Radio Nikosia: Mutiny on the Ship of Fools

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Abstract

This paper, based on fieldwork carried out over the past eight years, analyzes the operating dynamics and activities of Radio Nikosia, which is both a radio program in its own right, and a participant in various other radio programs in Barcelona. This programming is produced collectively by a team of 40 persons in psychiatric treatment, with the collaboration of anthropologists, artists, and journalists. Through radio as a channel of communication, the group constructs a social space in which they can be heard, a territory open to other narratives – those generally denied and delegitimated – that emerge from the subjective experience of mental suffering. Nikosia is a de-medicalized space, not initially constructed to be "therapeutic," that operates beyond the limits of the mental health care system, and offers persons with a diagnosis of mental illness the opportunity to participate actively in society. Its objectives center on deconstructing the stigma surrounding mental illness and creating possibilities of citizenship and meaning for diagnosed persons so that they are no longer the passive objects of psychiatric intervention, but socially active subjects. Radio Nikosia, in operation since 2004, has developed into a kind of liminal space in which historically sedimented preconceptions of madness may be deconstructed; a territory that favors a certain reappropriation of categories and semantics by diagnosed persons, and thus recovery of a degree of control over their lives, health, and illness. *Nikosianos*, as they are known to themselves and to their listeners, do not generally deny their mental suffering. What they try to do is disarticulate the interpretive circularity that leads to the fossilization of nosology and to a tutelage model of care presented as the only alternative.

Key words: Madness, identity, mental health, psychiatry, radio, communication, total illness, habitus, stigma.

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1. Defining themselves

The re-appropriation of the semantic field that defines them may be considered one of the pending needs of those we categorize as mad. The need to acquire a certain legitimacy through naming and defining themselves, and the construction – or at least participation in the construction – of discourses on madness is linked to the ability to take charge of one's own life, pathways to recovery, and search for well-being. Recently it has become evident to a greater or lesser extent that reflections, strategies and practices that emerge from the subjective experience of

mental suffering form part of the concert of voices that construct the meaning of mental illness and approaches to understanding it. This is the fundamental premise of Radio Nikosia[1], the first frequency in Spain to broadcast the experience of madness. Nikosia is an instantiation of communication.[1] The program – which is also a radio station in its own right – consists of a series of social interventions and community practices developed by a group of 60 persons diagnosed with mental illnesses, with the support of anthropologists, journalists, and psychologists who also form part of the group. It operates as a team of people who represent different kinds of knowledge and experiences that are in many respects complementary. The programs are planned and produced collectively within a horizontal structure, and most of them are linked to the need for an active role in the community, a legitimate space to talk about madness in the voice of madness.

Nikosia has been on the air since 2004. It broadcasts from the city of Barcelona, Spain, on the frequency of Contrabanda 91.4 FM, an independent non-commercial radio station. While the project developed within the mental health sector, as a radio station it operates outside the heath care system and the logic of therapy. The participants come into the project of their own free will. It is not a prescribed activity, but a space developed and constantly reinvented collectively in which the participants are free to speak and to establish a geography for Otherness from which bridges to the community may be built. The duration of the program is two hours every Wednesday afternoon, coordinated by the *Nikosianos* themselves. The theme of the program is chosen and discussed by all in the Monday afternoon assemblies. Themes chosen include, for example, "Medication," "Melancholy," "Laughter," "The need to reinvent yourself," "What is normal means?" and "Exclusion." The program combines different elements: personal reflections, debates, individual presentations of music and poetry, interviews with guests, and calls from listeners. The theme is not always or necessarily linked to madness, but madness is always present as lived experience in the atmosphere of the studio. Most of the programs join creative and artistic aspects with a more expressive dimension that corresponds to the need to speak, sometimes to cry out or even weep.

In general terms, it would be appropriate to say that Nikosia is a liminal context in relation to dominant discourses on madness. In Trias terms, Nikosia is a "habitable margin" that, given its peculiarities, makes possible a reinterpretation of established categories and opens up the possibility of approaching and thinking about madness in other ways. "The radio is the only place where I don't feel like a sick person, I feel like Dolors," says Dolors, one of the *Nikosianos*.[2] "Here we are independent of doctors, psychiatrists and family, we are what we want to be, more militant, I'd say," said Irene, another *Nikosiana*, during a program broadcast in 2007. Nikosia is a sort of intimate space, a small-scale public square where those who pass through come out strengthened, able to articulate new meanings that take shape in other practices. It is both a threshold and a space from which new categories emerge: a limbo for the traditional categories that describe the world of mental illness, and at the same time, the eye of the hurricane from which new

meanings and signifiers of madness emerge. These two aspects are intimately related and feed back into each other.

The radio is thus the channel of expression for narratives that emerge on the one hand out of the experience of madness, and on the other hand out of the experience of inhabiting the complex of clinical practices, techniques and technologies in mental health care. Nikosia is a tapestry of first-person voices of those who have lived in psychiatric hospitals and survived to tell the tale; those who suffer rejection and generalized mistrust daily; those whose voices are rendered mute by enforced silence that effaces their stories and annuls their lives. Nikosia is, then, a space that contributes to the recovery of speech, of voice, that makes it possible to speak and participate in the collective construction of other ways to think socially about madness. Fatima Alves reminds us in "Recognising madness in others; relativising madness in oneself – from lay concepts to therapeutic itineraries", an earlier chapter of this publication, that "having the label of mental illness triggers in others complex social processes that result, for the labelled person, in social exclusion and "forced" separation of everyday life". At the same time, this is usually related, as Alves said, with the semantic history of the idea of madness, usually associated with fear, violence or danger. And it is precisely these interpretations, these linkages arising from stereotypes, which become re-conceptualized, re-converted, through and from what occurs in the experience of Nikosia.

Also, what is important here is that this space is not governed by public services or institutions and designed as a sort of playground where the excluded may amuse themselves, but a territory collectively constructed through the constantly renewed initiative of the broadcasters/diagnosed persons in their continuing need for such a space. This is conquered territory, a space for horizontal and symmetrical social relations, not governed by externally imposed authority, with self-governing and self-developing capacities, a space predisposed to allow and facilitate transformation. Let us analyze it one step at a time.

2. Three appropriations

While the struggle to de-stigmatize madness is central to Nikosia's existence, it also attempts to shed light on a paradox: how is it that, despite the best intentions and high levels of professional skill, the very same institutions dedicated to providing care for the mentally ill end up becoming sources of suffering?

At present the model of mental health care shares the fundamental premises of the hegemonic model of biomedicine,[3] which largely determines how mental health care operates. As a result, one of the basic characteristics observable in both biomedicine and mental health care is the one-way flow of knowledge in the clinical encounter. Àngel Martínez has analyzed the historical influence of what he calls the Monologic Model, a system in which discourses circulate only in one direction. It is characterized by an absence of dialogue in favour of an expert knowledge monologue that represents itself as absolute and universally understood

as objective. In much of Europe this has been naturalized as the central component of the operating model of health care systems.

In this situation, the knowledge of those who are crazy,[4] as a piece of the puzzle of popular knowledge, is constituted on the margins of expert knowledge and is doubly subaltern. That is to say, it is socially categorized as subaltern in relation both to lay knowledge and to expert knowledge. It is, nevertheless, a form of knowledge that generates experience, a corpus of knowledge from which it is possible to construct a narrative of mental distress.[5] This knowledge is a product of the elaboration of experiences that instantiate and embody suffering, which itself constitutes a type of knowledge with possible practical applications and should form part of the wider discourse through which the ensemble of theories surrounding mental suffering and mental health are constructed.

We should not forget that social relations articulated through expert knowledge are relations of power that promote hierarchy rather than symmetry. In the domain of health care, underlying the imposition of a "more or less subtle form of domination" is the fact that biomedicine categorizes lay forms of knowledge as inexpert, imprecise, and unreliable because they are tenuously linked to the logic of the scientific method. This domination is even more evident in the domain of mental health, to the extent that we might say that this leads to practices that impede the development of almost any process of recovery or wellbeing. It is a form of domination that is materialized in the structuring of relationships between mental health professionals and diagnosed persons, in which the latter are generally viewed as patients subject to their disorder; that is, as deauthorized subjects, total patients. In sum, the hierarchical relation between expert knowledge and lay knowledge supports and legitimates the hierarchical relation between doctor and patient, which is at the same time supported and intensified by a prejudice made evident by the treatment of patients as passive subjects unable to articulate knowledge concerning their problems and the circumstances surrounding them.

According to Foucault, systems of expert knowledge say: We know enough about your suffering and your singularity -things you do not even suspect- to be able to say that they constitute an illness; but we know this illness well enough to know that you cannot exercise any rights over it or with respect to it. Our science allows us to call your madness an illness, and for this reason we doctors are qualified to intervene and diagnose in you a madness that prevents you from being a patient like the others: you are mentally ill.

Following Foucault, we can observe that the mad are subject to a triple appropriation:

1) An appropriation of the categories that define them, that name their madness: "I name you, I define your distress, I construct you in terms of an illness that I delimit and define".

2) An appropriation of legitimacy in the construction of the social image of madness: "Only the sane, and especially those who represent expert knowledge, are socially authorized to define madness".

3) An appropriation of possible treatment strategies, legitimate practices through which wellbeing may be restored: "I design the strategies and behaviours to be followed, and any deviation from this process may be interpreted as a sign that the problem has worsened."[6]

In most cases, patient careers are transformed into a process of adoption of an identity associated with the idea of illness.[7] The disorder and its semantic field impregnate the fabric of individuals' lives, transforming them into *total patients*. Their identities become fossilized as exclusively pathological. They are not just temporarily ill; they are ill as a condition of being, in all aspects of everyday social life. The socially dominant perception of madness in negative terms as deviant and even dangerous leads also to the de-authorization of subjective discourse. When there is no space for their narratives, they lose the ability to be socially active subjects. "I don't understand why I'm schizophrenic if I'm only crazy 10 percent of the time," said Nacho, one of the *Nikosianos*, during a broadcast. Being a total patient contributes to the de-legitimation of subjects as actors in their own right with respect to their condition. The contrast between the *non-knowledgeable* identities they are forced to accept, and the *total knowledge* of expert systems, is crucial to this process.

Elsewhere I have written that *Nikosianos* - and many diagnosed persons generally - have never denied the existence of a certain social and circumstantial split in their being in the world. What they deny are the meanings externally imposed on their pain. They resist classifications they perceive as reductionist in which the complexity of their experience is not reflected. They are denying, perhaps, that their genetic makeup is responsible for their distress because their suffering is traceable to real biographical events. They refuse to attribute any possible improvement in wellbeing to a pharmacological treatment followed by other treatment protocols in which there is scarcely any space for their perspective on the process. To question categories and their social connotations, to question certain labels and their meanings does not necessarily imply denial of difficulty, pain, confusion, or even the possibility of treatment. The problem results from the fact that this questioning is often seen by psychiatrists as denial of the existence of a problem, as resistance to the "correct" or "indicated" treatment as prescribed according to the biomedical model. Is it not possible to imagine that it is not a question of resistance to treatment but of resistance to a kind of treatment that emerges from the monologue of expert knowledge and resistance to what this treatment implies symbolically? Pau, *Nikosiano*, once said:

> "I prefer pain and suffering to being emotionally disabled by medication. I prefer pain, pleasure, laughter and tears…to the emotional death the pills cause. Rather than a petrified life, even at the cost of my life… I prefer to run, to love, and to feel…"

María José, a Nikosiana, is 27 years old and interested in astrology and what she calls "the world of the spirits." Her biography is closely linked to what is

commonly described as a magical vision of events in which supernatural explanations form the justification of her suffering. María José says that she is not necessarily crazy or, in any case, that what others call her madness is not a result of her genes but of having been "ensorcelled by a bad sorcerer, a black sorcerer who in some way intercepted my soul." It is an illness that was projected onto her by a dark shaman, an individual with whom she had a relationship at one time in her life. María José's explanations of her pain form part of her ability to manage her illness; the problem is that, as she frames them, they do not fit the logic of the biomedical model and are considered part of her symptoms. In 2008, after discharge from the hospital, she said during a broadcast:

> "I stopped trusting my psychiatrist when I realized that he didn't trust me. When I realized that he saw me as a hopeless case. The last time I was hospitalized, I knew that 10 percent of me was all right, there were things about me I was sure about even though I was ill. But my psychiatrist didn't believe even in that 10 percent, he didn't believe in me. He became more of an obstacle than a person I could trust for support in order to get well. From the moment I was admitted, I did nothing but give in to his demands, when they usually say that recovery comes from dialogue. But no, I gave in and accepted what he said, and I kept giving in, and I gave in some more hoping that at some point he would give a little on something. When I realized he wasn't going to give in one millimetre to what I told him my view of the problem was, I realized that I couldn't trust him. He was imposing his way of thinking on me, not trying to come to an agreement so I could get better. This was my third admission this year, and if things continue like this, I won't be able to rebuild my life, because every time I have to start all over again and I'm starting to get tired of being alone in this process. What's more, the guy labelled me "chronic" when you never know whether I'll turn out to be chronic or not."

The 10 percent María José mentions was linked to the possibility of articulating her own explanation, magical perhaps, and subjective, but in any case it might help her to make sense of what is happening to her, or what happened to her during an especially complex period in her life. In dialogue with the categories of expert knowledge, her explanation might be transformed into one that could help to restore health. Instead, however, following Gramsci, the subject of madness is de-historicized, a process that leads to her consolidation as a patient, as a product of an organic disorder framed in biological terms. The mad are "total patients" suffering from total illness, subjects deprived of agency, bodies inhabited by a fossilized identity isolated from cultural and temporal processes.

3. Lay knowledge and mental suffering experience

Nikosia was constructed, through its collective activities, in opposition to this de-historicization. Today it is a territory of legitimation of individual and collective history and narrative, a space where subjectivity is valued and lay knowledge has circulated from the beginning. It is a place where exchange of information and dialogue can take place on the categories relative to madness and the relativization of naturalized social meanings. We can think of it as a mechanism for rendering madness visible, and for making the voice of madness audible. Nikosia is a space that allows the certainty of diagnostic labels to be undermined. These are some of the most deeply rooted concepts in the symbolic universe of madness, and should at least be open to question if only to free diagnosed persons from their straitjacketing power. Any notions that criminalize or cast blame on madness, or even turn it into a disease, are momentarily suspended here. A mutation, so to speak, takes place in the forest of symbols.

The Nikosia experiment shows that the process of re-appropriation of language discussed here is possible if attempted from subverted territories,[8] spaces beyond biomedical logic that promote a certain flexibility in questions of identity. At the same time this re-appropriation requires what I have referred to elsewhere as recovery of the legitimacy of lay knowledge: narratives, subjectivities and forms of understanding that exist and are active and effective despite being constantly being denied and ignored. In its insistence on being given a hearing, lay knowledge is heretical in relation to the biomedical model, and has always manifested itself as what we might think of as an overflow in relation to the theoretical and practical obstacles historically placed in its way. Fatima Alves proposes the concept of lay rationalities, in plural, about mental suffering and illness, to describe the complex reality of lay knowledge about madness; here, our intention is to focus on the legitimacy of the knowledge, or rationality, that result from the experience of mental suffering. These forms of knowledge/rationality, not only exist now but have always existed, both as theory and as practice. They have been obliged to operate clandestinely, camouflaged in socially accepted forms in order to survive, "dressed up as 'normal' in order to be able to be with others," as Pau, a *Nikosiano*, put it during a 2004 broadcast. These forms of knowledge can be understood as a dimension of Pierre Bourdieu's concept of *habitus*; that is, what is produced by "limitations associated with particular conditions of existence." As Bourdieu writes, this "does not imply that the responses of the *habitus* are accompanied by a strategic calculation that attempts consciously to perform the operation that the *habitus* performs in another way." As the "active presence of the entire past of which it is a product" it produces practices that also constitute a body of knowledge that has the possibility of being effective. Bourdieu continues, "A product of history, the *habitus* produces individual and collective practices"; it is a form of knowledge that derives from one's own condition, situation, and experience in a given context, not necessarily rationalized or transformed into a strategy although it is potentially strategic. The idea of stigma, for example, may be an abstract category, something to be deconstructed, or the target of a publicity

campaign designed by public health policymakers. Persons affected by stigma, however, are the objects of an empirical reality. It is a source of omnipresent pain for which they are constantly developing survival strategies, an affliction resulting from their own actions grounded in difference, and social perceptions of that difference. This mode of being generates a *habitus*, a form of knowledge with the potential for amelioriating one's situation.

Xavier and Dolors, both *Nikosianos*, have been together as a couple for 16 years, and have lived together for the past 10 years. Both were diagnosed with schizophrenia, and met through their participation in activities in the day center in the district of Nou Barris in the city of Barcelona. From the beginning, both their respective psychiatrists and their families opposed the relationship on the grounds that one of them might hurt the other in critical moments of illness. Despite this opposition, Xavier and Dolors remained together, trusting in their possibilities as a couple, and their relationship continues in the present. "I know that the only person who understands me and accepts me as I am is Xavi," Dolors said in an interview published in the Sunday *Magazine* of the Catalan newspaper *La Vanguardia* in August 2008, "because he has experienced practically the same pain as I have. Both of us were diagnosed with schizophrenia and both of us were rejected by our families. We are very fortunate to have each other for support." Xavier added:

> "In madness there is distress caused by the illness and distress caused by others, people who point you out, marginalize you, make your life difficult because you've been labelled; and when that sometimes happens, Dolors is there to save me."

The hegemonic model of medicine neither promotes nor removes obstacles to Xavier's and Dolors' words. Their discourse takes place outside and beyond it, and it is there, in this overflow space where it emerges from the prison of expert knowledge, that it is constituted as lay knowledge.

Lay knowledge should not be thought of in terms of true or false, at least not in absolute terms. It is so only in relation to personal and subjective meaning, and its truth value can only be measured in terms of the symbolic aspects of constructing meaning out of events, and in specific situations in which persons make decisions and act in accordance with what they believe to be best for their own well-being. Of course, both of these aspects form two sides of the same coin. Lay knowledge is both a form of symbolic elaboration that contributes to the construction of the meaning of a particular event, reality, context or imaginary; and at the same time it is a form of practice in relation to one's own suffering and the complexities of one's own existence. We can find an example of these two dimensions in Albert's words.

Albert has lived alone for 23 years. He walks his dog every afternoon in the Barcelona neighbourhood of La Mina. He names the birds that come to his window. He can identify several of them and knows that they will come back, and for this reason he gives them names: the males get names of stones, and the

females names of minerals. In July 2007 when I visited his home he showed me all its corners, the different rooms in which he kept his collections of clothespins, of yellow objects, and of Tarot cards, and a mural painting of his astrological chart with Nikosia in one of the corners. He showed me the bathroom water heater. It was broken, and for five months he had been taking cold showers. When I asked why he didn't have it repaired, he showed me the birds' nest in the exhaust tube. "It's a family," he said, "that has come to live with me because they've chosen to, and I can't make them leave." Albert spent several months showering with cold water in order to avoid scaring the birds away.

During a presentation by Nikosia last year in the Summer School organized by the Diputació (provincial government) of Barcelona, he said:

> "In my way of life, animals can communicate with me. And this is good for me, relationships with animals protect me. For my psychiatrist, what's good about me walking my dog is that I get out and see people, that I get some air. But it has a different meaning for me that I can't explain to him, because he doesn't understand it. My relationships with the birds, the telepathic relationships of love and caring with the spiritual and natural world around me, with my animals, with Hippi (his dog) protect me, they care for me and make my life less lonely. When I go out for a walk I don't go out alone, I go out with them and in them, and while we're walking together I find happiness."

In recent years there have been cases in which expert knowledge has been able to accept the discourse of diagnosed persons as part of the knowledge field surrounding mental illness, but this takes place only as long as this discourse is closely linked to preexisting strategies for managing health; as long as it reproduces the rules of discourse dictated by the hegemonic and pharmacratic model of medicine; as long as it is a lay reformulation of psychiatric knowledge that speaks from a position of dis-ability, and its demands are oriented toward intensifying measures already instituted by expert systems of knowledge. Efforts are directed toward training sufferers to manage the therapeutic resources of the health care system. There is a tendency to involve them as active participants in health strategies grounded in expert models: not in their design and creation, but in their application. Shouldn't it be possible for the knowledge of those diagnosed to generate a new frame of reference from which alternative proposals for developing new models of health care can emerge?

4. A territory of complicity

Nikosia, as noted above, is a habitable liminal zone. This notion of the threshold should be thought of as a framework that makes possible two interrelated processes that construct, legitimate and reinforce each other. On the one hand, as noted earlier, preexisting categories are suspended, and on the other, there is a

consolidation of possible new meanings and practices that derive from the reflections of the participants themselves. Put another way, Radio Nikosia is a space in which two epistemological and phenomenological positions are generated simultaneously. Liminality is an instrument that permits *Nikosianos* to suspend or cancel previous meanings attributed to madness, and at the same time Radio Nikosia functions as a mechanism for the production of new meanings that replace prior ones. Following Delgado, we might say that it is a place "where things happen, where hypervigilance loses force and disrespect and revolt are allowed". "I like the word 'crazy', it's more like street talk, but the labels psychiatrists put on me are hard to swallow," Montse said during a program on diagnoses and the diagnosed.

These two epistemological positions return us to the idea that Radio Nikosia may be defined not just as a broadcast medium for new ideas, but also as a territory from which new practices may emerge. That is to say, a territory where there is a break between things as they are and things as they might be; where expert categories lose their hegemonic certainty and enter into contact with lay categories in a way that opens up new possibilities of practice in which the *Nikosianos* enjoy the authority and legitimacy to construct and define reality. They appropriate for themselves a broadcast space, a space in which they can be heard. To summarize: Nikosia is both a threshold and a through-the-looking-glass space in which new categories and meanings are translated into specific actions that seek dialogue with the social world as they deconstruct old meanings and their uses.

In his book *Pedagogy of the Oppressed*, Paulo Freire argues that no one liberates anyone else, and no one liberates himself/herself alone. Human beings are liberated in communion with each other. When he defends a pedagogy associated with the need for people to educate themselves through experience in everyday situations, he is talking about the contexts of possibility in which liberation takes place. These are spaces that generate new circumstances that promote emancipation, physical and/or symbolic spaces of reflection and analysis in which the aim is not to adapt oneself to the world as it exists but to transform it in order to make it more livable, in some way more one's own, more open to all. In the case of Nikosia as a geography, the question is not learning how to live "normally," but to contest this idea of normality and to demand that difference form part of the whole. "I'm not interested in being normal if being normal means watching "Gran Hermano" ("Big Brother," a popular television program) 24 hours a day; what I want is to be accepted as I am, with my own ways of being," said Cristina, one of the *Nikosianos*, in a program on the idea of stigma broadcast in 2008. For Freire, it is not a question of pedagogy "for" but pedagogy "with" the oppressed. It is from this kind of pedagogy, in dialogue with others, that tools for emancipation emerge. Freire mentions two moments that are necessary for emancipation: an initial moment linked to the raising of consciousness in relation to one's situation as an oppressed and excluded person; and a second moment relative to putting into practice the actions necessary in order to transform this situation. In Nikosia as a context of Otherness, both of these moments coexist permanently, feeding back

into and reinforcing each other. At the same time, the radio, as a means of communication, materializes transformative action, making it possible and locating it in social space, where it crystallizes and becomes effective.

Freire proposes that oppression, a circumstance manifest in different ways and to different degrees of intensity in diagnosed persons, has in liberation the possibility of creating dialogue. Thus, it is feasible to imagine that the construction of new meanings through dialogue among *Nikosianos* and between *Nikosianos* and the social world, owes a great deal to the fact that the *Nikosianos* have taken on a new role far removed from the stigmatized conception of the mentally ill. De-pathologization of identity, re-imagining oneself as someone other than a patient, takes place in the possibility of establishing real dialogue with others, with the Other, with expert knowledge, with family, with the social world in general. Becoming conscious of one's oppression within a particular geography, that of the public square on a small scale, the ability to reinvent or to take possession of the categories in terms of which one is defined, is the point of departure for initiating and activating this dialogue. Freire analyzes the importance of language in this effort, of the appropriation of language by the oppressed as an essential principle for the establishment of dialogue. There can be no dialogue between a discourse that pontificates and prescribes and another that attends passively, accepting these meanings and prescriptions. Dialogue emerges when both interlocutors, equally authorized, venture a verbal or gestural exchange in a situation of mutual respect, complementarity, and legitimacy.

To conclude, then, any process of getting well necessarily requires analysis from multiple points of view. My intention here is not to defend the lay knowledge of diagnosed persons as the one true pathway to health, but to propose that it is in the relationship between those outside madness, or at least the undiagnosed, and those who are immersed in madness and its social consequences, that a real transformation may emerge. As Paulo Freire says, it is a matter of dialectics, a give and take between different perspectives. This, however, given the circumstances, is only feasible if there is a re-appropriation of meaning on the part of the diagnosed. Nikosia seems to move in this direction. It is a kind of mutiny on the ship of fools.

Notes

[1] I have used the word *instantiation* here because it includes notions of time and space, and allows me to use a single concept to convey not only the temporal and spatial dimensions of the radio broadcast, but also its social and symbolic dimensions.

[2] *Nikosiano/a* is the word the participants in the project use to describe themselves. They prefer it to *mentally ill, diagnosed person*, or other categories. This article is based on my doctoral dissertation presented at the Universitat Rovira i Virgili in 2010 entitled *Radio Nikosia. la rebelión de los saberes profános. Otras prácticas,*

otros territorios para la locura. Like my dissertation, it is also the result of eight years of anthropological action research and participation in the Radio Nikosia project. This presentation combines material from the dissertation with post-thesis reflections of the sort characteristic of the Nikosia process.

[3] Eduardo Menéndez has analyzed in depth the characteristics of the so-called hegemonic medical model. In Catalonia the model is currently defined in bio-psycho-social terms (in this order of importance) but, as Emilio González argues, it is no accident that these terms appear together joined by hyphens in an order that implies their relative importance. The social dimension is always the last to be considered both as a cause of mental distress and in relation to health care strategies.

[4] In Spanish, *loco*; in Catalan, *boig*. I use this word as an emic category. Most *Nikosianos* prefer it to *mentally ill* because it does not fossilize them into a disease category.

[5] Not as a problem, but as a phenomenon.

[6] There is a factor that amplifies the coercive power of psychiatry over madness: ignorance of its biological or psychobiological causes. In large measure, this ignorance explains the almost religious character of schools of psychiatric thought. This is a way of averting a gap in knowledge by preferring dogmatism to inaction or acknowledgment of the unknown, which would detract from the credibility of an expert system of knowledge.

[7] This is what, in Gramscian terms, we could think of as an internalization of the categories of the dominant model. This manifests itself in the reproduction by patients of expert categories as if they were natural or commonsensical.

[8] Not exclusively. Space limitations prevent me from analyzing other factors and territories.

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