopharmaceuticals) is a central component of Brazil's search for an economic and efficient universal health care system. As this work illustrates, people's claims to health coincide with dramatic cuts in funding for health infrastructures and with the proliferation of pharmaceutical treatments (on the social life of pharmaceuticals, see Geest et al. 1996; Nichter and Vuckovic 1994). In engaging with these new regimes of public health, families learn to act as proxy psychiatrists. Illness becomes the ground on which experimentation with changes and breaks in intimate household relations can occur.¹ Families can dispose of their unwanted and unproductive members, sometimes without sanction, on the basis of

individuals' noncompliance with their treatment regimes. Thus, psychopharmaceuticals become central to the story of how personal lives can be made or unmade in this moment of socioeconomic transformation and how people create life chances vis-à-vis what is bureaucratically and medically available to them. The foreclosure of life chances for some is part of an elaborate if unconsidered common sense that is mediated by the widespread availability of psychopharmaceuticals. Such foreclosures run parallel with gender discrimination, market exploitation, and a managerial-style state that is increasingly distant from the people it governs.

In the early 1990s, anthropologists began to follow the production of new bioscientific knowledge and the making of biotechnologies, inquiring into their multiple deployments and their interactions with old and new forms of power relations and ethical models (Rabinow 1999; Rapp 1999; Strathern 1992). Paul Rabinow (1996), for example, notes a dissolution of the traditional social domain and the emergence of new forms of identity and moral reasoning around the technical possibility of the literal remodeling of life (what he calls "biosociality"). The recent work of anthropologists Veena Das (1997, 1999), Arthur Kleinman (1999), Allan Young (1995), Nancy Scheper-Hughes (2000), Margaret Lock (2002), Lawrence Cohen (1998), and Adriana Petryna (2002), among others, shows how medical and technical interventions affect—sometimes for better, sometimes for worse—the etiology, experience, and course of disease. The appearance and distribution of disorders such as drug-resistant tuberculosis and AIDS are also closely correlated with poverty and social and technological inequality. They are "pathologies of power" (Farmer 2003) mediated by biological, social, and technical and political-economic mechanisms. Concrete biological phenomena are thus intertwined with environmental conditions that are part of a larger context. And it is in this complicated web that the individual's life possibilities take shape. As Michael M. J. Fischer notes, "We are embedded, ethically, as well as existentially and materially, in technologies and technological prostheses. [Our] technological prostheses are also taking us into models of ethics which our older moral traditions have little experience or guidance to offer ... we are again thrown ... to ungrounded ways of acting, to new forms of social life" (2003:51).

In their longitudinal study of symptom management in several neighborhoods in Delhi, Veena and Ranendra Das, for example, explore how illnesses are combined with new familial, economic, medical, and pharmaceutical circumstances and assemblages—empirical processes that are both open ended and stabilizing. They argue that illness is ordinarily conceptualized and practiced as a "relational testing ground" and as an "experiment with life" (Das and Das in press). The individual's nego-

tiation for health within "local ecologies of care" recasts illness categories, kinship textures, and patterns of social exclusion and inclusion, giving occasion to a "domestic citizenship" (Das and Addlakha 2001:511; see also Greenhouse 2002).² In this study, I am interested in the place of psychopharmaceuticals in local ecologies of care and in the ways they affect changes in human values and subjectivity. Pharmaceuticals used allegedly to treat mediate the cost-effective decision of abandonment of the unwanted and create moral distance. Zones of abandonment such as I describe below accelerate death and fail to account for individual destinies.³ In this bureaucratically and relationally sanctioned register of social death, the human, the mental, and the chemical are complicit: Their entanglement expresses a common sense that authorizes the lives of some while disallowing the lives of others, and it is also the actual means through which the abandoned claim experience, past and present, and articulate desire.

Ex-humans

Vita, which means "life" in Latin, was founded in 1987 by Zé das Drogas, a former street kid and drug dealer in Porto Alegre, a comparatively well-off city of some two million people in southern Brazil. After his conversion to Pentecostalism, Zé had a vision in which the Holy Spirit told him to open an institution in which people like him could find God and regenerate. Zé and his religious friends squatted on private property near the downtown, where they founded a precarious rehabilitation center for drug addicts and alcoholics. Soon Vita's mission was enlarged. An increasing number of people who had been cut off from social life—the mentally ill and the sick, the unemployed and the homeless—were left at the center by relatives, neighbors, hospitals, and the police. Vita's team then opened an infirmary where the abandoned waited *with* death.

Vita is a place in the world for persons who have, de facto, been stripped of their humanity and terminally excluded from reality. Before biological death, they experience social death.⁴ What are the various interpersonal, medical, and institutional interactions that turn humans into *ex-humans* and make their abandonment not only possible but also ordinary?⁵

Consider a woman the size of a young child, completely curled up in a cradle and blind. As she grew older and could not work to feed her family—"and worse," I was told, "she was still eating the family's food"—relatives kept her in a dark basement for several years. Then they sent her to Vita, where she was "adopted" by Angela. "Now she is my baby," said the former intravenous drug user, most likely infected with AIDS. Angela long ago lost custody of her two children and spent her days caring for the old woman, who no longer spoke. "I found God in Vita. ... When I first came here I wanted to kill myself, now I feel

useful. . . . Today I have still not discovered this grandma's name. She shouts things that I can't understand."

I had traveled through and worked in several poor neighborhoods in the north and south of Brazil (Biehl 1999). I thought I knew the country. But nothing I had seen before prepared me for the desolation of Vita when I first visited it in 1995. A local human rights activist had told me to go there if I really wanted to understand "what it means to be human these days." Vita is indeed the end station on the road of poverty, the place where the unwanted become unknowables. Beyond any kind of accountability, most of the 200 people in Vita's infirmary in 1995 had no formal identification and lived in abject abandonment that had acquired a haunting stillness. For the most part, Vita's staff consisted of residents who had improved their mental well-being enough to administer care to newcomers and to those considered absolutely hopeless. Lacking funds, training, and proper equipment and medication, these volunteers were as ill equipped to deal with Vita's more debilitated residents as those running the establishment. Even though Vita's existence was acknowledged by officials and the public at large, it was not the object of any remedial policy.⁶ Over the years, Vita became a key site informing my thinking about Brazil's changing sociopolitical environment and new regimes of personhood and ethics (Biehl in press b).

Literally left to wither away, many in the infirmary had open wounds filled with maggots and lice. One 50-year-old man had the maggots drawn from his eyes by an application of Pine Sol and bleach. The inhabitants of the infirmary were treated as beings distinct from humans, argued Oscar, the resident-volunteer who guided my initial visits there: "Hospitals think that our patients are animals. Doctors see them as indigents and pretend that there is no cure. The other day we had to rush old Lucas to the emergency room. They cut him open and left surgical materials in him. He died from infections." What makes these humans turned animals unworthy of affection and care is their inability to pay, added Luciano, another volunteer: "The hospital's intervention is to throw the patient away. If they had sentiment, they would do more for them . . . so that there would not be such a waste of souls. Lack of love leaves these people abandoned. If you have money, then you have treatment, if not, you fall into Vita. O Vita da vida (the Vita of life)."

As I see it, Oscar and Luciano were not using the same concept of "human" that is invoked in human rights discourses, with their notion of shared corporeality or shared reason (Ignatieff 2001). Neither were they opposing it to "animal." Rather than referring to the animal nature of humans, they spoke of an animal nature of medical and social practices and of the values that shape the ways the abandoned were addressed by supposedly superior human forms.

In the wake of World War I, Sigmund Freud wrote an essay entitled "On Thoughts for the Times on War and Death" (1957b). Freud spoke of a generalized wartime confusion and disillusionment that he also shared and of people being without a glimmering of the future being shaped: "We ourselves are at a loss as to the significance of the impressions which press in upon us, and as to the value of the judgements which we form . . . the world has grown strange to [us]" (1957b:275, 280). This sense of an ethical and political void experienced by "helpless" citizens had been provoked by "the low morality shown by states which pose as the guardians of moral standards" and by the brutality demonstrated by individuals who, "as participants in the highest human civilization, one would not have thought capable of such behavior" (Freud 1957b:280). At stake, in Freud's account, was not the citizen's failure to empathize with the suffering of fellow humans but his or her estrangement from imaginaries gone awry. This anxiety over the discredited imaginaries of the nation-state and of a supposedly inexorable human progress stood for people's incapacity to articulate the function that the Other's death had in the organization of reality and thought.

We moderns—that is how I read this melancholic Freud—are time and again faced with a void in what constitutes the human. One's worthiness to exist, one's claim to life, and one's relation to what counts as the reality of the world all pass through what is considered human at any particular time, and this notion is itself subject to intense scientific, medical, and legal dispute as well as political and moral fabrication (Asad 2003; Kleinman 1999; Povinelli 2002; Rabinow 2003). It is between the loss of an old working concept of "humanness" and the installment of a new one that the world is experienced as strange and vanishing to many in Vita.

"There was no family, we ourselves buried old Lucas. A lone human being is the saddest thing, worse than being an animal." In emphasizing the "animalization" of people in Vita, Oscar and Luciano also conveyed a critical understanding of the relationality of the terms *human* and *animal*. The negotiation over these relations, particularly in the medical realm, allows some human-animal forms to be considered inappropriate for life.⁷

Zones of social abandonment like Vita proliferate in Brazil's large cities. They are not directly regulated by legal, welfare, or medical authorities or institutions. Yet these very institutions nonetheless direct the unwanted to such zones, where they are sure to become unknowables with no human rights and no one and nothing to account for them. Here one is confronted with realities that lie between and beyond formal governance and that determine the life course of an increasing number of poor people who are not part of mapped populations and who are reduced

to struggling, with no prospect of survival. What makes them die?

The abandoned in Vita know of death, and, when listened to, they offer insights into its fabrication. Their abandonment is part of a larger context—it was realized in many domestic and public sites and through intricate medical transactions coexisting with already entrenched strategies of nonintervention. In tracing the plot of a single life history, I illuminate both the common sense that lets persons die and the language, desire, and hope for life that remain in Vita.

Catarina

“In my thinking, I see that people forgot me.” Catarina said this to me while peddling an old exercise bicycle and holding a doll. A woman with kind manners and a piercing gaze, she was in her early thirties; her speech was lightly slurred. I first met Catarina in March 1997, during a return visit to Vita. She stood out from the others, who lay on the ground or were crouched in corners, simply because she was in motion. She wanted to communicate. Adriana, my wife, was there with me. In one simple stroke, Catarina told us this story:

I have a daughter called Ana, she is eight years old. My ex-husband gave her to Urbano, his boss. I am here because I have problems in my legs. To be able to return home, I must go to a hospital first. It is very complicated for me to get to a hospital, and if I were to go I would worsen. I will not like it because I am already used to being here. My legs don't work well. Since I got here I have not seen my children. My brothers and my brother-in-law brought me here. Ademar, Armando ... I exercise ... so that I might walk. No. Now I can no longer leave. I must wait for some time. I consulted a private doctor, two or three times. When needed, they also give us medication here. So, one is always dependent. One becomes dependent. Then many times one does not want to return home. It is not that one does not want to ... In my thinking, I see that people forgot me.

Later I asked the volunteers if they knew anything about Catarina. They knew nothing about her life outside Vita. I told the volunteers some of the names and events Catarina had mentioned, but they said that she spoke nonsense, that she was mad (*louca*). She was a person apparently lacking common sense, her voice was annulled by psychiatric diagnosis. Without an origin, she had no other destiny than Vita.

I was left with Catarina's seemingly disjointed account, her story of what had happened. From her perspective, she had not lost her mind. She was trying to improve her condition, to be able to stand on her feet. She

insisted that she had a physiological problem and that her presence in Vita was the outcome of various relational and institutional circumstances that she could not control. Catarina evoked these circumstances in the figures of the ex-husband, the boss, the hospitals, the private doctor, the brothers, and the daughter who was given away. “To be able to return home, I must go to a hospital first,” she reasoned. The only way back to her child, now living with another family, was through a clinic. The hospital was on the way to a home that was no more. And adequate health care, Catarina suggested, was impossible for her to access. She also suggested that medicine had worsened her condition. While seeking treatment, she had learned about the need for medication. This form of care operated in Vita, as well: “When needed, they also give us medication here.” She was referring to a *pharmaceuticalization* of disarray that made persons in Vita “always dependent.” 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.”

Catarina's exercising and her recollection in the context of Vita's stillness stayed in the back of my mind. I was intrigued by the ways her story commingled elements of a life that had been, her present abandonment in Vita, and her desire for homecoming. I tried to think of her not in terms of mental illness, but as an abandoned person who, against all odds, was claiming experience on her own terms. She knew what had made her so—but how was I to verify her account? Catarina thought through what had foreclosed her life, but the degree to which her thinking and voice were inarticulate did not depend on her alone—we, the volunteers and the anthropologist, did not have the means to understand them. As George Marcus points out, “Life histories reveal juxtapositions of social contexts through a succession of narrated individual experiences that may be obscured in the structural study of processes as such” (1998:94; see also Fischer 1991). Following the plot of a single person can help one to identify the many networks and relations—call it the “in-betweenness”—in which regimes of normalcy and ways of being are fashioned and, thus, to capture both the densities of localities and the rawness of uniqueness (Behar 1993; Crapanzano 1980; Das 2000; Desjarlais 2003; Goldstein 2003; Pandolfo 1998; Panourgiá 1995; Shostak 1981).⁸

Life codes

As I kept returning to Vita, more and more of the infirmary's inhabitants said that they wanted to tell me “*minha vida*” (my life), as they put it. Like crippled Iraci:

I came from Lages, state of Santa Catarina. I was raised in the interior and like it better than the city. I

lost my father and my mother. We had cows and pigs and planted corn and beans. I have ten siblings, all scattered. My sister put me in a bus to Porto Alegre. Nobody wanted to take care of me. I was already paralyzed. I got paralyzed when I was one and a half years old. I lived in the streets for five years. Now I am 41 years old and have been here for more than five years. Better to live in the streets than in a place like this for the rest of life. ... Vita makes me nervous ... here one dies. ... There's a sadness here. I want to get out of this place. This is not life. It's the end of life. The one who is ill gets even more ill, and one gets nervous. I am a nervous man.

I was struck by the similarity of the accounts. Most of them mentioned having been banned from the family, the rupture of relations, and the dangerous and now impossible desire for homecoming. These were not illness narratives channeling a search for meaning (see Good 1994; Kleinman 1988; Mattingly 1998). Neither were they the "schizophrenic recording codes" that Gilles Deleuze and Felix Guattari saw as opposed to or as simply parodying social codes, "never giving the same explanation from one day to the next" (1983:15). They were not a "diffuse and external rain of distractions" that Robert Desjarlais (1994:897) says marks the being-in-the-world of the homeless in the Boston shelter he chronicled. As I came to hear and see over time, the accounts of many of the so-called mad in Vita were not ever shifting. Rather, I was impressed by the steadiness, contextuality, and truthfulness (as I was to learn by tracking Catarina's account) that they maintained in spite of being repeatedly told by caretakers that they were "nonsense."

Instead of seeing these condensed accounts as proofs of "a retreat from the world" (Desjarlais 1994:897), I began to think of them as pieces of truth—let me call them "life codes"—through which the abandoned person attempts to hold onto the real (see Agamben 1999; Caruth 1996). As I listened to them, I was challenged to treat them as evidence of the reality the abandoned are cut off from and of their failed attempts to reenter it. The accounts of Catarina, Iraci, and their neighbors represent a sense of exclusion. As these bits and pieces give language to a lived *ex-humanness*, they also work as the resources and means through which the abandoned claim experience—they are sites in which destinies are thought through and desires reframed.⁹

According to the Oxford English Dictionary, the adjective *ex* means "former, outdated"; the preposition *ex* is used to mean "out of" in reference to goods; and the noun *ex* refers to "one who formerly occupied the position or office denoted by the context," like a former husband or wife. *Ex* also means "to cross out, to delete with an x," and the letter *X* stands for the unknown.

The dictionary

At the end of December 1999, I returned to southern Brazil to continue observations of life in Vita. Vita's infrastructure had improved with new government funding, particularly in the recovery area. In the infirmary, conditions were pretty much the same, but it now had fewer people. Catarina was still there when I arrived, this time seated in a wheelchair. Head down, she was holding a pen and scribbling with much effort. She looked up and recognized me. Her health had deteriorated considerably; she insisted that she was suffering from rheumatism. Like most residents there, Catarina was being given antidepressants at the whim of the volunteers.

"What are you writing?" I asked.

"This is my dictionary," she said. "I write so that I don't forget the words. ... I write all the illnesses I have now, and the illnesses I had as a child."

Her handwriting was uneven and betrayed a minimal literacy. The words were composed in block-shaped letters and formed very few full sentences. I was amazed by what I read:

Divorce
Dictionary
Discipline
Diagnostics
Marriage for free
Paid Marriage

Operation
Reality
To apply an injection
To get a spasm
In the body
A cerebral spasm

"Why do you call it a dictionary?" I inquired.

"Because it does not require anything from me, nothing. If it were mathematics, I would have to find a solution, an answer. Here there is only one subject matter, from beginning till the end. ... I write it and read it."

Catarina let me peruse the dictionary: "In the womb of pain." "I offer you my life." "The present meaning." Amid recurring references to medical consultations, hospitals, and public notaries, she wrote of a working woman and a wanderer, of sexual emotion and mental disturbance, of medication and food for a baby, of misery and abundance, of governmental officers and indebtedness. Blended with allusions to muscular spasms, menstruation, paralysis, rheumatism, and paranoia and a listing of all possible diseases from measles to ulcers to AIDS were names like Ademir, Nilson, Armando, Anderson, Alessandra, and Ana. Here and there, she wrote of motherhood, divorce, a rustic

life with pigs and insects, and veterinarians and a rural workers' association. I read striking statements from a lost but enduring world:

Question, answer, problem to solve, the head
Who contradicts is convicted
The division of bodies
Dead alive, dead outside, alive inside

There were expressions of longing:

Recovery of my lost movements
A cure that finds the soul
The needy moon guards me
With L I write Love, with R I write Remembrance

I returned to talk to her several times during that visit. Catarina engaged in long recollections of her life outside Vita, always adding more details to those she had told me in our first meeting in 1997. The story thickened as she elaborated on her origin in a rural area and her migration to Novo Hamburgo to work in one of the city's shoe factories. She mentioned having more children, fights with her ex-husband, names of psychiatrists, experiences in mental wards—all told in bits and pieces.

"When my thoughts corresponded with those of my ex-husband and his family, everything was fine. But when they disagreed with them, I was mad. It was like a side of me had to be forgotten. The side of wisdom. My brothers want to see production and progress. They wouldn't dialogue and the science of the illness was forgotten. My legs weren't functioning, working well. I didn't want to take the medication."

"Did the doctors ever tell you what you had?"

"No, they said nothing. ... I am allergic to doctors. They want to be knowledgeable, but they don't know what suffering is. They don't touch you where it hurts."

According to Catarina, her physiological deterioration and abandonment had been mediated by a shift in ways of thinking and meaning making in the context of novel domestic economies related to migrant labor and her own pharmaceutical treatment. Subjectivity had become the conduit by which her exclusion was solidified. The forceful erasure of "a side of me" made it impossible for her to find a place in a changing family life. What mediations effected her turning from reality and her reconstruction of it in madness—what guaranteed their success?

"My brothers brought me to Vita. For some time I lived with my brothers ... but I didn't want to take medication when I was there. Why was it only me who had to be medicated?"

Psychopharmaceuticals seemed to have played a key role in altering Catarina's sense of being and her value for others. And through these changes, family ties, interper-

sonal relations, morality, and social responsibility were also reworked. As she later wrote in her dictionary, "To want my body as medication, my body."

"Why," I asked Catarina, "do you think that families and doctors send people to Vita?"

"They 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."

Catarina insisted that there was an organized realm to her abandonment (Kleinman et al. 1997). As I tried to find out how her supposed nonsensical thoughts and words related to a now-vanished lifeworld and to identify the empirical conditions that made hers a life not worth living, I found Clifford Geertz's work on common sense illuminating. "Common sense represents the world as a familiar world, one everyone can, and should, recognize, and within which everyone stands, or should, on his own feet" (Geertz 2000:91). Common sense is an everyday realm of thought that helps one to effectively make decisions as one faces everyday problems. In the absence of common sense, one is a "defective" person. "There is something of the purloined-letter effect in common sense; it lies so artlessly before our eyes it is almost impossible to see" (Geertz 2000:92). What is unique to the anthropological endeavor is to try to apprehend these colloquial assessments and judgments of reality—which are more assumed than analyzed—as they determine "which kinds of lives societies support" (Geertz 2000:93).

Catarina resisted Vita's enclosure, and in ways that I initially could not grasp, she voiced an intricate ontology and the wish to untie it: "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. I think that people fear their bodies."¹⁰ How was I to enlarge the possibilities of social intelligibility that Catarina was left alone to resolve in her "withdrawal" from reality (Corin 1998; Corin and Lauzon 1992; Corin et al. 2003; see also Good 2001; Jenkins and Barrett 2003)?

Absence is the most concrete reality in Vita

I did not have a structured method to begin with, but I kept returning to Vita and engaging with Catarina on her own terms and then proceeded from there. Catarina refused to be seen as a victim or to hide behind words: "I speak my mind. I have no gates in my mouth." Clearly, it was not up to me to give her voice but, rather, to find an adequate understanding of what was going on and the means to express it.¹¹ The only way to the Other is through language, but language is not just a medium of communication or misunderstanding but also an experience that,

in Veena Das and Arthur Kleinman's words, allows "not only a message but also the subject to be projected outward" (2001:22).

In the essay "Language and Body" (1997), Das observes that women who were greatly traumatized by the partition of Pakistan from India did not transcend this trauma, as, for example, Antigone did in classic Greek tragedy, but they incorporated it into their everyday experience. In Das's account, subjectivity emerges as a contested field and a strategic means of belonging to traumatic large-scale events and changing familial and political-economic constellations. Inner and outer states are inescapably sutured. Tradition, collective memory, and public spheres are organized as phantasmagoric-like scenes, for they thrive on the "energies of the dead" that remain unaccounted for in numbers and law. Das scrutinizes this bureaucratic and domestic machinery of inscriptions and invisibility that authorizes the real—a machinery with which people have to forcefully engage as they look for a place in everyday life. In her work on violence and subjectivity, Das (2000) is less concerned with reality structuring psychological conditions than with the production of individual truths and the power of voice: What chance does speaking have to be heard? What power does it have to make truth or to become action?

In Vita, one is faced with a human condition in which voice can no longer become action. No objective conditions exist for that to happen. The human being is left all by herself, knowing that no one will respond, that nothing will crack open the future. Catarina had to think of herself and of history alongside the fact of her absence in the things she remembered. "My family still remembers me, but they don't miss me." Absence is the most pressing and concrete reality in Vita. What kind of subjectivity is possible when one is no longer marked by the dynamics of recognition or by temporality? What are the edges of human imagination that Catarina keeps expanding?

In posing these questions, I am not concerned with finding a psychological origin (a thing I do not think exists) for Catarina's condition or with simply tracking down the discursive templates of her experience. I understand the sense of psychological interiority as ethnological, as the whole of the individual's behavior in relation to her environment and to the measures that define boundaries, be they legal, medical, relational, or affective. It is in family complexes and in technical and political domains, as they determine life possibilities and the conditions of representation, that human behavior and its paradoxes belong to a certain order of being in the world.¹² How does one become another person today? What is the price one pays? How does this change in personal life become part of memory, individual and collective?

As I engaged Catarina, I was also informed by Byron Good's (2001) work on the social course of psychosis in

contemporary Indonesia. As he directs attention to the way epidemic-like experiences of acute brief psychoses are entangled with the country's current political and economic turmoil, the ghostliness of its postcolonial history, and an expanding global psychiatry, Good emphasizes the ambiguities, dissonances, and limitations that accompany all attempts to represent subjectivity in mental illness. He suggests three analytic moves: the first, working inward through cultural phenomenology to get at how a person's experience and meaning making are woven into the domestic space and its forceful coherence; the second, bringing to the surface the affective impact and political significance of representations of mental illness and subjectivity; and the third, interpreting outward to the immediate economic, social, and medical processes of power involved in creating subjectivity. Good unremittingly resists closure in his analysis, challenging one to bring unfinishedness into view. How is one to address this agonistic openness of lived experience methodologically? How can one incorporate this openness into the analysis of a person's estrangement from reality?

Noninstitutional ethnographic spaces

Taking Catarina's spoken and written words at face value took me on a journey into the various medical institutions and homes of people who had abandoned her. With Catarina's consent, I retrieved her records from psychiatric hospitals and local branches of the universal health care system. I was also able to locate her family members—her brothers, ex-husband, in-laws, and children—in the nearby industrial town of 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.

Had I only stayed with Catarina's utterances in Vita, the whole field of tensions and associations that existed between her family and medical and state institutions and that had shaped her life 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 juxtapositioning of several social contexts. Following her plot was a way to delineate the powerful, noninstitutionalized ethnographic space in which a family gets rid of its unwanted and unproductive members (on the politics of death, see Agamben 1998; Biehl 2001; Mbembe 2003).

The fabric of this domestic activity of valuing and deciding which life is worth living remains largely unreflected on, not only in everyday life, as Oscar pointed out, but also in the literature on transforming economies, states, and civil societies in contexts of inequality and democratization.¹³ As this work unfolded, I was challenged to devise ways to approach this unconsidered

infrastructure of decision making, which operates independent of the law in close proximity to the household. Fieldwork reassembled this decision making at various points and in various public interactions that defined normalcy and, ultimately, displaced Catarina onto the register of social death, where her condition appeared to have been self-generated. So, this is also a story of the methodological, ethical, and conceptual limits anthropology faces as it goes into these knotty fields and tries both to verify the sources of a life dissociated from her humanity and to capture the density of a locality without leaving the person behind. When I say "her humanity," I do not mean a circumscribed and definable thing but, rather, the ordinary and real-time efforts Catarina made to constitute herself as daughter, sister, woman, worker, lover, wife, mother, and citizen in institutions and exchanges that are meant to constitute humanness but that have deemed her efforts worthless.

Catarina embodies a condition that is more than her own. While reconstructing Catarina's pathways into abandonment, I developed a better understanding of Vita's imbrication in family and city life and of the ordinariness of the abandonment Catarina experienced. Catarina's life force was unique, but the human and institutional intensities that shaped her destiny were also familiar to many others in Vita. Despite appearing like a no-man's-land cut adrift, in terms of its history and maintenance, Vita is in fact entangled with several provincial, municipal, medical, and philanthropic institutions. As a "total fact," Vita captures the political, moral, and affective densities of that world (Mauss 1979:53; see also Kleinman 1999). On many levels, Vita is not exceptional. There are more than 200 institutions like Vita in Porto Alegre. These precarious places house the abandoned in exchange for their welfare pensions, and many also receive state funds or philanthropic donations. Some 50 million Brazilians (more than a quarter of the population) live far below the poverty line (25 million people are considered indigent).¹⁴ Although in many ways a microcosm of such misery, Vita is also distinctive. Many of its residents came from working- and middle-class families and once had been workers with families of their own. Others had lived in medical or state institutions and, at some point, had been evicted to the streets. Zones of abandonment are symbiotic with changing households and public services—they absorb those who do not have ties or resources left to sustain themselves.

An actual redistribution of resources, power, and responsibility is taking place locally amid large-scale political and economic changes (see Almeida-Filho 1998). Catarina's life is suffused with the elements, patterns, and contradictions of these processes. Her body and language are overwhelmed by their force; her personhood is made and unmade. This ethnography explores the

diffusions and contradictions of these larger processes with which families and individuals are ultimately left to cope. What are the political and cultural grounds of a state that continues to play its part in the generation of human misery and of a society that forces increasingly larger groups of people who are considered valueless into such abandonment zones, where it is virtually guaranteed that they will not improve?

Again and again, I heard Catarina conveying subjectivity both as a battleground in which separation and exclusion had been authorized and as the means through which she hoped to reenter the social world. "My ex-husband rules the city. . . . I had to distance myself. . . . But I know that when he makes love to other women he still thinks of me. . . . I will never again step in his house. I will go to Novo Hamburgo only to visit my children." Charting one human destiny helps one to understand the strategies and values people develop as they try to create life possibilities from whatever the changing institutions of state and market make available to them.

How can one restore context and meaning to the lived experience of abandonment?

Catarina is subjected
To be a nation in poverty
Porto Alegre
Without an heir
Enough
I end

How can an observer produce a theory of the abandoned subject and her subjectivity that is ethnographically grounded? To begin with, in her verse, Catarina places the individual and the collective in the same space of analysis, just as the country and the city collide in Vita. Subjection has to do with having no money and with being part of an imaginary nation gone awry. The subject is a body left in Vita without ties to the life she generated with the man who, as she states, now "rules the city" she is banished from. With nothing to leave behind and no one to whom to leave it, Catarina has only her subjectivity—the medium through which a collectivity is ordered in terms of lack and also a way for her to distance herself from the messiness of the world. In her writing, she faces the limits that a human being can bear, and she makes polysemy out of those limits—"I, who am where I go, am who am so."

The sense of exclusion

"These people in the infirmary represent the putrefaction of the street. They don't exist as a juridical fact. They have AIDS, tuberculosis, all these things that don't exist in statistics," explained Captain Osvaldo. Since 1997, Vita

has been administered by Captain Osvaldo, a civilian policeman working for the state of Rio Grande do Sul. Zé das Drogas was evicted from the establishment by a philanthropic coalition called Friends of Vita, headed by Jandir Luchesi, the region's most famous radio talk show host and a state representative. During Zé das Drogas's administration, daily life in the rehabilitation area had been structured around worship and Bible studies; now the emphasis is on personal hygiene, civic values, eating well, total abstinence from smoking and drinking, work therapy, and group self-reflection. As for the abandoned in the infirmary, the captain was straightforward: "We cannot bring them back to society. As horrible as it is, here one sees a truth."

As I talked to city administrators, public health officers, and human rights activists, I was able to identify some of the institutional networks through which Vita emerged and has been integrated into local forms of governance as well as some of the everyday practices that help to constitute its residents' nonexistence. With Brazil's new democratic constitution of 1988, health care became a public right, and many of the country's discourses and practices of citizenship during the following decade were related to guaranteeing this right.¹⁵ The activism of mental health workers was exemplary (Tenorio 2002). They engaged in lawmaking that shaped the progressive closure of psychiatric institutions and their replacement by local networks of community and family-based psychosocial care (Amarante 1996; Goldberg 1994; Moraes 2000).¹⁶ This deinstitutionalization of the mentally ill was pioneered in the state of Rio Grande do Sul (Porto Alegre is its capital), where it was well under way by the early 1990s. In practice, however, the mental health movement's demands and strategies became entangled in and even facilitated local government's neoliberalizing moves in public health: The mad were literally expelled from overcrowded and inefficient institutions, and little new funding was allocated for the alternative services.

On the one hand, this local psychiatric reform confirmed the role of the Worker's Party (Partido dos Trabalhadores, PT) as representative of a politics of social inclusion, occasioned a few exemplary services that treated "citizens burdened by mental suffering," and realized, if only partially, a socialized form of self-governance. As I later learned, Catarina was treated in one of the model services in the city of Novo Hamburgo. On the other hand, this psychosocial politics shifted the burden of care from state institutions back to the family and communities, which failed to live up to their idealized representations in the reform movement's discourse. People had to learn new techniques to qualify for services and to live with what were, by and large, the failures of new ideologies and institutions. Increasing numbers of mentally ill people began to live in the streets along with the other leftovers

of the country's unequal and exclusionary social project. Many ended up in places like Vita.

Everyday life in the 1980s and 1990s in that region was marked by high rates of migration and unemployment, the rise of a drug economy in the poorest outlying areas, and generalized violence (see Ferreira and Barros 1999). As police forces were increasingly engaged in erasing signs of misery, begging, and informal economies from the city, pastoral and philanthropic institutions took up the role of caregiver, albeit selectively. Simultaneously, families frequently responded to the growing burdens posed by new responsibilities of care and narrowing options for employment by redefining their functional scope and value systems. As a corollary to all of these institutional, economic, and familial processes, unemployed health technicians began opening their own care centers (modeled after Vita) for patients who had welfare benefits or some remaining assets. If, around 1976, there were some twenty-five "geriatric houses" in Porto Alegre (Bastian 1986), there are now more than 200, about 70 percent of which operate as clandestine businesses hosting the elderly, the mentally ill, and the disabled in the most precarious of conditions (Comissão de Direitos Humanos da Assembléia Legislativa do Rio Grande do Sul 2000; Ferreira de Mello 2001).¹⁷

"People are confined and have no adequate care. Some of these businesses are surrounded by barbed wire like camps," Mariane Gross, a journalist and human rights activist, told me. On July 2, 1999, a 58-year-old man in the Auxiliadora geriatric house that is located next to Vita (and was previously part of it) was bitten to death by dogs. "Bits of skin were all over the ground," Mariane and her colleagues stated in the annual report of the state's human rights commission. Novel human rights rhetoric, however, is not strong enough to close Vita and similar institutions down. Recently, the city's sanitary surveillance service had also begun to investigate these businesses and, according to health technician Jaci Oliveira, it was having a very difficult time getting support from judges to force them to close down. "The judges tell us that these houses are doing good after all. Where would these people go to if they were freed?" And had Vita been shut down, it most certainly would have reemerged elsewhere in the city. As a top city administrator admitted to me, the need to produce quick results for the alternative administration of the Worker's Party (see Pont and Barcelos 2000) has often led to the constitution of new commissions and the writing of new reports: "In truth, problems are identified, things are not solved."

In practice, the experimental mental health plan has also faced the widespread availability of new biochemical treatments. Brazil is the eighth biggest market for pharmaceutical products in the world (see Bermudez 1995 and Bermudez et al. 1999). In 1998, there were some 15 thousand drugs being sold in the country, and sales

reached \$11.1 billion (Luiza et al. 1999). With new patent legislation and no import restrictions, the Fernando Henrique Cardoso administration has successfully attracted multinational pharmaceutical industries and also made medication distribution a key element of public health. As part of the decentralization and rationalization of universal health care, the government began in the mid-1990s to implement a nationwide pharmacy program, whereby municipalities distribute basic medication (including psychopharmaceuticals) to the general population. This pharmaceutical policy is said to contribute to cuts in hospitalizations and to making families and communities stronger participants in therapeutic processes.¹⁸

In chronicling how the urban poor tinker with these developments, I observed the routine medicating of affective crisis within households, and families working as proxy-psychiatrists.¹⁹ That is, patients' family members find ways to dictate prescriptions, adjusting the dosages as they see fit. Psychiatrists in private practice are described as regularly telling families, "Try this; if it does not work, double the dosage." In the process, disturbed and unproductive family members are excluded and disposed of on "reasonable" terms—as mad, noncompliant, or beyond repair, like Catarina.

When I visited the Public Ministry in Porto Alegre, attorneys told me that they have the power to subpoena family members of abandoned people and to negotiate care or financial responsibility. But as Vita's history shows, that happens quite rarely, and a few cases then become emblematic of a supposed enforcement of human rights. The state is reborn empirically as it restores family ties for a few.

Seen in this light, Vita is a social symptom, not a solution. It is an outcome of recent political and economic readjustments that have driven large segments of the population further into poverty and despair. This harshness is amplified by a malfunctioning universal health care system—a supposed democratic gain of the late 1980s—and complicated by new pharmaceutical possibilities. The question of what to do with pauper and surplus bodies, with no apparent value and without ways to survive and prosper, is no longer a question at the core of sovereignty and its bygone populist welfare rhetoric. The destinies of the useless, so to speak, are determined by a whole new array of networks, and as formal institutions either vanish or become nonfunctional and as government becomes increasingly remote from the citizenry, the household is further politicized.

That so many are regarded as socially and morally superfluous testifies to the further dissolution of the country's moral fabric. The Brazilian middle class, for instance, has historically acted as a buffer between the elite and the most vulnerable, as both guardian of morality and advocate for progressive politics. In the wake of the country's democratization and fast-paced neoliberal-

ization, however, this vein of moral sensitivity and political responsibility has been largely replaced by sheer contempt, sociophobia, or sporadic acts of charity like the ones that sustain Vita (Caldeira 2002; Costa 2000).

The continuum of life and death

Yes, treating the abandoned as dying matter might release individuals and institutions from the obligation of some response. But after many visits to Vita, I also saw that the abandoned (*os abandonados*)—with their daily rations of bread and bean soup and hot water—are not kept alive in vain. While dying in Vita, they still have a final social function. Under the new regime, everyone admitted for rehabilitation (men only) has to spend a few days living in the infirmary as part of the initiation into Vita. Additionally, throughout their stay, rehabilitating men must come to the infirmary and take care of some of the abandoned, clean their feces, move their bodies back and forth. As one of Vita's new coordinators explained, the infirmary is useful as "a platform of information for the ones in rehabilitation. It is useful for getting the addict to fall back into reality, for if they don't change, that's their end." The captain was more straightforward: "These people in the infirmary are *cobaías* [experimental guinea pigs]. Their life is over, they show to the young ones what will happen to them."

Oscar and Luciano had told me that the abandoned in the infirmary had been made inappropriate for living by medical, familial, and state institutions. It was now evident to me that the negotiation over the human-animal boundary that had produced them had become a subjective technique. Lauro had been in Vita for three weeks when I met him. The 30-year-old man sat next to Lucas, formerly known as Vaquinha (little cow), about whom nothing was known. Lauro said that he had adopted and baptized "the poor thing" as Lucas. "Now he has a name. He is mentally retarded. I am responsible for him." As part of his initial rehabilitation therapy, Lauro has to take care of Lucas, bathe him, change his clothes, watch him as he crawls around, sit silently next to him. "I help him, so automatically he helps me too."

"How so?"

"By helping him, I am helping myself." Lauro then spoke of Lucas and himself in the plural, as belonging to two distinct collectivities: "They give force to us. Only to look at them already helps us to walk forward, to not stay in the same condition they are in." He voiced an impersonal feeling: "One develops a tenderness toward him, he is a well-behaved guy, right?" He then asked Lucas to speak: "Show him that you can talk." In that most disturbing encounter, Lucas became a spectacle, not meant to be heard or addressed. His worth as a human socially and medically devalued, Vaquinha-Lucas remains the

animal form through which the salvageable human, Lauro, constitutes himself.

The new role of these abandoned men and women as negative citizens stems precisely from their alleged incapacity to produce anything but bodily infections, parasites, and silent suffering. Their social death is the imago of the future. In the end, the negative ones are object lessons for potential citizens—or, better, they provide a ground for the appearance of a distinct concept of “citizenship.” I say concept of citizenship, because the state does not provide the means needed for this regenerated citizenship to become a structural possibility. Philanthropic sites like Vita make the personal regeneration of a marginal individual as citizen possible and livable either for a limited period of time or in the form of fiction. This concept of citizenship enlivens the image of the state as universal and life enhancing. Yet, empirically, citizenship remains a matter of triage and, of course, money. As some are being healed in that simultaneously “militarized” and philanthropic setting, they wake up next to those who are socially dead, without name, without origin, without ties. Like Cida, a nameless young woman with AIDS who, according to volunteers, “now and then asks us to tie her to her bed. She does that when she feels like killing herself. . . . Then a few hours later she mumbles to be untied. How do you understand such a person?”

Throughout the years, I have come to understand Vita as the negative side of a political and subjective paradigm increasingly familiar in late modern settings where changes in state and medical institutions, labor regimes, and the household all meet. Against an expanding discourse of human rights, one is confronted with the limits of infrastructures whereby these rights are realized, biologically speaking, but only on a selective basis. Social death and selective life extension are the poles of a continuum on which the state, the community, the family, and the citizen forge their presence these days. The negotiation over the human and the nonhuman forms part of a complex set of intermediary relations through which individual bodies are linked to the political body. In Vita, one sees that even life is achieved through death. The Other’s dying makes it possible for one to belong to a family-like institution, to a new population and subjective economy. The ethnographic challenge is to find these empirical relations and linkages—technical, political, conceptual, affective—and to bring them out of thoughtlessness.

Family complexes

I have worked with Catarina and her family for the past four years. During that time, she has written 21 volumes of her dictionary. I have read all of her writing and her medical records and have discussed them with her. I have

also scheduled medical examinations and brain imaging for her and others in her family and discovered that, along with immunodeficiency, Catarina has, in a doctor’s words, “the cerebellum of an 80-year-old woman.” In what follows, I want to give you a sense of what I found in this reconstructive work, particularly regarding how inner worlds are remade under the impress of economic pressures, the domestic role of pharmaceuticals as moral technologies, and the common sense that creates a category of unsound and unproductive individuals who are allowed to die.

Catarina was born in 1966 and grew up in a very poor place in the western region of the state. In fourth grade, she was taken out of school. The father abandoned the family, and Catarina became the housekeeper as her youngest siblings aided their mother in agricultural work. In the mideighties, two of her brothers migrated and found jobs in the booming shoe industry in Novo Hamburgo. At the age of 18, Catarina married Nilson Moraes and a year later gave birth to her son Anderson.

“When Nilson first brought her photo home,” said Sirlei, Nilson’s sister, “she was so beautiful.” It was not Catarina the person but her appearance that her in-laws first remembered when I introduced myself to them. Sirlei was adamant that Catarina’s present paralysis could not be read in the past: “She was then a perfect person, like us.” When she no longer mirrored the family’s image, Catarina had been consigned to the past and was now associated with a dismembering body: “Her mother also lost the legs and the hands.”

Catarina’s brothers told me that they, too, were beginning to have problems walking, but they did not know what the disease was: “It’s a mystery.” In Armando’s words, “When we were kids, Catarina was normal.” His wife again referred to Catarina’s appearance: “She was *very* normal. I remember the wedding photos.” I wondered about this definition of normality and what in one’s life or interests determined its application to another family member.

Shady deals, persistent bad harvests, and indebtedness to local vendors forced Nilson and Catarina to sell the land they had gotten to take care of Catarina’s ailing mother, and in the mideighties the young couple decided to migrate and join her brothers in the shoe industry. In the 1970s, shoe companies took advantage of subsidies made available by the military government to further expand their production for export. These were the years of Brazil’s “economic miracle.” Novo Hamburgo became an El Dorado of sorts, attracting many in search of work and social mobility. City officials went to the state’s western region, where Catarina and Nilson were born, to recruit a semilliterate and cheap labor force. Statistics show that at the end of the 1980s the city actually had one of the highest per capita income rates in the state but

also that at least one-fourth of its growing population lived as squatters. This situation worsened in the early 1990s, when the city experienced an abrupt economic decline and acute impoverishment mainly because of the country's inability to articulate a more lucrative export policy and because of the growing competition with China in the global shoe market. As yet, there has been no historical accounting of the massive migrant labor force that radically altered the economic and social landscape of the former German colony of *Neu Hamburg*.

Catarina recalls enjoying her work in the factory. "I had my worker's ID and made my money." Her husband found a job as a security guard in the city hall. Soon the couple had a second child, Alessandra. Catarina also took care of her ailing mother, who had moved in with them. Complicating her life further, at that time Catarina began having difficulties walking. "They fired her at the factory, because she began to fall there," said the sister-in-law. At the same time that she lost her value as a worker, she also discovered that Nilson was seeing another woman and her mother passed away.

Overwhelmed, at times Catarina left the house and wandered through the city. Her husband deployed his contacts at city hall and made sure that the police went after her: "They had to handcuff her . . . in the emergency ward they gave her shots and she calmed down," he told me. This happened a few times and then Nilson began confining her in psychiatric units in Porto Alegre. In the turbulent year of 1992 Catarina gave birth prematurely to her third child, a girl named Ana. Most of her hospitalizations took place between 1992 and 1994, when she and Nilson were no longer living together. "They gave her the best medication," said Nilson. "But she threw it into the toilet and flushed it down. At home, she didn't continue the treatment. She didn't help herself."

Nilson now works in a shoe factory and has a new family. Like other family members, he spoke openly about Catarina. "It's all past," he said, "it is not even in my mind." In the end, for him, Catarina's mental disturbance is the penalty she must pay for her evil behavior. "After her mother died Catarina began saying things that didn't correspond with reality . . . she said that her mother appeared to her. Her mom required lots of work. . . . She hit her mom and the old lady cursed Catarina. She 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.

Pharmaceutical ties

As I accessed Catarina's medical records, I saw something similar to what Roma Chatterji (1998), in her work

with dementia patients in the Netherlands, calls the "file self." Notes on medical treatment and family discussions enable the retrieval of the patient's voice and, more importantly, provide the narrative of its alteration and the conditions of its intractability. At the Caridade and São Paulo Hospitals, the diagnosis given to Catarina varied from "schizophrenia" to "postpartum psychosis" to "psychogenic psychosis" to "mood disorder." In tracing Catarina's passage through these medical institutions and treatments, I saw her not as an exception but as a patterned entity.

Catarina was subjected to the precarious mental health treatment reserved for the masses, the urban and working poor. Like many, she was conceived a priori as aggressive and was overly sedated, enabling the continued functioning of institutions in the absence of adequate care. Caught in struggles for deinstitutionalization, lack of public funding, and the proliferation of new classifications and treatments, this local psychiatry did not account for her singularity or social condition. Even though her diagnosis had softened over the years (mimicking the psychiatric trends), she continued to be overmedicated with powerful antipsychotics and all kinds of drugs to treat neurological side effects. On several occasions, nurses reported that Catarina experienced hypotension, a clear indicator of drug overdose. For Catarina, as for others, treatment began with a drug surplus and was then scaled down, or not, through trial and error. As I read her files, it was difficult for me to separate the symptoms of the psychiatric illness being treated from the effects of the medication, and I was struck that doctors actually did not bother to differentiate between the two in Catarina. To say that this is "just malpractice," as a local psychiatrist puts it, misses the productive quality of this unregulated medical automatism and experimentalism: Pharmaceuticals are literally the body that is being treated. And in the process of Catarina's overmedicating the symptoms that she calls "rheumatism" were being expressed. As doctors remained fixated on her supposed hallucinations, the etiology of her walking difficulties, which were actually reported by the nurses, remained medically unaddressed. The medical records also show that her husband and family were difficult to contact, that they left wrong telephone numbers and addresses, and that on several occasions they left Catarina in the hospital beyond her designated stay.

According to Ludwik Fleck, medical science in general defines the morbid as an entity by rejecting some observed data and by guessing at nonobserved relations. That is how the irrational becomes rational in its details, says Fleck (1986:39, 40), but that is also how some phenomena remain unremarked and unexplained. In Catarina's case, much was disregarded or subtracted from clinical theory or reasoning: the patterns of rationality that shape common

sense, the normative ideals of her family and neighborhood as well as of the health professionals, and her agonistic struggle for or against moral adaptation, not to mention her references to physical pain. And the “nonobserved” was subsumed under the neighbors’ and husband’s reports and the automatism of public psychiatry. In this context, medication did most of the work. The truth is, in this intersection of overmedication, medical automatism, and negligence, a different disease was emerging.

Catarina’s dictionary is filled with references to deficient movement, to pain in the arms and legs, to muscular contractions. At times, Catarina relates these symptoms and her growing paralysis to a kind of biological marker and alludes to a certain “blood type becoming a physical deficiency” or to an “expired brain and aged cranium” that “impedes change.” Most of the time, however, Catarina refers to her condition as “rheumatism,” as I alluded earlier, and speaks of the manmade character of her affections. I followed the word *rheumatism* as it appeared throughout the dictionary, paying close attention to the words and expressions clustered around it. In the following inscription, for example, Catarina depicts rheumatism as a mangling of threads:

People think that they have the right to put their hands
in the mangled threads and to mess with it.

Rheumatism.

They use my name for good and for evil.

They use it because of the rheumatism.

The symptom ties various life threads together. It is an untidy knot, a real matter that makes social exchange possible. It gives the body its stature and is the conduit of a morality. It is Catarina’s bodily effects and not her name that are exchanged in the social world: She becomes a symptom. “What I was in the past does not matter.” Catarina disappears and a religious image stands in her place: “Rheumatism, Spasm, Crucified Jesus.” In another fragment she wrote: “Acute spasm, secret spasm, rheumatic woman, the word of the rheumatic is of no value.” Catarina knows that there is a rationality and a bureaucracy to symptom management: “Chronic spasm, rheumatism, must be stamped, registered.” All of this happens in a democratic context, “vote by vote.”

As I saw it, the “secret” of Catarina’s condition stemmed from an unknown biology and the unconsidered experience of what had been made of it over time. The acute pain Catarina described and the authoritative story she became in medicine and in common sense—as mad and ultimately of no value—have to be considered and deciphered side by side. The names of the antipsychotic drugs Haldol (haloperidol) and Neozine (levomepromazine, the stronger and more sedating of the two) are also words in Catarina’s dictionary. In one fragment, she writes

defiantly that her pain reveals the experimental ways science is embodied:

The dance of science.

Pain broadcasts sick science, the sick study.

Brain, illness.

Buscopan, Haldol, Neozine.

Invoked spirit.

An individual history of science is being written here. Catarina’s lived experience and ailment are the pathos of a certain kind of science, a science that is itself sick. As Catarina sees it, in the current Brazilian context, the pursuit of wisdom has broken down and commerce enables ad hoc medical practice. The goods of psychiatric science, such as Haldol and Neozine, have become as ordinary as Buscopan (an over-the-counter medication for stomachache relief) and have become a part of familial treatment practices. As Catarina’s experience shows, the use of such drugs produces mental and physical effects apart from those related to her illness. These pharmaceutical goods—working, at times, like rituals—realize an imaginary spirit, rather than the material truth they supposedly stand for: Objects are then supposed subjects. There is a money-making science to Catarina’s afflictions. As transmitters of this science, her symptoms are of a typical kind.

The sense of symptoms, Catkini

In the lecture “The Sense of Symptoms,” Freud (1957a:271) hinted at the existence of a kind of symptom that could not be traced to an individual’s idiosyncratic history and that the science and skills of psychoanalysis failed to satisfactorily explain. He spoke of “typical symptoms of an illness” that are more or less the same in all cases: “Individual distinctions disappear in them or at least shrink up to such an extent that it is difficult to bring them into connection with the patient’s individual experience and to relate them to particular situations they have experienced” (Freud 1957a:270). Freud had in mind, for example, the repetition and doubt that would be common to all obsessional neurotics. Instead of biologizing these typical symptoms, Freud saw them as another level of experience, reflecting, perhaps, a kind of universal culture: “If the individual symptoms are so unmistakably dependent on the patient’s experience, it remains possible that the typical symptoms may go back to an experience which is itself typical—common to all human beings” (Freud 1957a:271).

Freud admits that the symptom that makes people similar actually enables the work of medical science: “And we must not forget that it is these typical symptoms, indeed, which give us our bearings when we make our diagnosis” (1957a:271). But rather than elaborating further on how the expert uses the symptom to produce science, Freud

shifts attention back to the individual's tinkering with it. Insightfully, he notes that the typical symptom activates a subjective plasticity: "On this similar background, however, different patients nevertheless display their individual requirements—whims, one is inclined to say—which in some cases contradict one another directly" (Freud 1957a: 270). Through typical symptoms patients actively project—manufacture, one could say—their own individual conditions and moods. But, instead of exploring the materiality and historicity of this prosthetic agency, Freud refers to it as a kind of nucleus around which the patient refashions his or her given neurosis.

In the end, not surprisingly, Freud universalizes. He suggests that this affect actually makes the individual and typical symptom one and the same: "I will try to console you, therefore, with the reflection that any fundamental distinction between the one kind of symptom and the other is scarcely assumed" (Freud 1957a:271). Thus, the repetition and doubt that are common to obsessional neurotics can be read as "general reactions which are imposed on the patients by the nature of their pathological change" (Freud 1957a:271). The problem with this interpretation in present times is that the subject is not simply the reflection of unconscious processes but is literally composed by morbid scientific-commercial-political changes.²⁰

In Catarina's writing and thinking, global scientific-pharmaceutical things are not simply taken as new material for old patterns of self-fashioning. These universally disseminated goods are entangled in and act as vectors for new mechanisms of sociomedical and subjective control that have a deadly force. In this sense, it is not the symptom per se that is ahistorical but our understanding of how these scientific identifications became so widely available and the concrete ways in which they replace social ties, voiding certain forms of human life in family and medicine.

One can now more fully understand what Catarina meant when she first said that she was writing a dictionary so as "not to forget the words, all the illnesses I had as a child and that I have now." The illnesses she experiences now are the outcome of a relational and medicoscientific engineering of the person she had learned to become. She has literally become the words Haldol and Neozine. The drug name Akineton is embedded in the new name Catarina gave herself: "Catkini."

Social psychosis

As I disentangled the facts of Catarina's existence, the ordinariness of her abandonment and how it was forged in the interactions of family, psychiatry, and other public services came into sharp relief. In the process, I also learned that the overpowering phenomenology of what is

generally taken and treated as psychosis lies not in the psychotic's speech (Lacan 1977) but in the actual struggles of the person to find his or her place in a changing reality vis-à-vis people who no longer make his or her words and actions meaningful.

Catarina's human ruin is, in fact, symbiotic with several social processes: her migrant family's industrious adherence to new demands of progress and its eventual fragmentation, the mental automatism of doctors, the increasing pharmaceuticalization of affective breakdowns, and the difficult political truth of Vita as a death script. Adopting a working concept, I began to think of Catarina's condition as "social psychosis." By *social psychosis*, I mean those materials, mechanisms, and relations through which the so-called normal and minimally efficient order of families and neighborhoods—the idea of reality against which the patient appears psychotic—is effected and of which Catarina is a leftover.

"Did Catarina tell you what happened in the hospital?" I asked her ex-husband.

"No, she didn't remember."

For Nilson, Catarina had no memory. Having been screened by the police and by psychiatrists, placed on all sorts of antipsychotic medication, and mocked by family and neighbors, Catarina lost touch with the reality of the changing family. I asked Catarina about the voices she was said to be hearing: "It's true," she said. "They were cries. . . I was always sad. . . I thought the voices came from the cemetery, all those dead bodies."

A complex plot had developed. After talking to all parties, I understood that, given certain physical signs, her husband, her brothers, and their respective families believed that Catarina 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.

As Catarina's situation worsened, Nilson found another woman, with whom he had a child, and he had a judge grant him legal separation from Catarina. She never signed the divorce papers herself. Her ex-husband also signed over his youngest daughter Ana to his boss in the city hall, but he insists that Catarina "gave her away." Nilson and his mother each kept one of Catarina's other two children, who still help in their respective domestic economies. At the height of Catarina's despair, her brother and sister-in-law made her accept a deal in which they took her house and she was moved into their shack, deeper into the slum.

Given that Catarina had "been given away" to Nilson and that the young couple had squandered the family's land, Catarina's brothers felt no obligation to her. This was the economic and gendered fabric of their moral thinking, beyond the domain of the blood tie. In more than one way, Catarina was repeating the script of her mother's illness experience: In both cases the development of the disease was entangled with spousal separation, the abandonment of the women who had the disease, and predatory claims over available goods.

Ethics

I located Catarina's records in the Novo Hamburgo psychosocial clinic where she was serviced before and between hospitalizations. On December 12, 1994, nurse Lilian Mello drove Catarina home and registered the intensity of the affective modes and practices that made her a double of sorts and empty of all concrete possibilities:

As she now lives alone, I left her at the house of her mother-in-law. 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 it clear that she will not be responsible for Catarina. I told her that the family should take Catarina to the general hospital for a clinical evaluation. She told me to call Nilson. I went to talk to him. He only said that, like other times, Catarina should be taken to Porto Alegre and hospitalized.

To Catarina's complete devastation, a few weeks later, at the end of December 1994, her shack burned down and she was hospitalized again. This time a Dr. Viola wrote, "I am against admission; patient should have a neurological evaluation." Nevertheless, she was locked up and treated, as I learned, with haphazardly combined antipsychotic medication. On discharge, she wandered from one relative's house to another. At some point, "I slept a whole month," recalls Catarina. Backed by a local psychiatrist, family members and neighbors experimented with all kinds of drugs and dosages. As the adoptive mother of Catarina's daughter said, "Dr. Gilson told us how to deal with her . . . if one dosage of the medication wouldn't help, then we should double the dosage."

Medication has become a family tool, and families have become psychiatrists by proxy. Inseparable as pharmaceuticals are from our biomedical regime of truth, one could say that in their deployment they constitute the register of the true. One who is medicated within the family is, then, in Catarina's words, "on a path without an exit." The abandonment of unproductive and unwanted family members is mediated and legitimated by pharmaceuticals, both through the scientific truth-

value they bestow and through the chemical alterations they occasion. Pharmaceuticals work as moral technologies—they actually make the loss of social ties irreversible.

"Bottom line, the ethics that the family itself installs around mental suffering," Simone Laux, the director of the Novo Hamburgo psychosocial service, told me, "guarantees their own physical existence." One of her colleagues agreed that "the family quite often replaces a state that does not care." The family is thus a "state within the state." Freud used this very expression to reiterate the constraining features of neurotic pathologic processes vis-à-vis "external reality" (in Loraux 2002:84). I take the interplay of political power and individual subjectivity to be more than analogical. The decision to make persons and relationships work or to let them die is at the center of family life. Medically known, Catarina was left without the choice to live, in her words, was "almost killed."

In sum, as I charted the various relational, medical, and institutional networks and practices that mediated Catarina's abandonment in Vita, I found a deadening language with a force of its own, and, as such, the link to her words, as if she and they were dead objects. Catarina had become a leftover in a domestic world that was being disassembled and reassembled in intricate interactions. She was the negative value, the unnecessary component of a migrant and urban poor culture. Finally, in 1996, after learning about Vita from a Pentecostal pastor who had heard of it on the radio, her brothers left her there.

Catarina's destiny is the outcome of a structure that operates like the law and that is close to home. Under such dire circumstances, how can a family be expected to make medical decisions in the best interest of an ill member? In this context, how does one speak of the "evil" that is done and the "good" one must do? Armando and other family members respond with a rhetorical question to which the unspoken answer is always "nothing": "It's tough, but what to do?" In the end, Catarina is a failed medication regime that, paradoxically, allows the lives, sentiments, and values of others to continue in a constantly changing social field marked by economic pressure and violence.

In her thinking and writing Catarina reworks this literalism that makes possible a sense of exclusion. Her subjectivity is actually constructed in relation to this tinkering. She demonstrates the possibility of rethinking reality and the subject from the absence she became. Abandoned in Vita to die, Catarina writes that her desire has been betrayed, it is now a pharmaceutical thing with no human exchange value:

Catarina cries and wants to leave.

Desire. Watered, prayed, wept.

Tearful feeling, fearful, diabolic, betrayed.

My desire is of no value.
 Desire is pharmaceutical.
 It is not good for the circus.

Biology and the unknown

At first glance, Catarina was just one more lost life in Vita, part of an indigent population with whom the country and its people had become accustomed to coexisting or placing out of sight and thought. But as this inquiry progressed, I began to see Catarina as embodying a specific genetic population that had been made medically and socially invisible. As I continued to work with her family, interviewing aunts and cousins and mediating Catarina's and her brothers' medical examinations, I discovered an elaborate culture around the disease entity that slowly mangled the bodies of many in that extended family. Family secrets and anecdotes of this unknown disease point to the existence of unconsidered social practices and an embedded moral economy that, given the local state of science and medicine, determine the supposed humanity of the afflicted as well as reproduction patterns and abandonment—I refer to these determinative elements as a "biological complex." Affective, relational, and economic arrangements are plotted and realized around the visible carriers of the disease and, ultimately, impact the course of dying.

I was able to get the genetics team of the Clínicas Hospital in Porto Alegre to see Catarina. Fourteen years after Catarina entered the maddening psychiatric world, molecular testing revealed that she suffers from a genetic disorder called Machado-Joseph Disease, which causes degeneration of the central nervous system (Coutinho 1996:15; Jardim et al. 2001b:899). It is inherited as an autosomal dominant disease (Jardim et al. 2001a:224) and was first reported in North American families of Portuguese–Azorean ancestry (Jardim et al. 2001b:899; Sequeiros 1996:3–13; see also Boutté 1990). The disease is characterized by a progressive cerebellar ataxia affecting gait, limb movements, speech articulation, and deglutition. I was extremely happy to hear the geneticists say that Catarina "knew of her condition, past and present, and presented no pathology." Dr. Laura Jardim, one of Brazil's leading young geneticists, who has seen hundreds of Machado-Joseph patients, is adamant that "there is no mental illness, psychosis, or dementia linked to this genetic disorder. In Machado-Joseph your intelligence will be preserved, clean, and crystalline." Of course, biopsychiatrists could argue that Catarina may have been affected by two concomitant biological processes, but, for me, the discovery of Machado-Joseph was a landmark in the overwhelming disqualification of her as mad and shed light on how her condition had evolved over time.

The high incidence of Machado-Joseph in the south of Brazil is due to a founder effect, says Dr. Jardim: Porto Alegre was founded in the 18th century by Azorean immigrants who apparently carried the genetic mutation (Jardim 2000). I also learned that after the onset of the disease, patients survive an average of 15 to 20 years, most dying from pneumonia in wheelchairs or bedridden. But there are ways to improve quality of life through physical and speech therapy as well as pain relief, which the Clínicas staff has made available to Catarina. She was also invited to participate in an emergent association of Machado-Joseph patients and families.

Scientists have established that the more serious the gene mutation is, the likelier the disease will manifest early. Among those with a severe mutation, 60 percent are likely to experience early onset, and 40 percent are not: "So, seeing the person's genome we could say a likely time of onset, but not with total certainty," Dr. Jardim told me. "There is a protective factor, however, that postpones the onset in some individuals in spite of the gene mutation. These can be genetic or environmental factors, social and psychological stressors." Among siblings, she continued, "the age of onset is almost always the same." How does one explain Catarina's much earlier onset (late teens) compared with, for example, her brother Armando (late twenties)? Variation in age of onset like this might be due, according to Dr. Jardim, to "environmental reasons, even due to issues related to a difference in personality. Who knows? We will remain searching for an answer to this question. We know that environmental influences are embodied, but we don't know how to get to them. We don't have the instruments to study how the history of the subject influences her own life."

The various relational and medical processes in which Catarina's biology was embedded and tinkered with, I thought, point to the materiality of this "unknown 40 percent"—the social science of the biological mutation. I was happy that there was room in this local scientific milieu to openly consider these social, relational, economic, and technical variables.²¹ Not only were the genetic researchers and I producing a broader and more complex understanding of Catarina's condition, but this collaborative process also seemed potentially generative of a science that could address some of the environmental unknowns and the implicit practices that affect the actual course of biology and of dying. As Dr. Jardim commented on Catarina's case, "At the peak of her suffering, they were dismembering her ... this dying flesh is all that remained." Rather than the residue of obscure times, Catarina's condition was part of a regularity, forged in all those public spaces and hazy interactions in which a rapidly changing country, family, and medicine met.

Coda

Catarina spends the days in Vita assembling words that give form to her being, both at the present time, such as it is, and in the past. Her writing is not only an extension of the refuse she has become in family life, in medicine, and in Brazil but also a reflection on her: naked and displaced ideals, deadlike objects with no ties, only a few verbs here and there containing the chronology of a life castaway.²²

"I am not a pharmacist," she once told me. "I cannot say which medication heals an illness, I cannot say the name of the pharmakon, but the name of my illness I know. . . . How to say it?"

Silence.

She then said, "Mine is an illness of time."

"What do you mean?" I asked.

"Time has no cure."

Although Catarina's external functions are almost dead, she retains a puzzling life and language within her body. She refuses erasure, and through apparently disaggregated words she gives the anthropologist and the reader a sense of how her condition as a body not adequate for reality and of how the society of bodies that is Vita have evolved in time. Catarina thinks through her condition and forces her violent exclusion from affection, care, law, and the possibility of life into writing.

"There is so much that comes with time . . . words . . . and the signification you will not find in the book. It is only in my memory that I have the signification. And this is for me to discern. So many words that have to be deciphered . . . with the pen, only I can do it . . . in the ink, I decipher."

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

The minor sin is to want to separate

My body from my spirit

Notes

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1. See Nancy Scheper-Hughes's (2001) study of how shifting domestic economies impacted family ties and mental illness in rural Ireland in the 1970s. See Luiz Fernando Dias Duarte 1986 for an analysis of "nervousness" among the urban poor in Brazil.

2. Veena Das and Renu Addlakha argue that the domestic, "once displaced from its conventionally assumed reference to the private, becomes a sphere in which a different kind of citizenship may be enacted—a citizenship based, not on the formation of associational communities, but on notions of publics constituted through voice. The domestic sphere we present, then, is always on the verge of becoming the political" (2001:512). On the politics of kinship and caring, see Borneman 2001 and Butler 2001.

3. Names of people and institutions have been changed to protect their anonymity (unless requested otherwise).

4. In his essay "The Physical Effect on the Individual of the Idea of Death Suggested by the Collectivity" (1979), Marcel Mauss shows that in many supposedly lower civilizations, social death, unaccompanied by any physical illness or injury, could ravage a person's mind and body. Once removed from society, people were left to think that they were inexorably headed for death, and many died for this reason. Mauss argues that such cases are uncommon or nonexistent in "our own civilization," for they depend on institutions and beliefs such as witchcraft, prohibitions, and taboos that "have disappeared from the ranks of our society" (1979:38). As I shall argue throughout this article, however, there continues to be a place for social death in the contemporary city. In the face of increasing economic and biomedical inequality and the breakdown of family structures, human bodies are routinely separated from their normal political status and abandoned to the most extreme misfortunes.

5. Consider Clifford Geertz's discussion of the Yanomami as *ex-primitive*. Geertz provides some chilling reflections on the Yanomami's technically and politically engineered demise as well as on a general public blindness to this modern form of life-cum-disappearance: "Now that their [the Yanomami] value as control group . . . is diminished or disappeared and the experiments upon them have ceased and the experimenters departed, what sort of presence in our minds, what sort of whatness, are they now to have? What sort of place in the world does an 'ex-primitive' have?" (Geertz 2001:21, 22; see also Fischer 2001a, 2001b).

6. Historically, Brazil's welfare system has been structured in such a way that the state's intervention varies according to the population segment claiming social protection. Citizenship has been conceived as universal for the minority rich, regulated according to market inception for the working class and middle class, and denied to poor and marginal multitudes. According to Sônia Fleury, these "non-citizens" might be entitled to some minimum form of social assistance and charity as long as they renounce political rights—this is their "inverted citizenship" (in Escorel 1993:35; see also Escorel 1999). Those occupying the upper strata of society not only live longer but their right to live longer is also bureaucratically decreed or biomedically ensured through the mechanisms of the market. For a review of Brazilian welfare policies since the 1930s, see Oliveira and

Teixeira 1986. For a critical review of current social policies developed by the Brazilian state, see Fiori 2001 and Lamounier and Figueiredo 2002. Also see Hoffman and Centeno's (2003) review of persistent inequality in Latin America.

7. On the symbolics of the animal, see Geertz's (1973) essay on the Balinese cockfight. On historical and contemporary debates over the human-animal boundary in science, see Haraway 1989 and Creager and Jordan 2002. Giorgio Agamben (2004) also explores the relationality of the human and the animal.

8. For ethnographically grounded accounts of self and experience drawing on theory of ritual and religion theory, see Csordas 1994, 2002, and Nabokov 2000. Ochs and Capps (1996) review the expansive literature relating notions of the self to practices of narration, and Desjarlais (1994) and Chatterji (1998) discuss how far such ideas carry in interpreting the lives and words of the mentally ill; Scheper-Hughes and Lock (1987) expand on the "mindful body." An influential narrative of "the modern self" can be found in Taylor 1989; see Rose 1998 for a Foucault-inspired reinterpretation of this history. Two recent collections of ethnographic essays focusing on the contemporary condition that examine selfhood and identification in the contexts of crisis and drastic social change are Greenhouse et al. 2002 and Holland and Lave 2001.

9. Culture is not a variable, it is relational, writes Michael M. J. Fischer: "It is elsewhere, it is in passage, it is where meaning is woven and renewed, often through gaps and silences, and forces beyond the conscious control of individuals, and yet the space where individual and institutional social responsibility and ethical struggle take place" (2003:7). On "the work of culture," see Obeyesekere 1990.

10. See Hannah Arendt's discussion on thinking and ethics in her book *The Life of the Mind* (1981). Could the activity of thinking, asks Arendt (1981:5), be among the conditions that make men abstain from evildoing or even actually "condition" them against it?

11. Ethnography is challenged to identify the "political economic order that reproduces sickness and death at its very base" and to listen to, collect, and inscribe the histories of lives "whom the state hardly thinks worth counting at all" (Scheper-Hughes 1992:30).

12. In dealing with psychosis, Jacques Lacan (1977:216) urged psychiatrists and psychoanalysts to halt diagnosis, to question their own trust in an order of reality, and he let patients define their own terms. "There is intuitive intelligence, which is not transferable by speech," said a patient in a conversation with Lacan, and "I have a great deal of difficulty in *logifying*. . . I don't know if that is a French word, it is a word I invented" (1980:27). One is faced here with the patient's making of meaning in a clinical world that would rather assign it (see Corin 1998; Corin et al. 2003). One is also faced with Lacan's important insight (coming not just out of intellectualization but also out of his psychoanalytical practice) that the unconscious is grounded in rationality and in the interpersonal dimension of speech: "It is something that comes to us from the structural necessities, something humble, born at the level of the lowest encounters and of all the talking crowd that precedes us . . . of the languages spoken in a stuttering, stumbling way, but which cannot elude constraint" (1978:47, 48). For Lacan, subjectivity is that failed, renewable, and all-too-human attempt to access the truth of oneself. For a more detailed discussion on truth production, subjectivity, and ethics in the works of Lacan and Foucault, see my article "Technology and Affect" (Biehl, with Coutinho and Outeiro 2001).

Philosopher Ian Hacking follows Foucault (1980, 2000) in asserting that subjects are constituted in and by the mechanisms

of knowledge and power and the ethical templates in which they are entangled and which generate the potentials for individual experience. Hacking has identified scientific and technical dynamics that mediate among processes by which "people are made up" (1990:3; see also Hacking 1999). Categories and statistical counting engender new classifications within which people must think of themselves and of the actions that are open to them, says Hacking. As classes of people have their ways of being in the world normalized, this process also has consequences for the ways in which people conceive of others and think of their own possibilities and potentialities (Hacking 1990:6).

13. As Foucault wrote, politics has been increasingly played out in modern human physiology: "What might be called a society's 'threshold of modernity' has been reached when the life of the species is wagered on its own political strategies" (1980:143). Agamben builds on these insights and argues that the original political element of sovereign power in Western democracies is "not simple natural life, but life exposed to death" (1998:24). The determinant structure of modern ways of ordering public spaces and political relations is the ban, argues Agamben: "The ban is essentially the power of delivering something over to itself, which is to say, the power of maintaining itself in relation to something presupposed as nonrelational. What has been banned is delivered over to its own separateness and, at the same time, consigned to the mercy of the one who abandons it—at once excluded and included, removed and at the same time captured" (1998:109–110).

14. The Fundação Getúlio Vargas estimates that some 50 million Brazilians earn less than a dollar per day. For official data on inequality in Brazil, see www.ibge.gov.br.

15. See Caldeira 2000 for a discussion of democratization and human rights in Brazil and Paley 2001 for a discussion of health movements and democratization. See Das 1999 for a critique of the measures, practices, and values related to international health interventions and Appadurai 2002 for a discussion of the urban poor and new forms of activism and governmentality in India.

16. For the broader literature on antipsychiatry debates and movements, see Laing 1967 and Scheper-Hughes and Lovell 1987. For interpretations of psychiatry and psychology in the United States and Western Europe, see Goffman 1961, Lührman 2000, Lunbeck 1994, and Rose 1998, 2001; in Brazil, see Costa 1976. On new taxonomies of mental illness and psychopharmaceuticals and their clinical and politicoeconomic imbrications, see Young 1995 and Healy 1999; on the braiding of imaging technologies with new regimes of personhood, see Dumit 2004.

17. "A man is no longer a man confined but a man in debt," wrote Gilles Deleuze (1995:181) as he developed his idea of the fate of *anthropos* within the developments of late capitalism. In addition to the erosion of disciplinary and welfare institutions, Deleuze spoke of the concurrent emergence of new forms of control in affluent contexts, which no longer operate by confining people but through continuous control and instant communication. Family, school, army, and factory are increasingly "transformable coded configurations of a single business where the only people left are administrators" (Deleuze 1995:181). The market, however, is not universalizing and homogenizing but keeps generating both wealth and misery. "One thing, it's true, hasn't changed—capitalism still keeps three quarters of humanity in extreme poverty, too poor to have debts and too numerous to be confined: control will have to deal not only with vanishing frontiers, but with mushrooming shantytowns and ghettos" (Deleuze 1995:181). That is, there are too many people to be included in the market, and, as I show in this article, the fate of the unproductive and unwanted is ultimately determined by complex

and largely unconsidered practices and networks that link the changing institutions of state, market, family, and medicine.

18. I elaborate on this pharmaceutical form of governance in the article "The Activist State: Global Pharmaceuticals, AIDS, and Citizenship in Brazil" (Biehl in press a). See also the discussion by Ferguson and Gupta (2002) of new forms of neoliberal governmentality.

19. See Lawrence Cohen's (1998) discussion of how neuropsychiatric diagnostics work as new technologies of the person in Indian households.

20. Jacques Lacan wrote that in 1960 science was already occupying the place of desire in the human: "During this historical period the desire of man, which has been felt, anesthetized, put to sleep by moralists, domesticated by educators, betrayed by academies, has quite simply taken refuge or been repressed in that most subtle and blindest of passions . . . the passion for knowledge. That's the passion that is currently going great guns and is far from having said its last word" (1992:324). The science Lacan had in mind was physics, specifically, the development of the atomic bomb and the nuclear arms race. Political powers, he said, had been taken in by science's propaganda and had provided the money for new machines, gadgets, and contraptions, "as a consequence of which we are left with this vengeance" (Lacan 1992:325).

21. Carol Ryff, Burton Singer, and colleagues (2001) explore the ways the cumulative wear and tear of lived experience—"allostatic load"—impacts disease—health outcomes.

22. Our grammars, writes George Steiner, make it difficult, even unnatural, to phrase a radical existential negativity, "but the failure of the human enterprise makes the doubt inescapable" (2001:39).

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