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Original article: a changing society

The psycho-social malaise of migrant private carers in Italy: a rampant, but hidden health demand

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Abstract. Despite having become an essential part of the national welfare system, the Italian private care market has developed in a situation of institutional disengagement. As a consequence, this sector, which has a high presence of female migrant workers, is currently characterised by serious flaws. What are the consequences for the psycho-social well-being of migrant private carers (MPCs)? This article highlights and analyses the high correlation between migrant women's involvement in the Italian private care market and their manifestations of psycho-social malaise, the latter being one of the main factors motivating the access to health services for MPCs employed in Italy. Based on qualitative data collected in Italy in 2009-2010: 32 in-depth interviews to MPCs, a focus group discussion involving seven MPCs, and 23 semi-structured interviews to providers working in close contact with MPCs, mostly in health services, it describes how the malaise of MPCs is generated, and how it is interpreted and expressed (or not expressed) by them. In particular, it investigates the social dynamics determining the latent nature of this phenomenon, and its tendency to work silently on MPCs' subjectivities without coming to the attention of health services, which are therefore not able to prevent or limit its negative consequences. Nevertheless, this article also shows that this malaise sometimes surfaces in the health service (albeit too rarely, or too late) and how it is generally managed by health providers. In particular, a timely encounter with the health system involving the simple externalisation and acknowledgement of this psycho-social malaise can have a crucial therapeutic value, meaningfully helping to prevent it from becoming a serious condition. On this basis, the importance is highlighted of creating channels for facilitating the meeting between this pressing but unexpressed health need and the institutions in charge of the health of society. (www.actabiomedica.it)

Key words: migrant, private care, health service, welfare, psycosocial malaise

Introduction

This article will deal with the high correlation between migrant women's involvement in the Italian private care market and their manifestations of psycho-social malaise, the latter being one of the main factors motivating the access to health services for migrant private carers (MPCs) employed in Italy (1,2). As will be highlighted, this incidence appears to be closely linked to the high level of de-structuring of this occupational sector.

In Italy, the growing demographic weight of the elderly population and the increasing participation of women in the labour market have not been accompanied by suitable policies of care support and conciliation between productive and reproductive work (3). Hence the increasing problem of non-self sufficiency and the families' shortage of care resources have not found any institutional answer (4). Within a family oriented welfare model, organised around a traditional social asset which is quickly disappearing, and a social welfare oriented much more towards the transfer of cash allowances than to the production of public services, families are assigned a vicarious role in the offer of care services (5). Overburdened with assistance responsibilities, they tend to farm out care work to privately paid workers (6,7). In the Italian private care market about 830,000 carers are employed (regularly or irregularly) (8). Ninety percent of them are migrants[1], for cultural reasons mostly women[2]. The total expense sustained by families within the private care market is about 9.8 billion euros (9). Out of 2.3 million non-self-sufficient elderly people living in Italy, about 1 million are assisted by a private carer (8). In line with a public expenditure for long-term care (LTC) limited in economic terms and below the average of EU countries, this is the main form of assistance provided to elderly people with LTC needs, after that provided directly by their families (10). All this clearly shows that the private care market has become a crucial actor within the overall Italian welfare system.

Nonetheless, we are dealing with a spontaneous social adjustment, generated by the accidental meeting between two pressing needs: that of families devoid of care resources, and that of migrant women seeking for work (11). Developed beyond any institutional regulation, the Italian private care market has not developed, as has happened in other EU countries, into more qualified and efficient market models, and still appears as a stopgap solution, characterised by several dysfunctionalities (12). Among these are the low level of qualification, due to the scant value assigned to professional competences in this sector, and the subsequent underestimation of professional training (13). Besides, a model of continual assistance, involving 60% of the carers employed in Italy (8), envisages the cohabitation of carers with those they assist, and the right to only two free hours per day and one free day per week, giving rise to exhausting working rhythms and deep isolation (14). Furthermore, there is a lack of any institutional intermediation between family and carer, which develops in the informal sphere. Starting from the recruitment stage, which occurs through the word-of-mouth process due to the absence of institutional mechanisms able to guarantee quality and transparency (15), families have to manage the presence of an employee mostly autonomously and without the necessary competences (16). Moreover, the care relationship develops in the domestic space without any possibility of external monitoring, with potential risks for both parties involved (17). In particular, the cohabitation between carers and those they assist (and sometimes the latter's family) implies a continual negotiation of rules within a high asymmetry of power (18), with high risk of abuse for the worker (19). The risk of exploitation is exacerbated by the strong diffusion of irregular work, which concerns 62% of the carers employed in Italy: 36% of the total are undocumented migrants, while 26% just do not have a regular employment contract (8). The cost of a carer can barely be sustained by some families, for whom physical evasion becomes a sort of "survival strategy", but the absence of an employment contract is often seen as an advantage by both parties involved(20). Therefore the Italian care market appears to be a semi-submerged sector, marginalized and particularly difficult to manage, mostly because of the presence of single workers rather than collective organisations (21). This prevents workers from mobilizing for claiming their rights (22).

The overall invisibility of this sector prompts some authors to describe it as a "hidden welfare" (23). Although in recent years several regional and local institutions have started to promote interventions for the qualification, regularisation and support of the private care market (24), we are dealing with the very first steps towards the integration of private care in the LTC system. A good level of policy coordination and a situation of homogeneity on a regional and local level are still objectives to be attained, and the improvement route is still at its beginning (10). The situation remains critical, with heavy consequences for the psycho-social well-being of MPCs (25).

The latter are often unaware of the serious impact of their malaise on their present and future health and

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[1] According to IRSS estimates, in 2013 about 57% of migrant carers employed in Italy come from post-Soviet countries, about 33% from South-America, and about 9% from Asia and Africa. Their average age is about 40. They usually emigrated alone in their middle age, leaving their own families behind.

[2] The emigration of those women who provide Italian families with care resources implies a care drain from their countries of origin.

have no possibilities for preventing, reducing and coping with its negative effects, accruing extreme risk levels and triggering vicious circles difficult to break out of also in the long term. For example, some authors1 (26) highlight that, if not adequately managed, the psychosocial malaise accumulated in Italy by MPCs tends to remain also in the case of permanent return to their home country: some Ukrainian psychiatrists have identified among these return migrants a specific depressive disorder classified as "Italy syndrome" (27). Indeed, this malaise is a significant social phenomenon, which however, being produced within a "hidden welfare", tends to be ignored or underestimated by public opinion, and to be approached superficially by the scientific literature.

Focusing attention on this meaningful consequence of the shortcomings of the Italian welfare system, this article examines in depth MPCs' malaise from a sociological perspective. Based on qualitative data collected work in 2009-2010 in Italy (1), it describes how the malaise of MPCs is generated, and how it is interpreted and expressed (or not expressed) by them. In particular, it investigates the social dynamics determining the latent nature of this phenomenon, and its tendency to work silently on MPCs' subjectivities without coming to the attention of health services, which are therefore not able to prevent or limit its negative consequences. Nevertheless, this article also shows that this malaise sometimes (albeit too rarely, or too late) surfaces in the health service, and how it is generally managed by health providers. In particular, a timely encounter with the health system involving the simple externalisation and acknowledgement of this psycho-social malaise can have a crucial therapeutic value, meaningfully helping to prevent it from becoming a serious condition. On this basis, the importance is highlighted of creating channels for facilitating the meeting between this pressing but unexpressed health need and the institutions in charge of the health of society. Preventing and treating MPCs' malaise means neutralizing a risk factor with multiple negative effects. This malaise obviously affects MPCs' quality of life, but also their professional care abilities and hence the well-being of those they assist and their families.

Materials and Methods

The research work: epistemological and methodological frame work

This article is based on a qualitative data collected in 2009-2010 in the territories of Parma, Reggio Emilia and Modena, which boast some of the best-organised social and health services in Italy. The analysis revolves around a basic question: given the critical knots existing in the Italian private care market, what is the relationship between MPCs' psycho-social well-being and their professional life in Italy? Once the close links between MPCs' work and their widespread condition of psycho-social malaise were verified, the factors influencing this malaise are analysed in depth, as well as its interpretation and expression by MPCs and its manifestations and management within the health services.

This investigation's epistemological framework largely draws on the social systems theory (28-30) and on social constructionism (31,32). Based on the assumption formulated by the social systems theory that the focus of sociological analysis is communication, this work explores a set of processes of communication, that is, of narrations shaped as interviews, through which it is possible to approach the representations, experiences and perceptions of MPCs. Particular attention is paid to those processes of communication which are constructed, within communication, as narrations of malaise. Therefore, the malaise[3] analysed in this work is a socially constructed phenomenon[4].

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[3] The choice of observing and describing their tales of malaise, without qualifying them *a priori* either as illness or as health compromised by an as yet sustainable malaise, arises from a reflection on the culturally constructed nature of the concepts of health and illness. Without defining the latter *a priori*, malaise has been allowed to express itself through the words of the narrators, who are free to describe it and to place it above or below the porous demarcation line between health and illness. This way of analysing has maintained a transcultural outlook, valorising to the full the richness of expression of the narrations collected and gathering the cues for critical reflection that these provide as to the society and culture in which the malaise arises.

[4] The production of the psychic system can be observed by the social scientist only when it finds expression in communication, through an individual's participation in a social process. Since each communicative action gives rise to a comprehension, it is obvious that individual participation in the communication is subject to a process of social construction that lends meaning to it.

Adopting a qualitative approach, data were collected through 32 in-depth interviews with MPCs, a focus group discussion involving seven MPCs, and 23 semi-structured interviews to providers working in close contact with MPCs, in different services.

MPCs were recruited through the support of two organisations providing services to these workers. Altogether, 37 migrant women were involved[5], who, either at the moment of the interview or in the past, experienced working in the private care sector. They have different national origins: 25 are from post-Soviet countries (Moldova, Ukraine, and Romania), eight from south-America (Ecuador and Peru), two from Western Africa (Ivory coast and Senegal), and one from Asia (the Philippines). Their ages range from 21 to 60 years, but the most represented age bracket, comprising 33 women, is from 40 to 60 years.

Providers were recruited through a snow-ball methodology. Most of them represent the health service: five psychiatrists, four psychologists, two specialists in infectious diseases, two general practitioners, two linguistic and cultural mediators, one specialist in preventive and public medicine, and one paediatrician, working in hospitals, territorial services and clinics dedicated to undocumented migrants. Moreover, albeit in smaller numbers, professional training agencies, trade unions, social services, and non profit organisations are represented in the study.

If, on the one hand, MPCs were invited to speak freely about their experience of migration, work, and malaise (if any), providers were questioned about their standpoint on MPCs' experiences, and about their own professional experience when dealing with these migrants. Thus, the explored phenomenon is observed through different perspectives: a more involved standpoint, and a more indirect, detached one, specifically linked to MPCs' relationship with the Italian services (particularly the health services, given the composition of the providers' group).

Results (Migrant carers' malaise: production processes, subjective experiences, and encounters with health services)

Main causes

A dangerous interweaving

The data collected clearly highlight the considerable diffusion of psycho-social malaise among MPCs working in Italy. In particular, health providers consider it to be one of the main factors motivating the access of MPCs to health services. Besides, as will be shown further on, a close relation emerges between the psycho-social malaise of MPCs employed in the Italian private care market, their professional conditions, and their position within the labour market. A fourth factor is relevant in this relationship: the meaning generally assigned by these migrants to their migration project, implying the very high value assigned to work as a source of income, which, as will be illustrated, strongly influences the generation, expression and management of malaise. Before analysing in detail every factor involved in this interweaving, it is important to highlight that there are three conditions which tend to strengthen its negative effects on MPCs' psycho-social well-being: the fact of being undocumented migrants, their cohabitation with those they assist, and the separation from their family, especially from the children they have left behind. At least one of these conditions was experienced by all the migrants interviewed, usually for several years at the initial stages of emigration[6]. All the narrations of malaise analysed in this work refer to a period characterised by at least one of these conditions.

An all-absorbing value

Let us firstly focus on the most common interpretation of the migration project. MPCs tend to perceive themselves as the driving force of a transformation process able to improve the living standards of their families left behind. The willingness to activate and

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[5] Two of the migrant carers who were interviewed in depth also participated in the focus group discussion.

[6] Irregularity, which often lasts for years, generally comes to light thanks to the amnesties periodically brought out by the Italian government. Family reunification usually occurs only after several years of stay in Italy, owing to migrant carers' situation of irregularity, economic difficulties, and logistical problems linked to cohabitation with those they assist.

strengthen this process is what triggered and keeps alive, often much longer than expected, their migration projects, founded on expectations of change[7]. The lifeblood of this transformation, which is the main motivation for migration, is work, or, more precisely, the income which it generates. Although MPCs are aware of being the main agents of their migration, they tend to perceive themselves as passive and powerless subjects. They feel themselves to be the victims of their migratory project, interpreted as a self-inflicted sacrifice made necessary by an adverse fate, and by their perceived duty to care for their families' economic needs. Thus the motivation and strength for overcoming the difficulties of migration comes from the sense of affection towards their families. The emotional lever which supports the migratory experience is precisely the attachment to what has been made absent by migration. Hence the feelings of homesickness, loss and grief become the cornerstone of the migratory project. This accounts for the persistence of a nostalgic attitude which, instead of featuring only in the first period of life in Italy, tends to endure over time, hampering these migrants' integration process.

As has been seen, work intended as a source of income is the essential ingredient which gives sense, from their own stand point to MPCs' migration projects. Sending remittances is their only way of expressing their attachment to their families over the long distance.

"Work becomes so important because you have left home, the only sign of your presence is the money you send" (MPC)

Before migration, this attachment was expressed through intimate communication, characterised by love. MPCs feel that, by making the decision to migrate, they have become guilty of distorting this intimacy, as distance renders love less effective in communication.

"In the distance love is..." "Filtered" "Abstract". Loving means being close, covering with a warm blanket, cooking something. Otherwise saying on the phone that "I love you"… "If you love me, then why are you not here?"" (focus group discussion– FGD)

In contrast money, produced through work, appears to have a strong communicative power over the distance. Therefore it is used in communication not only for fulfilling the expectations of socio—economic change, but also those affective expectations which generally characterise family communication. Thus money becomes a sort of surrogate of love, but reveals itself to be unsuitable in this role: affective expectations are constantly frustrated.

"Sending money isn't the same as being a mother, sending money, making gifts, does not give you affection. You don't feel gratified as a mother, that maybe you sowed what you wished." (MPC)

This is a source of malaise, to which MPCs react, paradoxically, by increasing their investment in work. They put all their energies into the effort of producing income, hence remittances to be sent home. This is the only strategy they know, although they are aware that it is vain, for trying to give sense to their absence and to alleviate their feelings of homesickness. Still, affective expectations in family communication remain unfulfilled, and a vicious circle is triggered towards an increasing focus on work, strongly reducing the possibilities of integration in the community of residence, already limited owing to the isolation implied in care work. The subsequent feeling of uprootedness reinforces the emotional attraction towards the community of origin, hence the projection towards the memories of the past and the intention of future return, constantly postponed. Work then becomes the only reality able to give a shape to everyday life and to fill the present dimension.

Work even becomes all-absorbing when MPCs realize, with dismay, that distance is wearing out every link with the "elsewhere" homeland they are longing for. Hence work, the main cause of their uprootedness,

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[7] According to the theory of social systems, contemporary western society, which is a functionally differentiated one, is characterised by two opposite but interdependent cultural presuppositions: individualism and personalisation. The communicative processes imprinted on individualism are animated by cognitive expectations, that is, expectations of change. The result expected in communication is innovation and development. Competitiveness among individuals takes on a positive connotation: through action, the individual must show himself to be capable of being better than his competitors. The individual, by continually improving his performance, must attempt to conform to the best of his ability to the role he plays in society. The participants in this communication are treated as roles and their contributions as heteronomous, generalised and reproducible.

appears to be the only handle they can grasp so as not to fall into the looming void.

"We have remained out of everything. We try to help this one and that one, but we do so because we realise we are detached from normal life, and the only thing we can do is make some money" (MPC)

Thus work represents a precious commodity, to be sought and safeguarded at all costs. To this end, MPCs make exhausting efforts, perceived as highly dangerous for their physical and psychological well-being. However concerned they may be for their present and future health, conceived as essential for safeguarding their job, they do not adopt any self-protecting strategy. For instance, they often prefer cohabitation with those they assist to working on an hourly basis, as this reduces living costs. Furthermore, they tend to do other jobs in their very limited free time, giving up their right to rest and putting their health in serious danger.

"I've been in Italy for six years and I've been working every day, also on Sundays. … […] My friends tell me I should stop working on Sundays, but by now it has got into my blood, and I can't change things." [MPC]

Work as a risk factor: a global affective investment

After analysing the critical implications of the peculiar function assigned to work, let us now concentrate on its most critical contents from the perspective of MPCs. They tend to conceive their profession as a process of communication based on intimacy[8]. An individualistic culture of work, where professional roles are performed on the basis of standardised rules, is all but absent. According to MPCs care relationships should be featured by a tight link of affection.

This tender familiarity, often described by MPCs in impassioned, idealizing tones, seem to answer and to be partly influenced by their pressing need for affective support. Love, which has become so weak in family communication, can instead find some place in the work environment. Besides, in the absence of any professional training, MPCs interpret their professional activity through their cultures of origin, which usually emphasize the dimension of solidarity in care activities. Moreover, they conceive it on the basis of their past experience, which saw them lavishing thoughtful assistance on their close relatives.

In their turn, employing families, not used to playing the role of employer and incapable of assigning a professional context to private care work, tend to interpret carers' role as a mere replacement of family members in their function of assistance and affective support. This conception implies the expectation of an intense relational involvement on the part of workers.

As a result of these interwoven factors, MPCs tend to confuse the relational competences of their profession with a global involvement of their persons. We are dealing with an all-absorbing affective investment, so different from the emotional detachment which characterises any professional performance and which has an important protective value.

"With a part of your brain you say: "this is work, then you can leave this job, if it is too much for you". With another part, really inside, you feel guilty, because you say: "this person is fond of me, how can I leave?". […] You can not make the separation, and this destroys you" (MPC)

Mostly in their first years of care work, MPCs have to face delicate tasks while feeling incompetent and devoid of the necessary professional preparation. This arouses in them feelings of anxiety. The impression that those they assist totally depend on them is very widespread and this implies the difficulty to relax, even during their limited free time. Tensions and concerns about those they assist follow MPCs out of their workplace, and intense guilty feelings arise when they discover that negative changes have occurred during their absence.

Therefore, MPCs are subjected to two centrifugal forces, which prevent them from listening to their own inner voice: on the one hand, the steady will to make every effort to improve the living standards of their

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[8] In intimate communication, that is, the communication featuring personalisation according to the theory of social systems, each participant is treated in the communication as a person. In the intimate communication, role performance has no value, only trust and love for the person. Each communicative action is oriented towards the experience of the other participant of this trust and love. Individuals are valorised, not for the type of intelligence that enables them to prevail in competition, but for their emotive intelligence or their sensitivity. The expectations are affective, designed to confirm the uniqueness, the specificity and the autonomy of the other person.

own families, and on the other the desire, based on affection and sense of responsibility, to increase the well-being of those they assist. This desire usually prevails over their personal needs, with the result that they do not claim their basic rights to rest and health.

Work as a risk factor: perception of denied freedom

Another perception closely linked to malaise emerges which is worth looking at in greater depth: the frequently recurring association between care work, mostly in cohabitation, and denial of freedom or imprisonment. Several forms of limitations of freedom are described, ranging from highhandedness and abuse of power perpetrated by others to self-imposed sacrifices.

In this respect, MPCs' perception of their weak position within the Italian labour market is very relevant. They consider the private care market as tending towards saturation, mainly owing to a decrease in demand: because of increasing unemployment, Italians find new care resources inside their families. Hence work is a precious, but rare commodity, and this meaningfully decreases carers' negotiation power towards employers. Moreover, MPCs are convinced of their professional segregation within private care, because of the peculiar characteristics of the Italian labour market, but also for their impossibility, linked to their very scarce free time, to undertake qualifying professional training or the procedures for the recognition of the qualifications acquired in sending countries. The only alternative to working in cohabitation is work on an hourly basis, a kind of job, however, where the competition of Italian carers is quite high.

Thus for many migrant women care work in cohabitation is a sort of cage, and the heavy self-denials it requires are unavoidable. Particularly hard is the feeling of being constantly subjected to someone else's will, even in the most simple, necessary acts. For MPCs it is very difficult to find some privacy within the restricted domestic space. With discretion, they live and work as guests in someone else's house, trying to adjust to the rhythms and rules governing the private sphere of those they assist. This gives rise to continual tension and the repression of their most spontaneous and intense feelings, for the tranquillity of those they assist .

"I was unhappy, but at work I played the part of a clown: always smiling and cheerful. But at night I cried" (MPC)

Relational life is limited to the domestic microcosm and to a duality where migrant workers represent the most proactive party. The daily routine, with its chain of gloomy thoughts revolving around the difficulties linked to migration and the professional contact with suffering, often involves accompanying a person towards death.

The condition of isolation implies the difficulty to externalise the daily accumulated suffering. Conversations with co-nationals, precious moments for the exchange of work experiences, have an essential consolation value, but tend to be too rare and brief. Moreover, the network of co-nationals is characterised by a high competition for work and this hinders the free expression of carers, afraid of circulating information which could compromise their capability to find a future job. Phone conversations with their families have a crucial emotional value, but do not help MPCs to externalise their malaise: a very protective attitude is adopted towards their relatives, who are kept unaware of the hardships experienced in emigration. The employing families can hardly become the recipients of MPCs' confidences, as they are often too involved in the experiences which need to be communicated. Hence, MPCs have very few possibilities for giving vent to their emotions, which would help them to come to terms with their hard, sometimes traumatic experiences. As will be seen in greater depth, this results as being one of the main risk factors for the rise of serious forms of psycho-social malaise.

The perception of denied freedom becomes even more oppressive when the relationship with the assisted subject is problematic. In fact, it is quite common for carers to become the target of the frustrations of those they assist, caused by the perception of non-self-sufficiency or by the fear of being abandoned by their relatives. If we consider that this rage is often fed by prejudice towards a foreigner who has entered their private sphere, we can fully understand the complexity of some care relationships, which can give rise to despotic behaviours ranging from psychological violence to sexual harassment. The issue becomes even trickier if the assisted person is affected by forms of dementia, often involving personality alterations and manifestations of aggression. Owing to the absence of training, these behaviours are often interpreted as intentional abuses, endured with frustration and humiliation. Only after years of professional experience is this misinterpretation corrected.

Professional experience provides little help in accepting the abuses perpetrated by other members of employing families, which provoke in MPCs an unexpressed rage. These mistreatments have to be placed in a context in which families are weighed down not only by the psychological burden of their relative's disease, but also by the significant economic and organisational effort involved in the carer's employment. Conflict arises mainly when the carer's salary is not correctly paid and her free hours are not respected.

MPCs' reaction to injustice tends to consist of resigned patience, linked to the fear of losing their job and to the conviction of powerlessness in claiming their rights in an effective manner.

"I remember that on the first day I didn't put tomato sauce in the minestrone, and she hit me. It was a Friday, and on Saturday I wanted to leave, but where do you go? What can you do? Nothing." (MPC)

Frail workers

So far we have analysed those of the functions and contents assigned by MPCs to their profession which contribute to generating their malaise. The sphere of work appears to be very relevant in this respect, but there are other factors contributing to the fragility of these workers, including the difficulties linked to migration, or traumatic experiences that occurred before migration or during the journey to Italy, such as sudden economic downfalls due to traumatic historical circumstances, family breakups such as divorce or alcohol abuse on the part of their husbands, or reaching Italy through the intervention of smugglers. In this case, the journey represents a dramatic experience, which absorbs all their emotional energies and leaves them devoid of psychological resources for adjusting to their new life. Hence care work can constitute either the main cause of malaise, or the factor which upsets an already precarious and fragile psychological balance.

Interpretations, manifestations and management

Without the right to be vulnerable

After analysing the main roots of malaise, let us now concentrate on its interpretation and expression on the part of MPCs. Firstly, they tend to describe their malaise as an illness, and more precisely as an illness that affects the psyche rather than the body. Malaise manifests itself through feelings such as self-absorption, crying without reason, or intense agitation or irritation. In this situation of emotional fragility, the work of the carer, who constantly has to put the needs and emotions of others before her own, is extremely difficult. Nonetheless, MPCs call on all their self-control to enable them to carry out their daily duties impeccably without the least change in rhythm. By creating small pockets of privacy in the house of the person they assist or by recourse to alcohol, they experience fleeting moments of escape, albeit temporary, from their excessive emotional burden, with all the risks that this entails, not only for the well-being of the carer but also for that of the person in her care, who is being entrusted to someone emotionally unstable.

"Luckily, I have never hurt anyone, because when you're nervy, you don't realise what you're doing. This is why I would go into the bathroom and hit something, to relax and calm down" (MPC1) "When my head is exploding, I open a bottle of wine and drink it by myself till my head is spinning and then I go to bed." (MPC2)

The aim is to manage the malaise in solitude. In fact, MPCs make intense efforts to hide every sign of malaise, above all from their employers. As has already been said, this silence is one of the main reasons why malaise becomes so extreme as to be pathological. It is due to the exulted value attributed to work and to the conviction of MPCs that the receiving society expects them to carry out their duties tirelessly. Presuming that in the houses of Italians there is only room for workers who are efficient, healthy and not likely to fail, MPCs tend to conform to this model, avoiding an appearance of fragility.

"I was exhausted but couldn't speak about it to anyone. I was afraid of losing my job. I worked for a very nice family, but in this case the family needs a healthy, normal person to work there" (MPC)

The will to work hard induces these carers not only to hide from others all traces of malaise, but also to deny themselves the right to be vulnerable, concealing even from themselves the consequences deriving from their work. It thus becomes difficult for them to link their malaise to their daily vicissitudes. While the association is immediately apparent to the operators as well as to the other workers who observe their workmates or analyse from a distance their own past experiences of malaise, the sufferer herself has trouble recognising it and hence does not put in place any self-protective strategy.

Determined not to allow themselves any weaknesses, the MPCs are deaf to any sign of their malaise until it reaches such a level as to compromise their professional activity. Sometimes, this happens suddenly, in the form of acute psychiatric pathologies. More often, the malaise manifests psychosomatic symptoms. And with the onset of physical pain, the malaise finally comes to the attention of the national health service.

However, there may be a certain difficulty on the part of these carers to use the health services because of their lack of free time and, for migrants without papers, the fear of being noticed by an institution. Services dedicated to migrants without papers or migrant-friendly clinics operating expressly during domestic carers' free time, generally made known through the networks of co-nationals, are an extremely useful resource.

When the malaise ends up at the door of the health service, it emerges gradually. In fact, almost in the same way as the work relationship with the employing family represents the only way in which to interpret the relationship with the receiving society, their relationship with the health institution, especially prior to the creation of a trustful linkage with the doctor, tends to be seen by MPCs as a professional one in which the patients valorise to the maximum their own worth in terms of the workforce. Hence, even when aware of it, carers are initially unlikely to air to the health worker their own emotional instability, whereas they are willing to speak about their abdominal, joint, back or heart pains, or about their tachycardias, their irregular menstrual cycles, their breathing difficulties and their insomnia, the symptoms most frequently reported by MPCs to motivate their access to the health service. In any case, these are messages rich in meaning that, if properly interpreted by the health worker, can be of significant preventive value.

Meetings with the health service: the therapeutic value of listening

We began by describing how malaise tends to destroy silently, with no escape valves. We then analysed how difficult it can be for the phenomenon to come to the attention of the medical profession, and then only when it has become a physical problem that is detrimental to the carer's professional capabilities. Let us now see how malaise that comes to light can be managed and treated within the health service. It is, however, important to remember that this analysis will be based on the narrations of operators recruited according to their sensitivity to the subject of inquiry. What follows will not therefore be so much an inquiry into the abilities and methods of the national health service to deal with the psychosocial malaise of MPCs, but rather a description of situations managed competently, showing the potential for interventions that, if timely and sustained by adequate methods and instruments, can significantly limit the devastating damage of the malaise.

During the first visit, two fronts are opened up: an evaluation is made of the physical health of the patient, and in addition she is encouraged to talk about the daily vicissitudes of her work. Interestingly, this invitation to talk tends to yield an extremely positive and immediate response on the part of the patients. Revealing their need to communicate, MPCs show themselves to be open to dialogue and keen to provide details of their daily difficulties.

"If usually between one patient and another we calculate ten minutes, in the case of carers it is twenty or thirty minutes. Because they have an incredible need to talk, they are waiting for nothing else!" (HP)

The visit thus tends to become an open interview that, besides making clear to the doctor the probable psychosomatic aspect of the problem, is in itself a meaningful therapeutic tool.

"I went to the doctor's: "I can't sleep at night, my back and kidneys ache", and he gave me some medicine for the evening [...]. But he also began to ask me questions, I

began to speak about home, to relax, as if he was a psychiatrist, and I realize that this helped me" (MPC)

The sense of comfort and reassurance deriving from this form of release sets off a process of psycho-physical improvement, enabling the patient to attribute a meaning to the malaise and to understand its more evident causes. Becoming aware of the link between life conditions and the presence of malaise allows the carers to accept their own vulnerability without self-blame. Also very useful and reassuring are indications as to recognising and managing the symptoms of the malaise in the best way possible.

Experienced operators have learnt not to suggest directly to carers that they adopt more sustainable and less harsh working conditions, since this does nothing to make MPCs aware of their own limits; instead, in great conflict with the motivation of the migratory project, it merely increases their anxiety. The preferred method of treatment is thus pharmacological, which fits in with the temporal limitations of live-in care work. Although this often has a positive impact on the health of carers, the necessity to pursue a tough work assignment in the presence of serious malaise can considerably aggravate the condition.

"They are in this difficult position of not being able to give up their job, but of not being able to go on either. So they accept this psychopathological situation, they take medicine and they struggle on. But because of this, one of my patients attempted suicide." (HP)

Instead, a therapeutic strategy centring around dialogue and active listening, if necessary with pharmacological support, will reveal over time the potential for restoring to MPCs a sense of their real needs. Once they begin to gradually disconnect from the centrifugal forces that have thrown them into disarray, they begin to regain their identity, start listening to their inner selves once more and become aware of their own limits, enabling them to choose acceptable work and better working conditions.

We can see, then, that the timely encounter between MPCs and health service, albeit too rare, has great preventive potential: placing the malaise within a protected space in the presence of competent operators is essential for instilling in MPCs the need for self-protection strategies and for claiming their right to good health.

Conclusions

Despite having become an essential part of the national welfare system, the Italian private care market has developed in a situation of institutional disengagement. As a consequence, this sector, which has a high presence of female migrant workers, is currently characterised by serious flaws. This analysis highlights the heavy costs of these shortcomings for the psycho-social health of MPCs, with obvious repercussions on the well-being of the other subjects involved: elderly dependent people and their families.

In recent years, still unanswered concerns about the quality of service provided in private households have arisen. Several interventions and measures have been activated by local institutions towards the regularisation of the private care market, the transparency and reliability of matching mechanisms between supply and demand, the implementation of a qualified training system, and the inclusion of MPCs in a professional community. In particular, the relationship between MPCs and the formal service system has become a crucial issue10. The pathway towards an integration of MPC within the LTC system is still at the beginning, as it currently consists of a series of interesting but sporadic experiences still not part of a coordinated and organic system. Nevertheless, borrowing these concepts from the analysis of the relationship between formal services and informal family care givers, we could say that a promising tendency is observable towards a shift from the conception of MPCs as a resource to their definition as co-workers (33). In other words, the formal sector, instead of conceiving MPCs as providing a separate, taken-for-granted service, increasingly tend to work in parallel with them, aiming at a cooperative and enabling role. Instead of perceiving themselves as free of any obligation and responsibility towards the private care sector, formal services tend to relate more actively to MPCs and to support them, in order to improve the quality of their professional performance and the ease and safety of those they assist.

Nevertheless, the serious situation of malaise described in this article, albeit often latent, is widespread among people employed in the private care market, suggesting the appropriateness of observing MPCs not only as co-workers, but also, in various circumstances and contexts, as co-users (33). This means also regarding them as the potential subjects of interventions carried out by the formal sector, which should become responsible for their well-being, considering it not only as a means for the health and safety of those they assist, but also as an end in itself.

This double orientation, promoting the role of MPCs as both providers and users, should stem from the acknowledgement of MPCs as potentially vulnerable workers, whose psychosocial well-being warrants particular safeguarding. It is a well known fact that all care workers are placed by virtue of their profession in situations that are particularly vulnerable with regard to psychosocial health: favouring the quality of their professional performance also means preserving their well-being in their work.

The health service is particularly concerned with this responsibility and could play a central role in this field. This article highlights the difficulty in surfacing of MPCs' malaise in the health service because of social factors hindering its acceptance, acknowledgement, and expression on the part of MPCs. When it actually takes place, the encounter is often too late, occurring when malaise has already reached extreme levels and is difficult to repair. However, the analysis has shown that, when treatment is timely and competent, it has an important function of containment, succeeding with time in prompting MPCs to be aware of and to adopt safeguarding behaviours that are fundamental to their well-being, in the same way as for the quality of their professional performance.

On this basis, with a view to prevention in the face of a phenomenon of great social impact that tends to be latent and to escape timely intervention on the part of the health service, there emerges the usefulness of outreaching actions based on a participatory approach, in the perspective of community welfare. This means, first and foremost, promoting the capacity of the services to meet the subjects halfway, without waiting for them shut up in their rooms; to intercept at an early stage and accompany the patient's malaise and to bring territorial proximity to groups and individuals, instead of waiting for the users at the outpatients' department or, worse, at the emergency department when the problem has already become unbearable or chronic (34).

Furthermore, in tackling a problem originating and generating from a wider social malaise - the unresolved question of non-self-sufficiency - the service should plan interventions able to activate a collective response to the malaise and to involve the whole community in helping to combat social suffering. Actions programmed on this basis, capable of actively involving not only MPCs but all those stakeholders involved in the issue of non-self sufficiency, could set in motion virtuous circles able to bring MPCs out of their existential and professional isolation. Moreover, such initiatives could help to create bridges between MPCs, civil society, social health services and other institutions, setting into motion ideas, resources and plans for an integration between the formal and informal care systems and, more broadly, for a more sustainable management of the problem of non-self-sufficiency.

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