

**THE INSTITUTION DENIED**

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**Introductory note to the new edition *by Franca Ongaro Basaglia***

**At the beginning of the 90s, when there was still discussion and battling on the modification or defense of the law "180" - as unanimously approved in 78 as opposed to its implementation - I felt the need to resume the radicalism of the issues and practices which had led to its emanation. The debate had now flattened out on the "ambition" of a law which, born under the pressure of practical experiences which, from the beginning of the 1960s, had shown that it was possible to overcome the asylum through the creation of territorial services, imposed it without offering the tools needed to implement it 1. On this basis, for more than fifteen years the discussion - both at parliamentary and public opinion level - has revolved around the modification of the law rather than the realization of concrete answers to the problems2. Under these conditions, the deeper meaning of the "institutional overthrow" implemented had, over the years, almost disappeared, now reduced to a sterile - albeit necessary - dispute between supporters and detractors of a**

**reform law that appeared to be no longer linked to the service to citizens that it should have produced, allowing to continue to do nothing on a practical level, pending its radical modification. It had come to the paradox that precisely those who, for the first time, were concerned and occupied with the conditions of the mentally ill, were accused of being responsible for his total abandonment.**

**To get out of this vicious circle that led nowhere - not to the creation of the adequate services that were dramatically required, not to a change of culture, but to a general aggravation of the problem - I had started a reconstruction of the "facts" (of how, that is, a law had been reached on the abolition of the asylum, approved almost unanimously), to make known the quality of work and the climate that characterized the experience in which the thing had proved possible.**

**I didn't want to tell the story in the first person. Instead, I was trying to reconstruct the process of change through the choice of fragments of "writings" which, chronologically, gave a picture of what had happened. When the work was finished I found myself faced with a dead thing: words, judgments, speeches, reflections that did not directly account for the facts, the minute things that were changed step by step and the meaning they assumed. It was a "reasoning about" an experience -**

**criticism and self-criticism - from which however vitality, physicality, fatigue, concrete contradictions, anxiety, difficulties, affectivity, sense of relationships and bonds escaped. Therefore, the life lived in Gorizia in those years did not transpire and it seemed to me that a rationalization of the facts did not serve to convey the "how" and "why" things had been possible, so that others could proceed. For me that was the purpose of the operation. After so many misunderstandings, intentional and unintentional *(mental illness does not exist; our patients are different from "these", ours are really serious, etc.)* , it was necessary to make known - after thirty years - the daily problems of "Open" and how it was possible to bring life back to those forgotten places and return to life "outside" so many people who have been canceled and disappeared.**

**I gave up waiting for the favorable moment to reprint the collective books, born in the course of work, which recorded, in real time, discussions, judgments, reflections on those concrete and minute things that marked the change and which, therefore, were books " alive".**

**For this reason - now that the asylums must be closed - it can be useful for young people, for students, for today's operators, to republish those documents in which so many voices tell step by step how these tragically useless institutions have come to be demonstrated: documents where all questions are still open e** **they re-propose the dramatic relevance of the themes then the subject of concrete discussions and overcoming.**

**Last year, in this same series, *What is Psychiatry?* . Released in 1967, it photographs an asylum that opens up, starting a process of liberation that would have set in motion another way of looking at the problems of diversity, closure, custody, protection, repression. However, there were still major limits to the value of the experience: two out of eight wards were still closed, the asylum was still there, both in terms of facts and in the possibility of reconfirming or proposing it again. It was therefore a stage of a process that had to continue and that would have proved its validity in the possibility, on the part of the liberated community, of holding onto total openness and in the ability to manage its problems.**

**It is in fact with *The Institution denied* of '68 that this problem explodes with all its strength, opening the doors to an institution, a science and a society that show their naked face in its most hidden shame: gratuitous violence and inhumane towards the most derelict, violence that made raped and rapists inhumane.**

**It all begins with a "no".**

**In the introductory part Franco Basaglia summarizes this** **the initial meaning of the experience:**

* ***We dialectically deny our social mandate which would require us to consider the sick person as a non-man and, by denying it, we deny the sick person as non-man.***
* ***We deny the dehumanization of the sick as the ultimate result of the disease, attributing the level of destruction to the violence of the asylum, the institution, its mortifications and impositions; which then send us back to the violence, the prevarication, the mortifications on which our social system is based.***
* ***Depsychiatrization is somewhat our leitmotif. And the attempt to put every scheme in parentheses, to act in a terrain that has not yet been codified and defined. To begin with, we can only deny everything that is around us: the disease, our social mandate, the role. That is, we deny anything that can give an already defined connotation to our work. When we deny our social mandate, we deny the sick person as an irrecoverable patient and therefore our role as simple jailers, guardians of the tranquility of society.***
* ***It is not that we ignore the disease, but we believe that, in order to have a relationship with an individual, it is necessary to set it independently of that***

***which may be the label that defines him ... The moment I say: this is a "schizophrenic" (with everything that, for cultural reasons, is implicit in this term) I relate to him in a particular way, knowing precisely that schizophrenia is a disease for which there is nothing to be done: my relationship will only be that of one who only expects "schizophrenia" from his interlocutor ... For this it is necessary to approach him by putting in parentheses the disease because the definition of the syndrome has now taken on the weight of a value judgment, of a labeling that goes beyond the real meaning of the disease itself. The diagnosis has the value of a discriminating judgment, without thereby denying that the patient is ill in some way. This is the meaning of our parenthesis of disease, which is parenthesis of definition and labeling. What matters is to become aware of what this individual is to me, what is the social reality in which he lives, what is his relationship with reality. This is why meetings are important, because they are the terrain in which confrontation beyond any categorization is possible.***

**On this denial - which is the rejection of the denial of the mentally ill implemented by psychiatry in dealing with an abstract definition that in some way**

**take no responsibility - the whole game is played. It is a radical denial that includes institution, disease as labeling, psychiatry, hierarchy, roles, society, starting from the analysis of what produces power " *as sources of regression, disease, exclusion and institutionalization at all levels* ".**

**From this we can well understand the impact of the release of *L'Istituzione denied* in '68, given that Gorizia, since the early 1960s, represented in practice the unmasking of the presumed neutrality of science, a concrete questioning of what young people were rejecting of their life, in the breaking of patterns, roles, authority and in the prefiguration of the "fantasy in power".**

**But, as we have learned, every negation is possible, in practice, if you build something else together: in asylum overturning if, together, you look for other ways, other tools, other life projects which, starting from a closed and all-encompassing reality (l 'Institution Total of Goffman), are capable of producing a protection that does not appropriate the protected person, but that starts from the recognition or the conquest of lost or never had rights (" *Rehabilitation is possible only starting from this real fact: the patient [ interned] is a man without rights and we discuss with him his being without rights* "). Are thefirst steps towards a concept of health and disease that you**

**relationships also with the living conditions of the person; that refuses the punitive nature of the therapy while acting it; that you accept to move in the uncertainty and anxiety in which you find yourself operating when the role does not repair you, does not defend you. Aware of the fact that it is this uncertainty, this exit from the role while playing it, that allows us to proceed in facing the true nature of conflicts, moving them to increasingly understandable and shareable levels. *The denied institution* is therefore the recording of a continuous discussion and reflection of everyone with everyone (patients, operators, doctors, psychologists, nurses, social workers, volunteers, visitors) on all the problems that open up by opening doors and gates, but opening the mind, emotional capacity, reason and ethics at the same time.**

**The themes are varied: restraint, punishment, opening of the wards (at the opening of the first ward a nurse comments " *Nothing happened, absolutely nothing of what we thought* "); the drugs ( *they serve to quell the anxiety of the patient but also of the psychiatrist, therefore they can allow a greater possibility of relationship at both poles* ); the problem of nurses (jointo the "vanguard" or to strengthen in the "reaction"?); escapes ("escaping from an open place makes no sense"); the beer, the work, the money, the meaning of life, the affections, the loneliness, the bonds, the responsibility of each one and of the** **group, projects, roles, power. But the central point remains the last department: «... *the island in which the norm is represented and this norm must be broken, there is nothing to be done!* ". All with the clear awareness of the fact that every moment of liberation is a point of passage; that a bumpy path is followed in an effort to open the contradiction to a different level; that if the reciprocal tension towards overcoming decreases, the risk of crystallization, closure, manipulation, therefore of distance, inertia and objectification is always at risk; that the tendency to calm down and defend oneself with new schemes is the simplest solution for the operator and for the institution, but it is deleterious for those who pretend to cure.**

**And therefore a continuous search to face the problems, not to mystify them with false answers, to support the conflict that each subject produces and the risk of the freedom of the patient as the first and only possibility of reciprocity for those who, however, know that they also hold power. to "open" and "overturn", therefore he knows he is an "avant-garde" that forces things together and denies himself as pure authority. (An example is the decision to open the last ward, the "C Donne", which had been discussed for too long now, without being able to fix a date. " *So on the evening of November 21, in the weekly meeting of all the nurses, the director asked:***

***why not tomorrow? and no one wanted to oppose* "). And it is a continuous self-criticism on the risk of democratism, of psychiatric reformism, of the proposal of a new model that would fix the evolving situation and propose schemes, rigid roles, new forms of self-defense on both sides. Therefore it is not an apology for the Therapeutic Community, but the proposal of a questioning (contestation, verification, comparison) of reality in every moment in which it is lived. "It is the type of relationship that is established within this community that will make it therapeutic, to the extent that it will be able to focus on the dynamics of violence and exclusion present in the institute, as well as in the whole of society".**

**What is surprising thirty years later is however the respect that is perceived between people, the union - even in the contrasts, in the acts of rupture, in the resistances and in the incapacities - that binds everyone in an experience, a common purpose. : to demonstrate that it is possible to break up total institutions by giving them back the formally declared purpose: care, welcome, help, support. But only on condition that the power and the distance between those who give and those who receive are broken and that we can look for the way together, outside the old schemes: objectification, exclusion, annihilation of the other, cancellation of all rights, needs and desires, the cancellation of all resistance**

**subjective capable of disrupting "order", preventing an assumption of mutual responsibility. What does it mean, in fact, " *nostalgia for the good old days* (the closed hospital) - reported by a patient to a doctor - *when, moved to the ward agitated, he could walk around naked, masturbating in front of others, regress in an unbridled protest ?* », If not a new responsibility for oneself and towards the group? What other meaning can all the forms of regression attributed to the disease then assume?**

**\* \* \***

**The volume closes with a political analysis of experience, an analysis which, although present from the beginning, here presents pessimistic accents on a possible evolution capable of affecting the concept of norm, the functionality of institutions, the social and economic system, company values. In search of identifying a face of the disease that is not yet, even on the outside, the "institutional" side, " *the institution is simultaneously denied and managed, the disease is simultaneously placed in brackets and treated, the therapeutic act is simultaneously refused and acted. And this is the sense of the countertransference character of our negation, or it is an expression of the limits within which our action is***

***forced beyond which there is no other alternative* ? ». But what quality is the denied and managed community, the parenthesis and the treatment of the disease, the therapeutic act rejected and acted upon, if quality is not an end but is the very substance of work, of every work with the person ? How did all this make it possible to break the madhouse and its logic? And if so, how to act more strongly on the scientific ideology that determines the norm, the disease, its institution as we know it?**

**« *The institutional career is what closes - at all levels each in the circle of their own competence. Trying to get out of it can mean being transferred to another institution or being thrown back into your own: the game is always the same. Is our current condemnation of having to continue living and acting for the preservation of the institution and the system? Or does the political opening of the problem give us a chance to escape?* ".**

**These are still questions that open new perspectives and new alliances but also the road to Trieste, where they will be re-proposed at a different level, in an asylum that will gradually be rendered useless with the creation of other ways of dealing with mental suffering that will bring within itself new ones. contradictions, new questions for operators, for those in need of services, for psychiatry, for**

**society: problems that always concern the relationship between norm and society, scientific ideologies and people's rights, which demand a new concept of health and disease, of normality and madness, new social and relationship responses as well as health.**

**Presentation**

**The material collected in this volume is presented as a set of documents and notes that want to be the concrete expression of an institutional reality in overturning, with the contradictions implicit in it.**

**The polemical and subversive tint evident in the testimonies (of the sick, doctors, nurses and collaborators) is not accidental, because the action started from a reality that can only be violently rejected: the asylum. The overthrow of a dramatic and oppressive reality cannot therefore take place without a polemical violence against what one wants to deny, involving in the criticism the values that allow and perpetuate the existence of such a reality.**

**For this reason our anti-institutional, anti-psychiatric (ie anti-specialist) discourse cannot be restricted to the specific terrain of our field of action. The controversy against the institutional system leaves the psychiatric sphere, to move to the social structures that support it, forcing us to a critique of scientific neutrality, which acts in support of values**

**dominant, to become criticism and political action. It would perhaps be easier to stay on your own ground**

**of action and study, maintaining the distance - indispensable for scientific analysis - between the investigator and the object of investigation. Scientific work, as long as it remains within the norm values, is serious and respectable in that it takes care and guarantees against being contradicted and denied by reality. But if a work is based on reality and its contradictions, without wanting to build a model that confirms and codifies one's own hypotheses, it brings with it the reproach of unrealistic amateurism with respect to everything that is not yet included in the norm, and leads to contradiction of a dialectical situation, always in motion.**

**This is the action of institutional overthrow that doctors, psychologists, sociologists, nurses and patients have proposed and provoked in a psychiatric hospital, contesting the asylum condition on a practical level. Referring also to foreign experiences (in particular to the English one of Maxwell Jones) we proceeded - through subsequent criticisms - to the denial of the asylum reality, highlighting the ambiguous position of a community as a micro-society that wants to establish itself on practical and theoretical premises in opposition to dominant values.**

**We have come to a moment that justifies putting in**

**crisis of a situation: the asylum reality has been overcome - with all its practical-scientific implications**

* **and *it is not known what the next step will be.* In the foreign experiences to which we initially referred, we recognize - even if not reported - the same contradictions, the same incapacities. The only possible alternatives, for us as for them, are those of withdrawing into the institutional sphere, with the inevitable involution of a dynamic movement that is fixed and crystallized; or to try to extend our action to the discrimination and exclusion that society has imposed on the mentally ill. How can we not go back from the excluded to the excluded? How to act from within an institution on what determines and supports it?**

**The discussions, the controversies, the notes collected in the volume have only this meaning: the analysis of a situation that seeks a subsequent overcoming by leaving its specific field and trying to act on social contradictions.**

**The psychiatrist's condition is, in our reality, more evident than others, in the sense that direct contact with the conspicuous condition of violence, oppression and abuse requires violence to the system that produces them and allows them: *or yes, they are accomplices, or it acts and destroys itself.***

**This radically critical attitude of what science has done to the mentally ill can be**

***considered* anarchist because it refuses to label itself, utopian because it denies any definition and classification; but it convinces us to use words of "revolution" and "avant-garde" which may sound empty and consumed in their meaning. It is the harshness of the reality in which we act that transmits this violence to us and suggests and forces us to use these terms, convinced as we are of not making "revolutionary literature".**

**The meaning of the volume is intended only to be the analysis of a series of problems, which are not particular psychiatric problems, to demonstrate how an action - full of all its contradictions - is possible within an *institution of violence* , and how this action refers us to the global violence of our social system.**

* **too easy for the psychiatric *establishment* to define our work as lacking in seriousness and scientific respectability. The judgment can only flatter us, since it *finally unites us* to the lack of seriousness and respectability, which has always been recognized in the mentally ill and all *excluded* .**

**FRANCO BASAGLIA**

**Documentary introduction *by Nino Vascon***

**«... Because earlier those who were here prayed to die. When someone died here once always rang the bell, now it doesn't use anymore. When the bell rang, everyone said: Oh God, maybe I was dead, they said, I'm so tired of living this life in here. How many of them did not die that they could be alive and healthy. Instead, disheartened, because they had no way out, they no longer wanted to eat. They threw the food down his nose with the rubber, but there was nothing they could do, because they were locked in here and had no hope of getting out. Like a plant when it is burnt because it does not rain and the leaves wither, so were the people here ».**

**This short story is by a blind man, whom I will call Andrea, who has been hospitalized for many years in the Psychiatric Hospital of Gorizia; leader of a small group of elderly people, he spent most of his life inside the hospital precinct or even inside a ward without ever leaving. These old men are Italians, Hungarians, Slovenes, Austrians, that is, representing some nationalities of the decaying Habsburg dominion; confined fifty-sixty years ago by the scribes of the «imperiai**

**royal government »with stamps, stamps and signatures in the last remote corner of society: the one reserved for the excluded. Andrea is a tall, old, blind man and was a bricklayer in his youth. Among the hospitalized in Gorizia he is one of the oldest and enjoys the respect of others and a certain authority. Since he is blind he always stands with his head held high, with his chest out and shoulders back, his hands and arms stretched forward: haughty, not conquered. A survivor, witness of remote events, the memory of which does not abandon him, he, like the veteran, makes his past pain a merit.**

**His words are completely spontaneous, because he did not know that I was recording them, because being blind he has never seen a microphone and a tape recorder, because being old he has no ideas about these instruments and while not ignoring their function they do not arouse in him no inhibition. His story can therefore be defined as authentic and legitimately serves as an opening in order to describe a new psychiatric situation such as that of Gorizia. Andrea's words are also the beginning of a radio documentary that I made for RAI some time ago, taking advantage of a moment of enthusiasm and attraction for the subject, also prompted by the stories of Franco Basaglia's professional experiences. Since then I have continued to be interested in it even if in a discontinuous way and through moments of alternating interest now**

**major, now minor, moved by an attraction-repulsion for the subject.**

**The first spontaneous interest was none other than the logical consequence of an attitude and a professional need: the search for the new fact. As Gorizia was in fact a unique experiment in Italy, describing its organization and function seemed to me to be a good news topic and a compelling proposal for listeners. But not only this: in the choice also played, as an exciting prospect, the possibility of entering the asylum (I use this term not by chance) and have contact with that particular type of sick person that one assumes to find in the asylum. This was due to the fact that I shared the opinion of the majority for the Provincial Psychiatric Hospitals and that, from previous superficial experiences, they appeared to me as something between prison and the clause: unusual places that solicit the subtle pleasure of violation. Analyzing my primitive behavior I would say that the attitude of the average citizen towards the mentally ill, when it is not one of fear or disgust, can be generically benevolent through some traditional and suggestive hypotheses: in genius there is a pinch of madness , madness is brilliant, etc. Basically, for me too, the first reasons for attraction to the asylum were**

**these. And there was also the hope of being able to recognize in the sick person, whom I was preparing to meet, some element that would justify or gratify my good inclination towards him. I had already experienced these feelings, without analyzing them, admiring the paintings of the sick exhibited in an art gallery and in the atelier of a mental hospital. I interpreted them as thrilling testimonies of unfathomable movements of the spirit and wonderful products of an uncontrolled fantasy, as well as vaguely and pleasantly disturbing and obsessive facts. Only after the meeting with Gorizia was he able to realize that these mechanisms were no different from those used by white when trying to exclude the black in countries where racial coexistence is impossible or not.**

* **never existed. In this situation the culturalized white faces the black problem by giving free rein to his sense of guilt - I suffer from the condition of the black and perhaps much more than the black - and attenuates this feeling through acceptance, knowledge and admiration for black poetry. , for the negro singing, for the negro elite. At the bourgeois level, the black poet, musician, writer is - as Fa-non would say - less black than the porter, the carpet seller, the African peasant. When white is about to make an opening, he doesn't realize that he is recreating an exclusion. In the same way the great Jewish musician and the famous Jewish scientist were saved, torn apart**

**to the Nazi fury with dangerous stratagems and saved before the others, because they are more deserving, more representative of the shoemaker or the ragman of the ghetto.**

**In essence, this series of attitudes are nothing more than a sum of misunderstandings to hide a sense of guilt, and an elegant loophole to hide fear and disgust, a way to avoid sharing the ideological positions of the majority of society towards the excluded, escaping a precise stance. In reality, the situation of the mentally ill in Italy is shameful: he is the only sick person who has no right to be ill because he is defined as "dangerous to himself and to others and a public scandal". We close it behind bars and gates and, to forget about its problem, we transform it into a "package", as a sick woman from Gorizia would say. Basically we make him a man-object entrusted to the game of fate: if he has money, passing through the maze of clinics, he will avoid the infamous fall of the stamp on his criminal record, if he has none, he will end up in the ghetto of the excluded.**

**We all know how scruffy and snotty the village idiot is, treated more like a beast than a creature, laughed at by the boys and cited as a baubu for the little ones, but when we enter an asylum the unbearable smell of closed wards ( the smell of**

**asylum), the bedlam of voices, drool and saliva at the mouth of the patients, the gray coat, the hair to zero, are the elements of the landscape of mental illness in the country that has the Uffizi, Portofino, the wedding room, Capri, Venice , Rome.**

**Some testimonies of old patients are used to describe what the state of things was in Gorizia a few years ago, but they also serve as an example for many Italian psychiatric hospitals. Here a consideration is useful: psychiatric hospitals are the poorest hospitals. The poor go to Italian provincial institutions, because if families can afford some expenses and intend to defend their relative, they deliver him to a private clinic or keep him at home. But when the conditions of the family budget do not allow it or when the cohesion of the group is lacking, and the common will towards the relative, the Psychiatric Hospital also becomes the last refuge for the patient of "good family".**

**The budget of the provincial administrations is certainly not prosperous, but in any case more attractive, more conspicuous and many times more electorally valid expenses have the right of precedence over those for the asylum.**

**The first of the patients hospitalized in Gorizia for many years, whom we interviewed, was precisely Andrea.**

**D In short, you say that now the situation is here**

**changed ...**

**ANDREA There's a big difference. Yes, because once here we were closed, closed with the net and it is not enough to close, we were also placed in the living room in eighty and we could not even find seats, we had to throw ourselves on the ground. We couldn't even go to the toilet. After that ... at five in the evening to have dinner and immediately to bed, even in summer, midsummer, when there were still three hours of sunshine. And they sent us to bed, with a bite in our mouths. I would go out to get some air in the courtyard and immediately someone came to get me.**

**Q But in what sense have things changed ...**

**ANDREA From day to night. Because at the beginning that we opened these assemblies, indeed I was president for a month and after that, no one opened their mouths, all the people were as if frightened, frightened. He did not have the courage to speak, I who was president begged them: you have something to say, talk, we are here for this, if you have complaints, tell them; but no one opened their mouths. This is because they were frightened after being closed for so many years ... It was all the director who did these things ... But the first**

* **it was Doctor Slavich who came to ward C and says: go on, take ten or fifteen sick people and**

**take them for a walk, around the colony ...**

**Q Was this the first time you went out?**

**ANDREW Yes, it was the first time we went out, with Doctor Slavich who also came with the director. Then everyone went for a walk. And to the people who seemed to be resurrected. There was immediately another spirit, another trend, then also the doctor would pick up someone with the car and take him for a walk around the colony chatting and every day he sent us for a walk.**

**Q So you think that this spirit of freedom has done well?**

**ANDREW Very well, very well, because before those who were here prayed to die. When someone died here once always rang the bell, now it doesn't use anymore. When the bell rang, everyone said: Oh God, maybe I was dead, they said, I'm so tired of living this life in here. How many of them didn't die that they could be alive and healthy. Instead, disheartened, because they had no way out, they no longer wanted to eat. They threw the food down his nose with the rubber, but there was nothing they could do, because they were locked in here and had no hope of getting out. Like a plant when it's burnt because it doesn't rain and the leaves wither, so were the people here.**

**D Also for the disease it was a benefit ...**

**ANDREW Of course, that's all! There are so many in here who don't want to go home now. They look good here. lina time the doctor came by and everyone: mister doctor, send me home! As if condemned, to pray. But the doctor went straight on without paying attention ...**

**Another testimony that immediately struck me was that of Margherita.**

**DE then tell me, what was the hospital like once? DAISY Once the hospital was sad, we were**

**sad.**

**Q Were there bars, closed doors?**

**MARGHERITA Yes, there were nets; he started with our department to remove the nets, he took off our bodices, in short, he did several things ...**

**Q But were you wearing these bodices all day? DAISY All day, from morning to evening e**

**even at night our feet, shoulders, everything were tied to our beds, like the Lord on the cross ...**

**DE this hurt you ...**

**MARGARITA Other than that it hurt me! Because even a person who is really lost, I think it doesn't do him good to be like that.**

**D Did you never go outside?**

**DAISY No, we never went out. I did not go**

**I didn't even work that time, because they had**

**afraid that we would start to break up ...**

**D Not even in the garden?**

**DAISY Yes, we used to go to the garden, but we were also tied up in the garden. When it was sunny when it was sunny, they tied us up in the garden. I was often tied around the bench, to the tree in the courtyard. They always tied me there.**

**Q Why did they bond you?**

**MARGHERITA Because that time we see that there was no cure like now, yes, there was but it is clear that the former professor did not use it. Instead now Basaglia has come and the treatment he is doing now has improved the hospital one hundred percent.**

**D Now everything is open, can you come and go as you please?**

**MARGHERITA PIZZA** **Yes, now yes, whereas before I couldn't, they wouldn't leave us.**

**Q But how did they connect you?**

**DAISY With the bodice, with the straitjacket. Afterwards our feet also tied us. My feet were tied with leather straps.**

**Q Why?**

**MARGHERITA Because I jumped, I was naughty, I jumped, I liked it, in short they thought I was so sick and they tied me up. That time it couldn't be**

**accuse a doctor: look at that nurse mistreating us who immediately tied us up, we had to let them treat us as they want and keep quiet. But now everything is different.**

**In short, there was a sense of rebellion inside and you couldn't let off steam.**

**MARGHERITA Yes. Because we were also afraid of being tied up and afterwards they also made us masks ... D Masks how?**

**DAISY They put a wet sheet around our face and then squeezed tight, tight and threw water on our faces, stuff that we remain dead!**

**Q Did this happen to you too?**

**DAUGHTER Yes to me too, unfortunately it happened to me too. And after that I also slept in a closed cage at night. Q How in a cage?**

**DAISY Because we had the beds with the net around them and there were padlocks part by part, and I was locked inside.**

**D Like a bird or a lion ...**

**MARGHERITA PIZZA** **Then sometimes I rebelled because I was tired of being closed, and since there was the string then I began to untie the net to escape out, because they did not want to open me ...**

**How long was it in this cage that covered the bed?**

**DAISY Throughout the night. We went to sleep at six in the evening, until the morning. Q What state of mind did the fact of being inside the cage give you?**

**MARGARITA It hurt me because I saw that everyone was free and I alone locked in the cage ...**

**So what was he doing, screaming?**

**DAISY Yes, I screamed and then I unraveled the net to escape outside, I walked with the net, I carried it with my feet to come out ...**

**DE the more she did, the more others thought she was sick?**

**MARGHERITA Yes, and then they tied us up. If we did something more they would tie us together so we couldn't move ...**

**D So when they lifted the nets ...**

**MARGHERITA We thought that it seemed a strange thing to us after so many years to find ourselves like this and all of a sudden we felt relieved.**

**D Are you happy?**

**MARGHERITA Happy and how! Q Did it seem strange to go outside?**

**MARGHERITA Yes also strange because always inside, inside, inside and after seeing that they have removed the nets, to be able to walk ...**

**DE now what do you do in the community?**

**MARGHERITA I also go to canto twice a**

**week. In the afternoon I go to school and as a work I go to do the electroencephalogram. Up in the direction. I put the cap with the different electrodes that you put on your head. Like some kind of EKG just done in the head. Does DE do other jobs?**

**MARGHERITA Here in the work department, I always go to the irons, because I can't sit idle or else I get nervous.**

**D Work** **EEG as an employee, as an assistant?**

**MARGHERITA As technical assistant.**

**D You learned well then ...**

**DAISY Yes and I'm jealous, I don't want to teach anyone because I like it. Q This is your job, then as a leisure activity do you go to music?**

**MARGHERITA Yes, I go to music and twice a week we sing and on Saturday there is the cinema and on Sunday the dance and we do some trips ...**

**Q In your opinion, for what reason did they once bond you? DAISY Once they tied us up because there wasn't**

**care that you do now. Yes, there was but they didn't use it.**

**D Now that the cure is done, it no longer binds. So are pills like the bodice to you?**

**DAISY I think so, because those keep you calm. If one is not enough, he gives him two, three and in the meantime the person calms down ...**

**D So if there were no pads it would be like**

**Before...**

**MARGHERITA It would be as before. Just see how**

**one word is enough and immediately they start jumping up ...**

**D Look, are you taking pills now?**

**DAISY Not me.**

**DE was once tied up. So?**

**DAISY Once they did something else with it, they gave us electroshock ...**

**Q But don't you think that the fact of being free, of going to work, of no longer being tied up, forced, was this that did you good?**

**DAISY Yes it was.**

**DO THE MEDICINES?**

**DAISY No, it wasn't because I don't take any more medicine and yet ... I feel better.**

**D So you have to think that it was this sense of freedom ...**

**MARGARITA Yes, the sense of freedom, because a person who finds himself closed gets nervous even if he is not nervous, to find himself closed, to see that he cannot do this and that and instead he feels like doing ...**

**Q Are there other sick people here who were forced like you?**

**MARGHERITA Yes, there are several, now they go to work, to the bar, to the cinema.**

**And here is the interview with Carla, one of the best known and most listened to inpatients in the hospital.**

**Q You have had a very complicated and difficult life ... It is**

**was also in a concentration camp ...**

**Two or three bars of the interview are canceled due to a technical defect of the tape recorder.**

**CARLA ... in the concentration camp where I was there was also poor Princess Mafalda.**

**D Look, what concentration camp was that?**

**CARLA Auschwitz.**

**D Then she was here for some time, when the methods were different ...**

**CARLA Very different because we were all tied up with the jacket. Some around the trees, others around the bench and until the evening they no longer untied us. So yes it was, she will understand under what conditions. We were all dirty on us. In the evening they untied us and put us to bed tied wrists and ankles.**

**Q Do you have any duties in the community?**

**CARLA Yes, as a secretary; to be at the table in daily meetings. When there are committee meetings I have to follow those of the gentlemen as well** **doctors and then report ...**

**D On a bulletin ...**

**CARLA Yes, the daily bulletin and in addition I did the monthly one for "Il Picchio". I also had to interview all the doctors and the only one who didn't answer me, and I was also a little sick, was a doctor, I don't mean, who told me "no comment".**

**The Gorizia community operates on a vast green area, shaded by centuries-old trees, among which nine two-storey pavilions, services, a church and an agricultural farm are distributed. The hospital wall is a stretch of the state border with Yugoslavia. The sick are about five hundred, nurses one hundred and fifty, doctors nine, plus a psychologist; a chaplain, some religious, social workers and volunteers complete the staff of the institute. The sick wear civilian clothes and not the gray smock still in use in many Italian hospitals, so that everyone is free to put on what they like best according to their taste and possibilities.**

* **It is rare to find a hospital located in such a beautiful, large and well-kept park, continually cheered up by the singing of thousands of birds of all species and it is painful to think that until a few years ago grass, trees, flowers, birdsong served to make only sadder is the life of the patients.**

**Now the area is practically open to everyone, because al** **place of the so frequent: «it is strictly forbidden to enter except etc. etc. », There is a sign inviting people to visit the sick when and how they want.**

**For some time, after the fear has been overcome, some teams of amateur soccer players have been going to train in the hospital field.**

**After passing the gates, which are always open, the occasional visitor advances along the park's avenues, perhaps intending to reach the community bar which is located three hundred meters after the entrance. During the journey you will have the opportunity to meet numerous people, men and women walking, sitting outside the pavilions, playing bowls and knitting. Arriving at the bar you will find a small crowd around the tables outside under a large canopy, or in a noisy and smoky room like that of all suburban bars. At this point he will feel completely uncomfortable, because he will no longer be able to recognize the sick person, the doctor, the nurse. Then in an attempt to re-establish terms of comparison he will inevitably ask: where are the dangerous ones?**

**There are no dangerous ones; those who scream, get agitated, try to attack the doctor, the nurse, the visitor, are not there because since there are no bars, gates, straitjackets, means of coercion generating violence in this community, there is no sense of that climate of violence. tumultuous anxiety typical of similar institutions.**

**But the visitor's question is justifiable, even legitimate, because it falls within the logic of his culture and his mental habit. In the general hospital, the sick are in bed, or stroll through the corridors in their dressing gowns or pajamas; the nurses are dressed in white, the doctors too, but with differently shaped coats: hygienic-military that of the nurses, long and professorial or short and flirtatious that of the doctors. It is thus very easy and less tiring to distinguish the three classes; as in the barracks, in the prison, in the school, officers are emblematically distinguished from soldiers, prisoners and guardians, pupils and teachers. Here there is no external classification, which is generally considered as a comforting sign of a pre-established order, a just distinction. A more embarrassing fact for the occasional visitor, indeed only an authentic embarrassing fact, that derives, in fact, from the difficulty of deciphering the various categories, which makes it difficult to choose the type of language with which to open the conversation with these people: I am speaking with deference to a nurse, while I have been overly familiar with a doctor and now exchange the good nurse for a madman? This is why the first approach to the community is generally silent and the first hours are punctuated with questions addressed in a low voice to the friend, in search of complicity between healthy people, between people who come from outside.**

**The release of this curious, cold relationship occurs with the beginning of community activities and precisely with the general assembly of the community which opens every morning at ten.**

**The general assembly of the community brings together the sick, doctors, nurses and social workers every morning, in the largest room of the hospital, which is in fact the refectory of a ward. The patients help the nurses to set up the audience for the meeting by arranging the chairs in a semicircle and put them back in their place at the end of the work. The assembly is a spontaneous event, in the sense that there is no obligation to be present, that one can enter and exit the meeting when one wishes, that no lists of absent or present are drawn up. At least apparently there is no formal or substantial distinction between the members of the community; doctors, patients, nurses take their places in the room confused urii at the others. The occasion allows for some manifestations that are common to all public meetings: the most casual and extroverted in the front row, the leaders distributed with a certain strategic intuition in the key places of the semicircle, while in the innermost corner, defended by a wall without openings (the others have windows, doors and a large glass door) the most regressed or those who, while participating, are still in a polemical or critical attitude towards** **the assembly. Two or three patients in turn sit at the table of the presidency, who, made responsible for the conduct of the assembly, reveal remarkable qualities of prestige, dialectics, distribution and relaunching of the topics. Do not**

* **infrequent that a sick person in crisis wants to sit at the central table disturbing the work and generating a strong tension in the group with his attitude; in this case his provocations or his trifles are tolerated or misled by the patients with extreme delicacy. In fact, he is reproached for his behavior not on the level of illness, but on that of common relationships, mutual sensitivity, etc.**

**In this sense it should be noted that many of those present are workers and peasants: their language has been refined over time and their behavior in the discussion is, in Italy, even with respect to parallel institutions outside, almost exceptional. This is due to the fact that some have actually learned a different and better way of maintaining their relationships by noting the behavior of others (nurses, doctors, patients) towards them and being conditioned by this behavior to improve and adapt theirs. The assembly of the OPP of Gorizia denies a very widespread phenomenon in Italy: the almost impossibility of a coherent and positive development of a public meeting at any level. As a negative fact**

**I would point out a certain tendency towards mimicry on the part of some subjects, while the attempt to freeze the discussion around some fixed topics highlights some essential themes for community and therapeutic purposes: wages and trips.**

**The wages are very modest fees decided on the administrative level that the patients receive weekly for their services. They should give a logical sense to the performance of work, except that in many institutions and in situations similar to that of psychiatric hospitals they are a vehicle for colonization (just think how much are the contracts of prison productions). However, the few hundred lire a week have, rightly, their economic importance within the hospital and it is therefore right that wages, increases, etc. are frequent topics of discussion. As far as trips are concerned, they are required as opportunities for recreation and as an alternative to the monotonous life of the hospital and also as contacts with the outside world.**

**The entire life of the hospital is governed by meetings. In fact, the day passes not only through the traditional program (visit of the health workers to the wards, breakfast, opening of the bar, etc.) but also according to the rhythm of the meetings; on the contrary, I would say that by now the traditional deadlines of hospital life are secondary accidents with respect to community needs. Meetings**

**during the week there are over fifty; they do not engage the same people at the same time but force all the members of the community to a state of continuous mutual availability. A typical morning begins at half past eight with a meeting of nurses, nuns, social workers and medical staff. It ends at nine. From nine to ten the doctors visit the wards. At ten the general assembly begins which lasts an hour, an hour and a quarter. At a quarter past eleven - eleven o'clock the doctors, nurses, social workers and leaders of the sick (spontaneous, traditional or improvised) gather to discuss the progress of the assembly. At half past one, nurses in and out of each ward meet, taking turns once a week. In the afternoon there are ward assemblies (daily for the admission wards and for alcoholics, biweekly for the other departments), doctors' meetings, committee meetings. The participation of visitors in these activities is very frequent.**

**Before starting to record the assemblies, I wanted to question the director of the hospital about some general problems.**

**D If the life of the hospital is regulated by the assemblies, it must be deduced that they are the community fact more**

**important. Are they necessary, useful, therapeutic? Qual**

* **their purpose? Is it essential that they are so frequent?**

**BASAGLIA Le** **our meetings cannot be considered as group psychotherapy, ie they do not have a psychodynamic basis in development and interpretation. Rather, they should be incorporated into the general meaning of group dynamics, without a specific reference to this particular type of psychotherapy. In other words, the number of meetings that are held during the day essentially have two meanings: 1) to offer the sick person, in the hospital, various alternatives (coming to meetings, going to work, doing nothing, staying in the ward, taking care of other secondary activities); 2) create a ground for comparison and mutual verification. When a patient participates in meetings, it means that his level of spontaneity is quite high, because he accepts the comparison with the other. On the other hand, group psychotherapy usually involves a certain obligation to participate: groups are stimulated and activated by a medical intelligence. Here we tend to ensure that the life of the community, daily life, is not regulated by medical intelligence, but is the result of the spontaneous activity of all those who participate, in whatever capacity, in the day.**

**hospital. As you will have seen, doctors, for example, do not always attend all meetings. Probably because they are prevented from doing so by other health activities, but it can also happen that they want to avoid expressing, in meetings, some state of personal tension or aggression; so it is with nurses. These examples highlight how the very presence or absence of the characters and roles of institutional life have their own meaning. Meetings have value and weight only to the extent that the presence of a person is the expression of a decision, of a choice between several alternatives. This is perhaps the main meaning of all the activities that take place during the day, activities that are partly spontaneous and partly organized by the medical staff. Making sure that choices are made: this is the basis of our work. The people who work in the field must find the possibility to decide personally, without being organized according to a specific order and a specific purpose. It is important that all members of the community, doctors, nurses and the sick, participate in these situations of spontaneity of choice; without, of course, pretending to create an artificial reality that does not take into account the situation, the social role, the status of the patient which is different from that of the doctor and nurse.**

**Unfortunately, the patient is still linked to a social reality that recognizes him as an individual without rights. We put aside his not being considered a "person", just as we put his illness in brackets.**

**D The fact is that the impression from the outside is that the propellant of the community is these meetings.**

**BASAGLIA It is true that it is, but only if the meetings are understood as the occasion in which the members of the community can meet and discuss: this is their only meaning. The fact that the sick have a social status, a different role from nurses and doctors is a reason for discussion and contestation in the meetings; dispute through which each one clarifies his own position to himself. The patient sees in the doctors and nurses as "free" people, whom he challenges the role of power they play, in the institution. They therefore analyze, in the face of a power that excludes them, their condition of exclusion. On the other hand, doctors and nurses, in addition to representing the limit of reality for the sick, represent in their eyes the refusal to be excluded, through the dialectical denial of their social mandate. The social mandate of the psychiatrist and that of the nurses coincide in being objectified and determined in the role of jailers and defenders**

**of society towards the sick. In a sense**

* **albeit to a different degree - psychiatrists themselves are excluded insofar as they find themselves playing, unwittingly, the game of the ruling class. On this basis, the level of reciprocity is sustained which makes a comparison valid.**

**D So to give him a new or renewed social status, especially towards the outside that denies him, it is necessary to give it to him in a continuous sense ...**

**BASAGLIA Continuously and independently of any psychodynamic interpretation of meetings and groups. We keep in mind that the first reality of the patient is his being a man without rights and we try to start from this reality. Rehabilitation is only possible starting from this real fact: the patient is a man without rights and we discuss with him his being without rights; the sick**

* **an excluded person and we discuss his exclusion with him.**

**D The feeling from the outside is that you ignore the disease, as if the disease does not exist.**

**BASAGLIA It is not that we ignore the disease, but we believe that to have a relationship with a**

**individual, it is necessary to set it independently of what may be the label that defines it. I have relationship with a man not for**

**the name it bears but for what it is. So, the moment I say: this individual is a schizophrenic (with all that, for cultural reasons,**

* **implicit in this term), I relate to him in a particular way, knowing precisely that schizophrenia is a disease for which there is nothing to be done: my relationship will only be that of one who only expects "schizophrenia" from your interlocutor. It is therefore understandable how - on this basis - the old psychiatry had relegated, imprisoned and excluded this patient, for whom it believed there were no means or tools for treatment. This is why it is necessary to approach him by putting the disease in brackets, because the definition of the syndrome has now taken on the weight of a value judgment, of a labeling, which goes beyond the real meaning of the disease itself. The diagnosis has the value of a discriminating judgment, without thereby denying that the patient is ill in some way. This is the meaning of our parenthesis of disease, which is parenthesis of definition and labeling. What matters is to become aware of what this individual is to me, what is the social reality in which he lives, what is his relationship with this reality. This is why meetings are important, because they are the terrain in which confrontation is possible**

**beyond any categorization: these are individuals who are in hospital because they are ill, and through their constant confrontation with reality, the possibility of understanding something about their illness may arise.**

**D Talk about depsychiatrization of your work. BASAGLIA Depsychiatrization is a bit like ours**

**leitmotiv. It is the attempt to put every scheme in parentheses, in order to act in a terrain that has not yet been codified and defined. To begin with, we can only deny everything that is around us: the disease, our social mandate, the role. That is, we deny anything that can give an already defined connotation to our work. When we deny our social mandate, we deny the sick person as an irrecoverable patient and therefore our role as simple jailers, guardians of the tranquility of society; by denying the patient as irrecoverable, we deny his psychiatric connotation; by denying its psychiatric connotation, we deny its illness as a scientific definition; denying his illness, we depsychiatrize our work and] or we start on new ground, all to be plowed.**

**Q What considerations did you start from?**

**BASAGLIA We started from the encounter with the asylum reality, which is tragic because it is oppressive. Do not**

**it was possible that hundreds of men were living in an inhuman condition just because they were sick, and it was not possible that we - as psychiatrists - were its architects and accomplices. The mentally ill is "sick" above all because he is excluded, abandoned by all; because he is a person without rights, towards whom everything is possible. For this reason we deny, dialectically, our social mandate which would require us to consider the sick person as a non-man and, by denying it, we deny the sick person as non-man. On the practical level, we deny the dehumanization of the sick as the ultimate result of the disease, attributing the level of destruction to the violence of the asylum, the institution, its mortifications, prevarications and impositions; which then send us back to the violence, the prevarications, the mortifications on which our social system is based. All this could have happened because science - always at the service of the ruling class - had decided that the mentally ill patient was an incomprehensible patient and, as such, dangerous and unpredictable, leaving civil death as the only possibility.**

**General Assembly of May 17, 1967**

**Note: many present, widespread tension and anxiety. Renato in**

**crisis: it is aggressive and provocative. Giovanna presides.**

**GIOVANNA Are you interested in what procedure must be followed to obtain this subsidy? It seems to me that this affects everyone.**

**MASO** **The procedure is not very difficult, there is practically only to fill out the application. I filled it in, but it was rejected. I did it again and we will now see the result, the procedure is not difficult. Here, I believe that it is the understanding that is lacking, that is the will to apply this law: this article says that a subsidy is due, but there are those who interpret it in one way or another, and so you are left with nothing .**

**GIOVANNA What was wrong with the question?**

**what did she do? Did they tell you why?**

**MASO Yes, they told me: they told me that of course I don't enjoy privileges, but that my next relatives,**

**like my father and my sister they have a house, a piece of land, as if they were landowners. So they say I don't need the subsidy.**

**LUCIA You're not a minor who has to live off their backs.**

**MASO Yes, but in their opinion, what is right has never been true.**

**ANDREW Because if you work your relatives give you a bowl of soup, otherwise they say you are arranged, try to earn a living, you are no longer with us, you have come out.**

**RENATO For example, I came in here eight years ago and the director and the doctors gave me fifteen electroshocks, they broke all my teeth on top, is this right? I denounce you. The fault is theirs. (Blasphemy, curse).**

**MASO Renato, I believe that this is not the right time to have these discussions.**

**GIOVANNA I listened to everything Mr. Maso said and I also understood everything, but I would like to say a few words. He says that he asked for this pension, that his family members are comfortable at home and that they could think of them for him. But he was hospitalized, he is not free. We have a law in here and I don't know if it's right, but I don't believe it, and it says that when we are discharged, we are always**

**trust someone who has to sign for us. This is because we are never sure of ourselves. We are equal to a package, that package must be guarded, but woe betide if that package is opened, moved in one way or another that something is missing. Here, this is also the sick person when he goes home, his relatives think for him. But I say, then it is useless for me to go outside; if one gestures to me and I react, if I begin to react with that one, to react with that other, then the relatives who look after me say: this one is causing us trouble, we carry her inside.**

**MASO This is poor reasoning and let me do it. I heard one thing: so much in society, so much in prosecutors, so much in large offices, there is practically the law of evil, that the big fish eats the small fish and the small fish must let itself be eaten.**

**GIOVANNA This is outside, outside, between the workers and the rich and the poor, who take advantage and exploit them, I agree on this. But we are sick, we admit that we are sick, then we must be protected, maybe for a period, then it changes, like children at the beginning.**

**ELDA I say it is absurd to think that we are like children who must be protected when we go out of the hospital. Small children**

**they will be fine in kindergartens, but we are big people and at our age we have our right, not small children from kindergarten.**

**RENATO Now I tell you, we cannot have our rights: when one is relapsed from the hospital, when one has been in a psychiatric hospital for five years, one has no civil rights.**

**BASAGLIA Precisely for this reason Mrs. Giovanna said that when a person leaves the psychiatric hospital it is like a package.**

**GIOVANNA It's like a parcel, because I know when my son comes to pick me up he has to sign, at home he won't treat me like this for many things, he won't because he sees that I reason thanks to God, but in certain points I see that we are equal to a package.**

**VOICE We are not all the same please, there are two families:**

**the brothers of Rome and the workers.**

**SLAVICH Mr.** **Maso was discharged; this package feature, does he feel he has it?**

**MASO I started going to school in 1946, I went to Trieste every morning, I practically lived**

1. **Trieste and returned at nine to ten in the evening, sometimes even midnight, with two blocks in Aurisina and Monfalcone; after school I went to the military and away from home again, then I went to the railway, away from home again to Venice, I always made do** **alone, I never needed a mother or a sister, I always had to be alone, that's why it doesn't do me that much to be alone.**

**GIOVANNA You don't feel you need to, but when you are out, I don't think others are calm, because there is always that tension, because they wonder where he has gone, who knows if he comes home, who knows if he drinks ...**

**PIETRO I agree on all this, then you need to have a family. When you don't even get the chance to live, when they refuse even that little help, that little sustenance, how could I support a wife, pay rent, pay electricity, taxes and all at the same time? How could you do it, in what way without work and without anything, how can you, can you explain to me how you can? Who would not like to have a family, what do you think that until I had my mum, my dad, my sister, do you think it was not okay? I was like a great gentleman, I have never been so good and I think I will never be again, even if I take a Sisal.**

**GIOVANNA Listen Mr. Pietro, now I don't want to offend him, he must speak without offense, you have been discharged, you are out now, but you cannot stay without coming here, then you have taken the strength of the habit of being here, you are feel safe here, is that right? She feels good here, she feels good here.**

**ANGELA Here I find peace, comfort and here I feel out of danger; yesterday was my birthday, and i came ^ but i know that when i feel like i go out, instead if i go out and after i make a mistake, i have to take me inside, instead i came first to be sure not to make mistakes and so after i can go out . As usual, like yesterday we had a party at home, for my birthday, we drank something ...**

**VOICE So you, Mrs. Angela, do you feel safe practicing the hospital during the day?**

**ANGELA Yes.**

**VOICE Then it's useless to dismiss people if they all come back here later.**

**ANGELA It's not true, we come here in a moment of despair.**

**ELDA I'm fifteen years away from home and the director always says for August 15th or Easter, and that day never comes.**

**ANGELA Yesterday three ladies came to look for me at home and with all this I came in here.**

**RENATO What did you come here to do, stay out that freedom is beautiful, they put you in the cell.**

**ALDO You came here because you can drink outside, and you are afraid of drinking ...**

**ANGELA I'm afraid of drinking because it hurts me, it doesn't take much to hurt me, I can't stand alcohol.**

**BASAGLIA Listen Mrs. Giovanna, I ask you: why is a person hospitalized?**

**RENATO Because others laugh at us. How old are you here?**

**ANDREW I don't even remember.**

**RENATO I have been traveling around the asylum for eight years, not a month or two; now lately they make fun of me, it's time to stop it. The nurse accompanies me every day, did I kill someone perhaps?**

**ANGELA Four years in a row, without seeing the sun ...**

**RENATO Too little, one more ten would take you and you'll go inside again. You don't go that far anymore, I'll take you inside.**

**PIETRO If I had a big commitment that I could not come, but I thank the good people, even the patients themselves, I am pleased to see them always.**

**RENATO I have a sick heart, not my head, remember well and if you remember the director too, I have a sick heart, not my head.**

**BASAGLIA What do you mean by heart patient? RENATO Seeing all these poor wretched people**

**that you only make them bazilare and nothing else, I've been here for years, when I go home? Tomorrow, for Easter, for Christmas, for August 15th, a crap in here. It takes more seriousness in here, more seriousness and more severity.**

**VOICE I believe that if you had heart trouble, in** **this moment you would find yourself in the Civil Hospital, in a medical ward, not in a psychiatric hospital.**

**RENATO They want to send me here, I'm crazy, no! I have heartache, I cry every day, you know?**

**VOICE However seriousness also involves a rule, it involves many things, severity and other things also take over in the same sense and we would not find ourselves in these conditions in which we are today, seriousness should not be considered only as seriousness ... practically the others "serious" hospitals as you say, practically do not have what we have.**

**RENATO I have been in here for two months, I am at C and the Health Fund pays me not to eat like the pigs of C and that's enough.**

**ANGELA But she says she has a heart disease, I am sick with liver and I was in ward C for four years, I had to be in ward C because there is the infirmary, she cannot expect another ward with her heartache .**

**A long silence.**

**ELDA I have observed that nurses have pay**

**conspicuous as they receive a lot of money ... GIOVANNA Nurses do not have a conspicuous salary, a father of a family has few …**

**ANGELA And they have many responsibilities, if one fucks and then gives the broom on the head of another, the nurse is responsible ...**

**VOICE Then what are you fucking him! This morning I swept the stairs and I missed the snack with all the bread, to facilitate the nurse! And I'm not crazy, I'm wise, I'm in an asylum for delinquency!**

**OTHER VOICE The responsibility is never of one only, as the fault is never of one only, it belongs to everyone.**

**GIOVANNA If you go beautifully towards a sick person, that sick person cannot react towards you.**

**VOICE Here, I have to tighten my belt until noon even if I'm hungry, I'm used to having a snack when I work.**

**ANGELA Sir, don't believe you have to tighten your belt until noon. If he wants to eat something, if he needs it, I come from outside, but if I ask for a bowl of milk they give it to me.**

**VOICE Me too, but I have to ask for it! I didn't need to ask, because I had the eat! And the other day they stole my snack, but if I saw who he was, a bad quarter of an hour would pass, nurse or sick that he was!**

**ANGELA But it doesn't have to be like that, it must have been someone without malice, like that. I have to thank the doctors, the nurses, the patients who helped me, but if** **I had to go to another hospital, for my illness, how should I go, I prefer to come here. The doctors and the director know what a sacrifice it costs me to enter here, I came one evening at nine to pray that they would take me that I could no longer, how many times have I prayed, help me that I can't take it anymore! I asked everyone on the street, if Mr. Antonio wants to talk, he can say it, how many times I have prayed help me, I can't take it anymore. The Cassa no longer wanted me to do the papers or anything, there was no other way to abandon the boy of twenty-two in bed with a fever of 39 and come inside, I was at home, I was crying, I was screaming. My son came home, he was in the army, he came home and he was sick, I have always found myself happy here, I cannot complain and accuse the doctors, I only ask you one thing, I will still need you, instead of giving me the pills that are not for my stomach, give me something else. I must also point out one thing: Mr. Director, 1300 lire were stolen from me last Sunday, naturally I did not accuse anyone; but it didn't just happen to me, it also happened to another sick person. I do not accuse anyone, neither the nurses nor the mother, because the poor mother cannot take responsibility, I am sane.**

**OTHER ITEM These are things that need to be solved** **within the department.**

**ANGELA I wanted to say that even in the A women's department as in the A men's department, Mr. Director, it would take wardrobes to close the things you have inside, because otherwise you can't keep them with you. We don't even have a chair by the bed, a locker to put our things. I don't want to accuse anyone, even the patients, they are sick, they don't do it on purpose, they get lost, they don't know what his stuff is, it happened to me the last time I went out with Irma, she took my dress, she said which is his and he has no longer wanted to give it to me.**

**RENATO (much calmer) What does this stuff have to do with the assembly?**

**ANGELA It has something to do with it, in here it's good, you eat, drink and sleep and if I don't have children, I'll sign up to stay here. I am well, I am very well, and I have never been so well and I owe it to the director and to Dr. Slavich whom I first met.**

**BASAGLIA When a sick person is discharged, he is entrusted to a relative and is entrusted as if it were a parcel.**

**GIOVANNA I don't take back what I said. BASAGLIA We must also hear the others if they are**

**agree on this point of view.**

**GIOVANNA Yes, not all of them, apart from those who come for** **a month or two months, which take a cure, but those who are so many years here; before handing over the patient herself, she gives him some advice, tries to do so, there, because if it is no longer safe, then a signature is needed.**

**VOICE There are many who live outside and don't come here and live outside and are happy!**

**GIOVANNA It means that those have reacted, that they have been good and that it is okay, but they are not all, it will be 10%. It will be 10% who are good and perform well.**

**RENATO We should send them to work, outside, not keep them closed and give them something to eat. We should take other sick people inside, there are more sick outside than inside. Here it gets moldy, we should work.**

**GIOVANNA But I already said the other time that this is not an establishment; you others must think that this is a hospital and if they give you a job in here, they give you a job to pass the time and in addition you also take this money and have a leisure in the day. Because the day is long, especially for men and you have that satisfaction of taking those 500800-1000 lire a week, which for you is also a viaticum, it is a relief. It is I who am sixty years old who work morning and evening and I am happy** **when I work, work makes you forget many thoughts, Renato! You don't have to get angry.**

**RENATO** **Meanwhile they have increased the beer, they have increased the coffee, etc.**

**GIOVANNA They had to increase. RENATO Where is this money? GIOVANNA I'm in Bled.**

**VOICE There is no money for a trip to Bled, yesterday you said there is no money.**

**GIOVANNA How can there be no money? Nobody said there is no money.**

**TOMMASO Yesterday it was me and it seemed to me almost a mockery of Mr. Furio, that is, he refused to let us know the amount in the Club's cash register for trips and the rest.**

**GIOVANNA It's not true, she doesn't know.**

**LETIZIA JERVIS Tommaso is not a refusal, because I too don't know.**

**FURIO I could only tell him about. It will be 400,000 lire, I don't know. I can tell you how much was spent on the circus, 47 000 lire was spent, I can say this because it was reported to me.**

**ANDREA Do you think it's okay to go and spend 47,000 lire to go to the circus?**

**GIOVANNA That on my own was a mistake, I immediately said no.**

**BASAGLIA Listen, then what is the money for? GUIDO The money is used to go on trips.**

**ANDREW From one cage to go to another, was that a trip? In your opinion, was it a trip?**

**BASAGLIA I think so, it was a diversion.**

**ANDREW For you who have freedom, but we are here like dogs, like slaves. Paying a beer 150 lire, a Coca-Cola 150 lire, how do these poor people here, do you think that is good? Why don't you take a trip to Castelmont or Barbana?**

**BASAGLIA If they wanted to go to the circus, I don't understand why you are against it, they wanted to go, we didn't impose it on us.**

**CASAGRANDE There were one hundred twenty-five who wanted to go. Those who did not want to go did not go.**

**ANDREW If it was to pay, not even twenty went. RENATO I believe that now it could be questioned that one trip a month could be taken. ANDREW Now let's go on a trip or to Capriva or to**

**Cormòns. Pay the club and do not throw anyone in remengo. At least you have a lunch, have a drink on the trip, but pay 150 lire for an ice cream? A Coca-Cola 150 lire of the small ones? But if they go out on a trip, at least they have a lunch, they eat everything at least they have a steak. Director, they all went five hundred without paying, but if you had to pay not** **not even twenty went.**

**RENATO Even on a trip, if you had to pay for the trip nobody would go.**

**ANDREW But the trip is always a trip, the trip is eaten.**

**RENATO But you have to pay if you want to eat well. VICTORY Yet you have been, you have enjoyed yourself and now**

**protest.**

**BASAGLIA How does Vittoria say?**

**VICTORY They went first, they did so much to go and now they regret it.**

**FERRUCCIO We are not sorry, it was nice.**

**FURIO It seems to me that the decision to go to the circus was taken right here and I think it appropriate that if anyone had any contrary ideas they should have talked about it first.**

**RENATO I wasn't here, I was sick.**

**GIOVANNA Now there will be two trips, in June and in July.**

**FURIO The problem of trips, it seems to me that a way of choosing how to do them must be set up. How to do them, that is, whether to do them in large groups, in small groups, where to go, study the itineraries.**

**RENATO If we always say, if we say every day, what do you want to talk about, turnip head!**

**ANDREW Now if you have to take a trip, let's go to** **Cormòns or Capriva. Not that far. RENATO And what do you think I'll stay here for two years?**

**Long break, small group discussions.**

**ELDA Since Professor Basaglia and I have already known each other for several years, I would like to ask him a favor, send me to ward A, because I don't sleep with those women, do we agree? I don't sleep with the other sick people because they make me sick, okay? Let them send me back to ward A, there will also be a place for me, they kept me for eight years and all the nurses loved me, I never realized I was fighting or anything; so, could I go?**

**FEMALE VOICE Listen, we don't do so much disgust ... ELDA You are really disgusting!**

**MALE VOICE So when do we take the trip, Giovanna?**

**GIOVANNA We need to discuss how, when and where, not just a trip.**

**MASO Make an agreement and take a nice trip to Venice.**

**ANDREW No, not in Venice, it's too far, Venice is for going to the baths, we don't go to the baths.**

**GIOVANNA To do the trip you have to do things right** **perfection, argue, don't do that.**

**MASO In my opinion, after what I heard on the radio, with the arrival of the new system of psychiatric hospitals, there will probably be some improvements. I believe, and on this I am almost sure, that services will also be improved, the treatment of nurses will be improved and this will also lead to an increase in some expenses, perhaps a few billion, or 500 million that will also be donated to these poor sick people; I am almost convinced of this, because when something is changed, it brings about well-being in all branches. Then we can also do other things, even for these sick people.**

**BASAGLIA Why are these sick people different from others? Why are they considered last?**

**MASO Are they different from the others?**

**RENATO Because we are slaves in here, not sick. MASO Among the people I met here, there**

**there are many who are afraid of war, many are disabled as happened to me, I have thrown myself into a cow after a car accident. Many, on the other hand, were born just like that, but they are few. It is, let's say, the malaise that reigns in society that forces people to get sick and then to hospitalize in these hospitals, because naturally one who has** **well-being, of course he does not throw himself into drinking or do extravagance, it is very difficult, it is the misery that leads to all these things.**

**BASAGLIA It is also the rich, you know, who throw themselves like this ...**

**MASO But they are very few, they are other amusements that bring them here, they are other reasons.**

**ANGELA It's also a disease, because I know people who are well, who have comfort, who have everything they want, and yet they drink.**

**GIOVANNA It becomes a disease.**

**MASO Yes, but the rich, the millionaires are placed in clinics, they do not lose their civil rights and they are not written down.**

**ANGELA I also say that it is the human miseries that bring in here.**

**RENATO I've been around the hospital for eight years to get well, why don't you send me to another clinic?**

**GIOVANNA Now all walks of life are in the hospital. BRUNO Yes, of course not, but from what I have seen, I observed, you can look in here, we are in the seventeenth-eighteenth century in this hospital and they are all poor people and so it is also in the other hospitals. Perhaps those who are well, let's admit fifty out of six hundred, will be 5% and the others are all poor people who are really driven by misery. I see when a poor wretch has only 100 lire in his pocket, not** **he gets to buy a sandwich filled with 100 lire and nothing else arrives, what does he do? Go and get a quart of wine, and without eating, of course: give today, give tomorrow, that's it. On the other hand, if one has one thing to eat and the other, it does not even occur to him to drink, he will drink a glass and goodnight sounders!**

**GIOVANNA But if she has the money to buy a glass of wine, she has the money to buy food too.**

**BRUNO When money is tight, one practically says: what do I do now? I don't get a meal, a stuffed sandwich I can't even buy, with 100 lire I go to drink a quarter of wine and he is satisfied with a quarter of wine, he is drunk and then falls down, continuously like this, the nerves weaken, yes it weakens the mind and does not think about misery. And even if he doesn't drink, misfortunes and sorrows make him sick.**

**MASO But you, sir, can stay here as long as you want, because I eat as much as I have seen you eat, I have never seen anyone. She can stay, because outside, to maintain someone like her, it takes at least 3000 lire a day.**

**RENATO When you know that life is like this outside, you can't go out if you don't have support ...**

**ANDREW You like being here, because here is eating** **enough, what you want, but outside, you have to work.**

**MASO Even those who drink, if they drink a regular thing and also eat, in a certain sense the wine is then like a medicine.**

**BASAGLIA What are the problems of other sick people who are not mentally ill?**

**MASO I don't know, I'm not a psychiatrist, you must know that. Changing a state of nature would be possible, almost certain. Those who get sick are in my opinion treatable, then it's all in you, in your abilities.**

**The liberalization of the hospital had for a long time its flag in the men's B ward, which was the first to be conducted in a "community" way. The liberalization of the B was also possible thanks to the common will of the nurses of the ward. The following testimony is transcribed from the recording of a meeting that gathered around the microphone some doctors, and the nurses of the B, after some time and on the theme of the function of the first pilot ward and its current situation.**

**BASAGLIA** **I would say this discussion could represent the judgment of the nurses in the ward** **B, bearing in mind that these nurses were the first to fully open a ward. Since the sense of community has expanded from this department to the rest of the hospital, I think this problem could be discussed.**

**DIZORZ I think the other departments haven't gotten to where we were then.**

**BASAGLIA Do you think that a ward is more or less communal with respect to the type of sick people it has? It seems to me that this is his point of view. Also in other meetings she said: ward B had been constituted in that particular way, a group of about fifty patients at a moderate level of rehabilitation had been put together who had to represent a particular type of patient, etc. Later, these patients were discharged and others were admitted, and this changed the meaning of the ward.**

**DIZORZ My point of view I have told you what it was; we are not at that level now that we were before; those twenty-five sick people who were discharged were particular sick ...**

**BASAGLIA That is, do you think that a department like department B will no longer exist?**

**SLAVICH Basically, I think that every department is really made up of the people inside it. The things that** **those that are not done depend on whether the people who participate do them or not; that the department is now different from 1964 I think it is undisputed, perhaps to be discussed is whether it can be said that it is worse, that is, not always different means "worse".**

**DIZORZ Worst** **rather I think it is for us nurses; for you, from your medical point of view, it may be different.**

**BASAGLIA Excuse me, what do you mean by worst department and best department?**

**DIZORZ I don't say worse, I say that now there are problems that weren't there before; before we were worried because it was a new thing, because the park was never open, we were worried about being careful, we wanted to know where the sick were, what they were doing. This is what we are trying to do even now: but now they are no longer the sick as before, they knew each other well, some for years, many were long-term patients ... It seems to me that the security we once had now we do not have .. .**

**SILVESTRI In the meetings it is always those two-three who speak, those twenty-twenty-five sick people who were arguing and protesting were discharged; now there is only Massi, Lucchi left ...**

**STURM They are more dull, less active, they do not participate …**

**DIZORZ We have adopted the policy of letting go; in the beginning almost all went to work, and all of these had a weekly wage; then someone no longer had a job or did not feel too well, they received the remuneration anyway, and the others said that it was not worth working because they always received the same remuneration.**

**BASAGLIA In your opinion was it a policy of letting go, or was it an attempt to start a different kind of life in the community?**

**DIZORZ You have to see how far you want to go; it was a study, a test, an attempt ... everything went well, we were all satisfied, we still are.**

**BASAGLIA I have the feeling that the nurses in this ward feel mortified in some way compared to the rest of the hospital, and I don't know how to realize this reason, this mortification. That is, this ward was constituted with fifty patients and a very small group of nurses. These nurses rehabilitated these fifty people, twenty-five of whom were discharged; in place of these twenty-five other twenty-five people were put, which gave a different characteristic to the department. Now I have the impression that all the members of this department see this new job as mortifying.**

**MIAN** **No, I would not say that we have been mortified, twenty-five have been discharged, and we are delighted.**

**BASAGLIA But the department as it is now is a department that no longer gives so much satisfaction.**

**MIAN It is certainly different.**

**STURM Once the ward was more alive, now it seems dead.**

**JERVIS It seems to me that two things have changed: the composition of the ward has changed in the sense that those more active patients who kept it lively have been discharged; and the fact has also changed that the "therapeutic community", your ward, is no longer the nucleus of the hospital; now the other departments are also open, and it is no longer the model department.**

**DIZORZ It's like when you paint the walls and the doors look ugly; the doors are always the same, but the walls are better, so we have remained the same as before in relation to the other departments. It seems to us that we have taken steps backwards.**

**BASAGLIA But it is always the same situation. JERVIS Perhaps there is also a third factor, which is when there is**

**a renovation in a department everything goes on, there is a transformation; then at a certain point this renewal may come to a halt, at least there are no more big news, and when there is no news, the thrust is also missing; in short, when there is something** **that it is transforming, there is enthusiasm, when a certain result has been achieved, new results are sought, new transformations are sought, something completely new; if, on the other hand, it is believed that the results have already been achieved then practically everyone sits down for a while, and I believe this happens everywhere. Many times, taking certain initiatives, I realized that things were going well as long as we were walking, in short, as long as everything was on the way; then when you thought you could slow down, this actually made everything collapse a bit, as if things could only go on by dint of running; I think this is quite general in a job like ours.**

**DIZORZ Mr. Director said earlier that it looks like we are humiliated.**

**BASAGLIA Yes, I have the impression that all the staff in ward B feel a little mortified compared to the rest of the hospital. Ward B was the ward that initiated this new type of approach to the patient; as the rest of the hospital opened and adapted to what was initially ward B, ward B felt like staying in line, in short.**

**SILVESTRI This crisis of the ward, of us too, is due to the crisis of work, of ergotherapy: why** **once there was more work, they were busier.**

**DIZORZ We are rather dissatisfied.**

**SLAVICH I think that the crisis derives not so much from the fact that the department has changed from better to worse, but from the fact that being different now one has the feeling that the tools to adapt the activities of the team to the new composition of the department are lacking, especially that the numerical composition of the team was designed according to the composition of the patients who had been chosen for the ward. Patients have changed, and certain tools have ceased, one feels more need, another less (generally all nurses think that work is a very important tool for hospital life), these tools have ceased, and being somehow the percentage composition of nurses with respect to patients has become insufficient, a part of the team may feel uneasy.**

**BASAGLIA I think it's different now too. Nurses do not see fast enough results, as they did back in the day: this is certainly not a very rewarding situation for nurses.**

**JERVIS I believe that the loss of certain job opportunities for patients has its importance, because** **I had the impression that in the hospital these work activities ceased before they were replaced by less institutionalizing and more advanced activities.**

**DIZORZ Yes, also because a pensioner who is away, for example, who has no commitments, if he does not have the reason to get up in the morning, says: I'm here, a lot! If, on the other hand, he says every day: I have to go to the Isonzo bridge for a walk, he has a reason to get up, in short. The sick no longer feel this.**

**BASAGLIA It seems to me that you are saying that the patient today, in your ward, has no other alternative; or that of being idle or that of running away. One of the two, these are the alternatives that the patient has, that is, they do not have the alternative of working and not working. Since they don't have the opportunity to work, whether they come down at seven or ten in the morning ...**

**SLAVICH There are thirty of them working, right?**

**DIZORZ Yes, thirty-thirty-five. Like Brizzi. This morning I told him: are you going to work? Him: yes, I go from half past nine to half past eleven, is not two hours enough? I said: if you can't do more, two are enough!**

**SLAVICH This alternative, whether to work or not to work, does Brizzi have it or not?**

**DIZORZ This is someone you can talk to, with certain** **can not be done!**

**SLAVICH The problem concerns precisely the other thirty who do not work; in '64 there were three who did not work, one because he was blind, another because he was hemiplegic) and the third did not work and that's it; now there are thirty of them and they populate the ward and stay a little here a little there. The fact is, however, that they are no longer around the wall or sitting on the bench, instead they are perhaps in small groups, two or three, talking; this is still in the ward, I think, I don't know what it looks like to you, there is still a certain relationship life.**

**DIZORZ We don't need much the same, because we were used to it a little better.**

**BASAGLIA Are they frustrated by this situation? MIAN We also feel guilty because we fail to**

**conduct the department as before.**

**SILVESTRI I also think it is a question of money; they say: a lot on Saturday we take that much, if we work and if we don't work! And then they just work that hour in the morning and that hour in the afternoon, someone doesn't even go there ...**

**BASAGLIA It seems to me that Mian has raised a very important topic. Maybe we feel guilty, because we had to try to rehabilitate these new patients as we did with the others; if we were able to do it with sick people who were** **certainly in a better situation than these, with these we are not capable, and then we feel guilty.**

**SILVESTRI Why are we not capable of it?**

**SLAVICH Very indicative is the favor with which the nurses' initiative was welcomed by the third "flying" nurse; this third nurse does not go to increase the number of nurses who are in the ward, but goes around the hospital all day, talks to this, talks to this other, collects observations, discusses them with the others, so it also partially solves his problem; everyone is more happy to do this work of multiple contacts around.**

**BASAGLIA The argument raised by Mian seems very interesting to me. SILVESTRI It may be our fault, but it may also be that it is not.**

**BASAGLIA We were able to rehabilitate 50% of the patients we had, which is an enormous result; now we have changed the type of "customers", we say, and we are not able to face the problem as we faced it last time. What is the reason for all this? Are they patients whose rehabilitation is impossible? Does it take longer? Is it anxiety about what you would like to do and fail to do, or what has been done earlier in a shorter time?**

**DIZORZ It is also seniority. I've averaged a** **day, and I concluded that as inpatients we are on the average of sixty years: and then, once upon a time, the saints did miracles, now they don't even do them anymore!**

**JERVIS The average age of sixty is very high. SLAVICH It is probably no coincidence that while in the**

**'64 were all physically fine, after four years there are now several medical-internal problems.**

**BASAGLIA It could then be said that this type of activity with patients aged sixty is a type that frustrates a lot. Yes, because if we tend to rehabilitate even those who perhaps cannot be rehabilitated, for many reasons ...**

**SLAVICH Perhaps the fact is this, that it is not so much working with old people, as seeing them age under the eyes. A ward of elderly people is one thing, instead a ward of people that ten years ago or five years ago, when it started, were valid and now they are still here and they are starting to have heartache and they could not be discharged at least that for this reason: one thinks that for these the efforts have been in vain.**

**BASAGLIA In other words, the ward would have been transformed into a ward for the assistance of elderly patients; it would no longer be a rehabilitation ward as it once was, but it would be a ward where assistance is provided.**

**JERVIS There will be many causes for this discontent on ward B, but I believe the fact that patients of the** **ward have changed in this way and that now there is an average age of sixty, in a sense enough to explain many things; it seems impossible to me that in conditions of this kind we can continue according to the previous line, I believe that there is a clearly different and more difficult reality, it is a new problem.**

**SLAVICH A new problem, and in my opinion the difficulties concern this new problem, which now it is difficult to face, and not the confrontation with the past, the nostalgia for the "golden times".**

**BASAGLIA But nurses make just this comparison. When they fail to achieve what they were used to, they naturally feel frustrated, as they see their efforts fail. This is my guess. When one is discontented, discontent has it for something.**

**DIZORZ Because you work and do, I think what I'm saying is everyone's aspiration, to get satisfaction from their work; and instead in this period it seems to me that we do not have any.**

**BASAGLIA What do you mean by job satisfaction?**

**DIZORZ The results; for example to see Pilates from time to time come out of his room, to see him one day talking, something, I have no words …**

**BASAGLIA Would this be a result?**

**DIZORZ On my own, yes.**

**BASAGLIA And the sick? There are twenty-five left: that they have a humiliation, a frustration from the fact that they are no longer homogeneous with the others?**

**SILVESTRI I think so. There were several who had to go home, and they took it out on that point there; while the others went home, they stayed, for family or other causes.**

**SLAVICH This is, in fact, a disastrous year for the resignation from ward B.**

**STURM Also as for work, Doctor; as they go out, they go to town on Saturdays, they go here and there, they see and know the importance of money. And then I think that for this the work does not please them very much, as they know how much they get, that poor pay, they compare with others and see that they are little money and therefore they say: why do I have to work so hard if they give me this proceeds?**

**SLAVICH For some time, at least this year, the ones who went home are the ones who had recently come, and they were in the observation department first; they stay there for two or three months, and if we talk about resignation now we are talking about these, and not about those who hoped to be discharged instead.**

**MIAN It was a great satisfaction for us to see Marri** **and others, after so many years of hospitalization, be discharged. BASAGLIA The discharge of 50% of patients is however already**

**huge.**

**JERVIS And after? Are the scraps left, then? It means that there is enough in the ward to create a very serious discomfort.**

**DIZORZ ... That the sick have been discharged, that they come to visit us, tell us about their problems, all this pleases us, and it also makes us think about what was being done and about the things that cannot be done today.**

**BASAGLIA That is, what did they do?**

**DIZORZ With what we have done we have managed to discharge those patients and those come in, they come there and greet us, it means that they recognize that they have had something from this ward, that we have given them something, something that can no longer be given.**

**BASAGLIA This is the fact, if nothing can be given, or if we are no longer capable of giving, this seems to me to be an important topic of discussion. Reality must be seen as it is. That is, the department is made up of sixty people of which three quarters are people over sixty.**

**VASCON How did the fact that there was a concentration of elderly people or at least the replacements inevitably all take place, towards** **this ward, with older people? The young people were discharged in agreement, but then the replacements must have almost always occurred with elderly people, for having had such a high average.**

**SLAVICH Because those who "settle down" now in the hospital are always elderly people; the other major source of origin of the patients who came to ward B,**

* **state department C; when this ward was closed in four months he sent about fifteen people to ward B, and they were all elderly people. That is, after all, it is the whole hospital that is old; it is old both because the years pass for those who have not gone home, and because today, among the new entrances, only elderly people settle down.**

**VASCON This could also be a positive fact indeed.**

**SLAVICH To look at it from the outside, yes; to live it from the inside, one must take into account the sense of helplessness that can derive from it ...**

**BASAGLIA The fact is that if the sick are not "things", they are not things for us, and neither are we things. It is not that we are an object that serves to cure the sick, we are people and therefore we have emotional psychological repercussions in ourselves. Precisely I say, if we do not consider the sick as things, we must not consider ourselves as things either ... This** **state of suffering, of anguish that we have in reference to the ward that is no longer the same as before, perhaps also highlights our projection towards the sick; a projection that is wrong, because since we are anxious because we are unable to do what we would like to do, certainly the result in the evaluation of the patient is also not positive.**

**VASCON Of course, working with less satisfaction, as they say, "we don't even have job satisfaction" ...**

**DIZORZ Of course, now we have less than once. BASAGLIA It always happens when you work in a department of**

**long-term patients; in the other wards the situation is rather gratifying, because the sick come in, leave after a month, recovered, so we all feel very good because we are able to cure and discharge. The long-term ward from which seven-eight people leave in a year, if they leave, is a very frustrating and heavy job. Since Ward B was able to dismiss many people in a short time, it was somewhat approachable to the observation ward.**

**SLAVICH And this indicates a little like satisfaction**

* **seen in the production of discharge from the hospital.**

**BASAGLIA In other words, in making ... "healthy" people.**

**SLAVICH ... And if there is no other purpose, in the absence of a discharge it seems that everything will collapse.**

**SILVESTRI But I think that a certain discontent in our department was also caused because too many promises were made a year or two ago. Twenty-five were discharged, twenty-five remained, perhaps these could also go out, but then family reasons took over ...**

**BASAGLIA We are not omnipotent.**

**SILVESTRI It wasn't** **discharged not for hospital reasons, but for family reasons ...**

**DIZORZ I think it is because of the ergotherapy that they let go ...**

**SLAVICH Often nurses and doctors, when they see a patient in the ward all day who "behaves well" and therefore "is well", in quotation marks, feel the urge and the need to discharge this person who they always have an eye on, perhaps to more than that patient who is away all day and works, neatly, here or there in the hospital. I therefore think that it is not so much for the job, but rather perhaps the mechanism to really put the patient in contact with the outside world is in crisis, of course not only in the sense of going for a walk around the city.**

**JERVIS When we consider a patient who hoes at the agricultural colony all day, we don't** **let's see, for us it is not a problem, also because it is there, we know what it does, it is fixed, in a certain sense it has found its solution: hoe. If the same patient stays on the ward all day, we say "in short, what does he do, he does nothing, something must be done": he puts us in crisis.**

**BASAGLIA Yes, but we also think that by hoeing, that patient does a certain activity that is useful to him; and sitting in the ward all day we think is less useful for him than digging the earth.**

**JERVIS Without a doubt.**

**BASAGLIA Whether this is true or not, I think it is a problem to be discussed.**

**DIZORZ Because we talk about integration into society, I think it will also take work, because not everyone will have the good fortune to get out of here and live in glory ...**

**JERVIS** **Yes, but work means qualification; certainly one of the most necessary things to include a patient in society is to qualify him, that is, to give him knowledge that allows him to carry out semi-specialized or specialized work; now I do not think that hospital work activities are qualified activities, at most they produce a laborer, and a laborer is no longer a qualification today, it is useless.**

**DIZORZ The sick, men and women, are those**

**which are ...**

**JERVIS I point out that there is really a difference compared to what it could have been twenty-thirty years ago; twenty years ago it could be said "this sick person works in an agricultural colony, he knows how to hoe the land, he is an agricultural worker, he finds the job on a farm, outside"; today the same person no longer finds a job on a farm, so this job has to change. It may be that hoeing the earth is useful, but it does not help to re-enter a sick person in the outside world. Someone who is a bartender is already better off, yet I don't think a bartender will find it very easy to work outside.**

**BASAGLIA Danieli has found a job outside.**

**JERVIS But we were lucky.**

**VASCON But now I really think it's a question to be considered from the outside; whoever directs the activity of the agricultural colony, has never thought of more modern forms, which would also be a pedagogical vehicle, that is to implement fruit crops (for example strawberries which are inexpensive as a crop, but which one must learn to cultivate) , in such a way that those who worked on this type of cultivation would have a possible use, very simple but already slightly specialized. Perhaps this is an agricultural colony a** **generic management, like a farm, without thinking that perhaps agricultural conversions that were also therapeutic could be done with a minimum cost. The link between agricultural conversions and therapy seems distant but it can exist.**

**JERVIS I think well that it can exist; I believe that an agricultural colony like this is identical to that of the last century, both from the point of view of its therapeutic treatment for the sick, and from the point of view of its productivity.**

**VASCON In the countryside, currently, there are some things where certainly the farmhand no longer exists, but there is for example the orchard worker who must be a specialist, who replaces the old farmhand; he is already a specialist, he must know some specific things, so perhaps the agricultural conversion done in a certain way could be productive here.**

**BASAGLIA Yes, but we are always on two different points of view; or everyone works because they have a certain rehabilitation while they work, because they "forget" they are sick, or because they spend the day. Or the aspect, let's say community, is emphasized instead, work as an opportunity for meetings, discussion, etc. There are really two different ways of approaching the work of the sick.**

**JERVIS There is no contrast between ergotherapy,** **activity and discussion; it is a question of arguing with the old conception of ergotherapy and of creating a new form of activity; and this work activity can be used to discuss and dialectize this work; the contrast between work and discussion does not seem right to me.**

**BASAGLIA Perhaps we can agree on this. What do they say about this? Do you think of work as the only alternative, that is, work itself done from morning to evening, or do you think it should be considered as a source of opportunities for discussion and encounters?**

**DIZORZ I understand, Mr. Director, or at least I think I understand what you are saying; I know that the discussion is very important, but with this discussion, I don't want to make a criticism, the meetings we have every day, even if someone intends to work or to do something, is interrupted, and then you rather break the discussion that seems to be more useful, let it go with ergotherapy.**

**SLAVICH Excuse me Dizorz, but in my opinion here comes a problem on which we have already discussed for a long time. At some point, why can't you do both? That is, if we consider that occupational therapy is linked to the hospital as a medical initiative, then** **I don't see why it has to be done for the whole twenty-four hours of the day; perhaps it is a question of organizing ergotherapy so that there is a period of the day in which one works and another period of the day in which one discusses, or one discusses while working; however, after all, eight hours of work in the hospital has nothing to do with "ergotherapy", it only has to do with the fact that the general services do eight hours of work: that is, these eight hours do not depend on a therapeutic request, but the needs of the hospital.**

**JERVIS It seems to me that eight hours are still too many, I see no reason why one has to work eight hours, growing old with such a large measure of time, of daily work undoubtedly prevents many interpersonal contacts and many community participation.**

**VASCON It is probably a question that you have already asked yourself, a question from the outside, like this: according to the experience made by you, those who worked, what availability did they then have regarding the activity of the community, that is, they found their way of being only in work and then became estranged from the rest of the community?**

**DIZORZ No, they also had community attitudes, they talked and gladly attended meetings too,** **and they talked to each other too.**

**VASCON So you suppose that the work somehow made them more available to the community?**

**DIZORZ This I don't know; people understood, they said "you have to work, even if you go out of here you have to work" and therefore they worked and participated.**

**In the spring of 1967 the C wards, men and women, were the fault of the community: the only wards still closed in a hospital without bars, were the image of the old institution. They blamed the care team anxious to hasten the stages of total liberalization, and uneasily the "free" patients who reluctantly passed along the avenue in front of the cage pavilions. The community had already implemented transformations and improvements in those departments, but not yet opened the doors and torn down the networks. The oldest and most regressed among the sick had also ended up in the C wards, so that the environment did not deserve the title of "snake pit". Sick dirty, slobbering, noisy, ready to fight for a butt or silent for years, petrified, that only with the gesture of the hand and the movement of the lips still revealed the presence who knows where sedimented by images and words. More things than men. On the other hand, all liberalization had taken place gradually and it was logical that there was a phase** **last, after the others. Furthermore, the opening of the Cs was subordinated to the total adhesion and conviction of all members of the community. Nevertheless, this moment had been experienced by all with considerable impatience. The following interview was recorded with the doctor in charge of the men's C ward shortly before it was liberalized.**

**Q Can you give me an example of what happens in the closed ward and that this example also applies in its "drama" to say what C is compared to the other departments of the community?**

**PIRELLA The closed ward represents in a certain sense the preservation of hierarchical relationships that we consider anti-therapeutic, preservation and even exasperation because they concern not only the treating team, but precisely a hierarchization in the patients themselves. That is, there is a disposition of the patients within this closed structure, of this institution closed and separated from the wider community. Patients live with each other like ranks. For example, there is the patient who can take advantage of the cigarette to the full, if he smokes it quietly, despite the more or less pressing requests made by other patients and there is the patient instead who cannot smoke until bottom because he has to give his cigarette to someone else** **patient who is begging or demanding. Then there is another type of patient who others ask for the butt and usually don't ask for a cigarette. There is even a patient or two who line up for this second butt, that is, for this very thin butt that passes into the lips of the latter. I believe that this is a kind of residue of an institutional situation that we have inherited and against which we obviously fight.**

**Q Does this hierarchy of the butt, so to speak, take place according to the degree of disease of the patients?**

**PIRELLA I think it is largely independent of the disease and instead has a relationship on the one hand with the fragility of the personality of certain patients who have thus suffered more the pressure of the closed institution, the violence of this closure, on the other hand with a side that I would say socio-economic. We in this ward, and this is quite significant from a social point of view, have over 50% of patients who do not receive external visits. Some are Yugoslav citizens and others are people who no longer have relatives or who have relatives who no longer come to visit them, who are not interested. D They are abandoned men ...**

**PIRELLA They are abandoned people and do not have the possibility of having money easily, they are not in** **able to carry out activities and therefore I think that more easily they have passively accepted this rule of requesting the cigarette. D All this contrasts incredibly with the rest of the hospital, the community and therefore perhaps becomes even more dramatic ...**

**PIRELLA Yes, there is the problem of the closed ward mainly as a relationship between this severely institutional residual reality and the rest of the hospital that is maturing. Precisely in this regard, a significant effort has been made to focus our attention on this department and results have already been obtained in this first year of commitment, which suggest that there are possibilities to modify this situation quite profoundly too. DI patients in the closed ward, ward C, are sicker than the others, do they have injuries for which the disease manifests itself in a more violent, more dramatic way?**

**PIRELLA** **Earlier I mentioned the fragility of the personality of these patients; undoubtedly some of these patients have organic lesions, they are serious demented, cerebropaths, for which it can be said that abandonment in a situation of closure has more easily led to such a regressed behavior. For other patients, however, this is the case** **it is not fair; they are patients who we think are the bad fruit of a therapeutic failure, of what we often call the failure of institutional psychiatry. Q So you think that breaking down the wall, breaking down the bars, opening the department in short, you would get results?**

**PIRELLA** **The removal of the physical barriers of the ward and therefore the opening of the ward is conditioned by a series of commitments that in our opinion are not only the commitments of the staff, of the medical team but also of the whole community. I think that if the community as a whole, and therefore also the patients of the open wards, do not collaborate, do not commit themselves so that these last two closed wards can be opened, we will not be able to obtain results.**

**Q Is there emotion in the rest of the community for the closed ward?**

**PIRELLA Quite significant, so much so that in long discussions in the general assemblies it was decided to do something for these departments and this something from time to time has materialized in a somewhat fragmentary way until it assumes a very precise connotation. That is, it was established that at the bar a small tax on consumer goods would benefit these two closed departments and now a monthly sum is paid to these departments.**

**Among the rest we can say that while this sum testifies to the interest of the inpatients of the open wards towards the inpatients of the closed ward, it also makes it possible to concretely obviate some of the inconveniences mentioned above, that is, for example, the lack of money on the part of some patients in closed wards.**

**Ward meetings take place before or after lunch between 5pm and 7pm, outdoors or indoors, depending on the season. An average of fifteen to thirty people are present. The discussion arises spontaneously and not preordained. In long-stay wards it develops between very long silences, pauses and fractures of speech; rapid and normal in its progress among the patients in progress in the wards of short-stay patients. General topics or problems of the department are discussed. In the conversation, tales of relations with the family, with the work environment, with society in general and the discussion of permits to leave are prevailing. These permits are, in fact, granted during ward meetings, after the group, including doctors and nurses, has examined the conditions of the patient, discussed them with him and received assurance of good behavior outside, self-control, respect for the time allowed. These**

**Insurance is particularly in demand in the alcoholics ward, where the recovering elements dominate the situation and are absolutely uncompromising on the lack of speech. The doctor in charge of the ward tells us about it.**

**CASAGRANDE The community considers a success or failure of others as a success or failure of its own. Very often, for example, it happens that a person gives his or her word and makes promises that he does not keep. Upon his return, sooner or later, even after some time, the community reminds him of his responsibilities. The person feels noticeably frustrated, not least because he feels he has betrayed others. When, on the other hand, one person asks another not to drink and he goes out and does not drink and on his return he has not drunk, he feels the success of the other as his own success because he sees that he too has a chance if the other has succeeded. to make it. So I would say that this is what keeps these people together, the fact that they have a problem in common and face it together. As I said before, this creates a bond which, however, is not sufficient and that is why relatives are also invited to intervene often: once or twice a week there are meetings with family members, moreover they often go out to**

**trips alone or with the nurse: trips they decide themselves, trips in which they very often feed them, in which they commit each other to fight their battle outside. It often happened that many of these people going on a trip with the others in the hospital did not drink and if it happens that sometimes someone drinks and at the most it happens that one drinks a quarter of wine, the first thing they do on their return is a discussion about this fact, not only to accuse the other of having drunk or not, but to see the reasons why the other drank.**

**D It is a re-assumption of responsibility in essence. CASAGRANDE And then they are used to making small ones**

**choices, continuously. I am reminded of a very recent example of a person who had started drinking again. He came to the community and wanted to be hospitalized; hospitalization for special reasons was not possible (he had a trial and the lawyer did not want him to be hospitalized at the very beginning of the trial). Then the community offered him help through other modalities, but these modalities had to pass through his responsibility. At this point the community confronted him with responsibility, and it was not the doctor, but the community. They said: we are willing to help you if you do this. And what he was asked was for**

**come to the hospital from morning to night and make a commitment to come every day. He said: postpone to Thursday. The community said no, we want to know now, we are willing to help you but we want to know now. This greatly embarrassed this person, it was a very small choice he had to make and he didn't know how to make that either. Until he was almost forced to do it: he accepted what the community offered him after having examined various possibilities; they tried to favor him as much as possible, but at this point they put him in front of an either-or. In this way he had to choose and now he comes; is a person who is okay at present. They are small daily choices that prepare the individual for a greater possibility of choice and also of vision of the situation.**

**D You have this feeling every day, of having inpatients in the ward who are co-responsible with the medical action ...**

**BIG HOUSE** **Yes, I would say that they are continually subjected to actions of responsibility, because it is the situation itself. Not being in a closed situation, there being a lot of freedom of movement, being able to make daily choices, for example to participate in work or not**

**of others, go out for a drink because somehow**

* **easy enough, or not to go outside, try to have wine brought inside or not, participate or not in various activities, etc. Well, it is continuously the community that makes him responsible, in the sense that by participating in all the activities together, if one is missing, he is noticed and that is called to responsibility, but of course the same person who is calling the other to his responsibility in some way must self-responsibility, because he knows very well that one day he too would be called back. And it is no longer neither the mother, nor the father, nor the doctor who does it (the doctor could be seen just as the constituted authority), but it is the others, the others with whom he has contact, the others that he tries continuously to exploit but by which it is continuously exploited. Sooner or later the person, by dint of exploiting others and being exploited in turn, is put into crisis, he finds himself at the point where he must somehow make his choices.**

**The empowerment of the group seen up close is an exciting event even if it is the opposite of perfection, given that it makes its way in a difficult, suspicious environment, which suffers severe moments of**

**irresponsibility, regression and in any case it costs a great deal of effort to the sick and the care team. After all, the situation varies from one department to another. In the A women's ward, which collects all the new entries and is mainly composed of short-term patients, group interrelationships are more fluid.**

**Q You have ward meetings with the patients, I see. Were you able to detect any effects after these meetings?**

**JERVIS I've never really asked myself, but you also need to know what effects you are looking for. The meetings are daily, and when by chance we interrupt them for a few days, we feel the need. After all, the structure and the climate of the ward change due to a number of factors, most of which are not directly controllable: think of the network of emotional dynamics that bind patients, nurses, doctors to each other; the whole department is affected by unconscious factors that affect very many people and cannot be examined except very crudely, and often the evening meeting does nothing but collect them. When you see that something is changing in the structure and in the climate of the ward, it is not always possible to understand exactly what was the main cause of the change: it is certain, however, that ward meetings are very important from this.**

**point of view.**

**Q Do you lead these meetings?**

**JERVIS Not always, but in any case I direct them more than I would like. Patients easily contact the psychiatrist directly, attributing to him a power that he does not have and cannot have, and this is naturally one of the most frequent topics of discussion. The ideal would be to have even more informal meetings, in which the presence of the doctor is not decisive, or even ends up becoming marginal. Sometimes it seems that you can, but practically the presence of the doctor in a meeting of patients is always decisive, whether you want it or not. Keep in mind that meetings of this kind are more than anything else occasions for meetings for large groups, of twenty or thirty people, and not psychotherapy meetings or business meetings. The meeting is easily divided into smaller groups, sometimes it happens that many patients in the ward are absent. The dynamics are very varied, often exciting.**

**Q This is a short-term ward, and this is where a sick person enters when she arrives at the hospital: in general, do you notice that there is some difficulty in settling in, for example regarding these meetings?**

**JERVIS It is difficult to give a general answer. It largely depends on the type of hospitalization and the difficulties**

**the greater are evidently with forced hospitalizations, with the sick who arrived here by ambulance, perhaps tied up, or brought by deception. However, there are also some inpatients who are voluntarily assisted by mutual societies, sometimes with family neurotic problems that do not improve except in an apparent way with hospitalization, and who perhaps belong to slightly more affluent classes: with these people there is difficulty to break a certain tendency to isolation, or to seek a privileged interpersonal relationship with the doctor. Meetings are often avoided in the first days of hospitalization: then the question arises whether to encourage a personal relationship with the patient, or whether to push her towards informal groups and meetings.**

**Q If I understand correctly, do you prefer the group approach to the individual one?**

**JERVIS I don't know if that's the problem, although I'd say yes. In a certain sense, the doctor-patient relationship cannot be eliminated, and its complexity must be known. On the other hand, any relationship, individual or group, risks being a technical relationship, in which the doctor accepts to be considered omnipotent, or only "good", or "just", or "punitive": in short, ghosts are created . For this I try if possible to involve in this**

**I always report other people, the relatives of the sick person, a nurse or two, other sick people, depending on the case, of how the situation happens. It is not a real group, but the informal nature of these meetings makes them more real. Sometimes it is better to be alone, but the psychiatrist-patient relationship can be as artificial and mystified on its own as in a standardized and aseptic "group" approach.**

**A psychologist works full time in the Psychiatric Hospital of Gorizia. Here too, the definition of a role is very different from the traditional one.**

**Q You came to work here as a psychologist: what does your job consist of?**

**LETIZIA JERVIS It is not easy to describe a work that for a long time did not have, let's say, "positive" characteristics, but was only "negative", almost suspended in the air for several months. I did some tests, of course, but few, and at first not even those.**

**Q But in what sense do you call these negative characteristics? LETIZIA JERVIS I could better say "denial". Mine was a privileged condition, because I had the choice between carrying around the traditional paraphernalia of clinical psychology and trying to**

**to use it "in a new way," and not take anything with me, just enter the field and try to act. I chose this second alternative, which is why I was talking about "remaining suspended": you see, doctors have a traditional role to destroy as their point of reference, they are continually confronted with what they do not want to be, and they could not do otherwise because their services are required. "Techniques" that cannot fail to give. My choice was different just to be able to compare with their position following another itinerary. D So you tried a different way, completely abandoning the techniques of your specialty.**

**LETIZIA JERVIS I would say that it would be illusory to think of being able to abandon all techniques: you can choose not to use certain tools, but of course you always act in the situation with all the way of being that everyone's specialty makes him absorb, makes him wear together with the techniques. My choice was not to use the traditional role as a term of comparison, only this, to try to compare myself with people not with roles, or at least see if it is possible. After all, many psychologists are looking for what their role is in the psychiatric institution and there are many uncertainties and also many divergences on this point. In France for example they dealt with**

**the problem on an issue of the Information Psychiatrique, and they concluded that the psychoanalytic training is the golden key for the psychologist who really wants to enter the psychiatric institution.**

**Q I don't think you are of the same opinion.**

**LETIZIA JERVIS** **I am trying to free myself from one technique of objectification of the patient, and I think that before embracing another one it is necessary to verify what the rejection of a technicalistic objectifying attitude means.**

**Q Did the experiences of these first months of work give you any indication?**

**JOY** **JERVIS Yes, of course, but I think they are still ambiguous indications. On the one hand, the lack of reference points to "place myself" somewhere suggests that I am some sort of incomplete doctor, because I do the same things as my psychiatrist colleagues without prescribing drugs and, obviously, without taking care of the general medical aspect patients, which they sometimes have to deal with. DE Is this patient reaction difficult to change?**

**LETIZIA JERVIS I would not say only of patients, on the contrary I would say that this attitude is perhaps more than colleagues, or nurses, and mine: my fear that all the effort not to confront the traditional role of the psychologist is reduced to comparing oneself to doctors.**

**Indeed, many patients immediately grasped the new side and asked me a number of personal questions to try to give me an identity. There were no techniques to act as intermediaries: medicines, tests (indeed I could say, more finely, the test situation). D In this way, a new type of relationship was created with the patients.**

**LETIZIA JERVIS An alternative to the traditional stereotype of the psychiatrist has been made evident. Being defined by the patients, and constantly trying to overcome this definition with them, is the first anti-institutionalizing indication of my work here: for the psychologist, at least! Of course there are big risks: not to realistically analyze this "new" relationship, and to fall into the extemporaneousness of daily practice, also detached from technique and therefore completely uncontrolled. Or to use a false reciprocity for the acquisition of a good conscience, which justifies the effort of losing one's identity with the role, losing the usual facade, and being forced to continually rebuild in comparison with others.**

* **When we see that the sick person comes here and seems lost and must be followed, followed, followed and we follow him and then we can say: here he is, he can finally go alone. For us it is a satisfaction ». This he says**

**Nurse Di Lillo and with this simple and spontaneous phrase summarizes the mood of most of his one hundred and fifty colleagues, men and women. In particular, the youngest are satisfied and proud of the results achieved by the community and their new position. For some years now their function has completely changed: it was the men who mournfully released the bolts. We were jailers, they say. Now, in constant contact with the patients in the wards, during walks, at the bar, in card games, they have the possibility of approaching the patient who can tune in from time to time with the individual subject in relation to the general situation and vice versa. They therefore have an indispensable median position between the patient and the medical team; a lens that can focus or confuse the relationships between the parties. Some remained indifferent to the change that took place in the hospital, others even have nostalgia for the ancient time when it was enough to close and take care that the sick did not run away, the responsibilities were few, the satisfactions none. Basically, if there is a small opposition group between nurses and nurses, I believe that it feeds its attitude in a disappointed expectation of economic improvements, expressed by the equation: greater responsibility, greater pay. Unfortunately this type of improvement cannot be implemented by the**

**micro-society to which they belong, but from large society through its rules, employment contracts, trade union struggles and the evolution of the general conditions of the Italian hospital sector.**

**From the interview with some nurses (Augusto Benossi and Silvestro Troncar) and nurses (Anita Jerman and Luciana Marega), the great themes of institutional renewal and the value of discovering a new type of relationship with the patient emerge.**

**D Basically, by implementing current methods, do you struggle more than once?**

**JERMAN I would say not. It is no longer difficult. This is a new work situation, completely different than before where the nurse is a member of the community instead of being a guardian. Q Can you give some examples?**

**MAREGA For me, the important thing is to assist these patients, but not so much assistance as to instill self-confidence to be reintegrated into society. And this is something that I think everyone here has understood. Q How do the sick react?**

**JERMAN The sick react well, I would say, if they are approached adequately. That is, when the approach between nurse and patient is as free as possible. So if the nurse and the nurse was given**

**trust and responsibility in his work, to the same extent he will know how to instill it in the sick. Therefore, the freer the nurse is, the better the relationship with the patient will be.**

**DE how do you deal with those who come here for the first time?**

**MAREGA First of all we try to understand them, at the first moment, and to stay close to them as much as possible; but they settle down so early because here is such a free environment ...**

**Q But don't they arrive at the hospital biased? MAREGA Yes, they arrive biased but they settle down immediately**

**to the first approaches with us and also with the environment.**

**As soon as they look around they settle in immediately.**

**JERMAN More than one is biased. I would say that this is precisely the struggle that the hospital has to face: that of the prevention of the external society towards the mentally ill. The mentally ill who comes here for the first time gets biased.**

**ED after this prevention passes to him?**

**JERMAN Yes, he passes by, because he can see that he is not being treated as he thought.**

**MAREGA** **Like the old psychiatric hospital cliché ...**

**JERMAN** **Society always thinks of the psychiatric hospital as it was several years ago and thinks**

**to the classic sick of jokes; instead it is quite another thing. Here everyone lives freely; it no longer even has the sense of a hospital. The sick person finds himself free and helps himself.**

**Q Have you witnessed any visible progress with regard to any sick person?**

**JERMAN Regarding all the sick I would say, progress**

* **visible. I have been working in this hospital for five years and have practically lived this experience from the beginning. I arrived that the bodices no longer existed, nor the mechanical means of restraint, but the wards were still closed, so I was able to see the first ward open.**

**DE what happened?**

**JERMAN Nothing happened, absolutely nothing of what you thought. It was thought that they had to come out en masse ... Instead what happened was the discontent of many nurses and even some doctors who did not consider this method suitable and thought that it was not possible to have improvements by opening the hospital, in practice freeing the sick. While many of these now, I believe all of them, have changed their minds because the improvement is so evident ...**

**Was there loss of ED in the sick?**

**JERMAN I would say not. The biggest problem was**

**to move them out of their apathy. As for the escapes, their frequency has not increased at all, rather it has decreased. Q Why were they apathetic?**

**JERMAN They were apathetic because they have remained closed, abandoned to themselves, forced into this cloister for many, many years and consequently have not had the opportunity to put into practice any personal initiative.**

**D Do you find difficulties in meeting with patients? BENOSSI Especially in the first days of hospitalization; yes**

**tries in every way to encourage their insertion into the community, into groups. I think this is a great method, which also simplifies our task. Q Is there satisfaction in holding meetings?**

**BENOSSI A lot; opinions, desires are heard, and everyone, even us nurses, is free to express their thoughts, and this is very important. I have been here for about twenty-four years and have been able to personally follow this progress. D Practically the visitor, like me, the layman, wandering around the hospital does not have the feeling of being in a psychiatric hospital.**

**BENOSSI I believe it, especially when entering some department, like ours, where everything has been modernized, in the walls and furnishings; but it is above all the environment and**

**the atmosphere that has changed is a family environment.**

**Q A week ago I saw a boy who was showing strong aggression, now I have seen that he has already calmed down. What does this improvement depend on, in your opinion?**

**BENOSSI** **Above all from the contact with others and from the environment he has found; you see, we try in every way that this community really exists, not only in words, but in deeds.**

**Q You too, Troncar, believe that resuming a relationship is facilitated ...**

**TRONCAR The conversation in groups is a good thing, because you put yourself on a real level, you can discuss various problems and advise, understand ...**

**Q My impression is that you make it so much more effort than otherwise.**

**TRONCAR In any case it is much more difficult, because in this work we are more committed; however, there is also more satisfaction, seeing the progress that is being made and seeing that it is useful; you know, once upon a time we were a bit like jailers. They did a job, they came here to get their pay, and off they went.**

**D Basically, you now have a more precise function ...**

**TRONCAR A little more precise, and in any case also heavier, because one is always a little anxious: I have**

**I did it right, I did it wrong. Before the responsibility was more limited, because one would lock with the keys, he was careful that the sick did not beat each other, they gave each other those four pills, the therapy that the doctor ordered. In short, we were under "orders, and when one had carried out the orders well he was in place with his conscience and all; the improvement of the patient was considered only the work of doctors. Now you can see someone improve, see them improve under the eyes, being close to them ...**

**D In short, you too collaborate in the therapy. How do you behave with the patient, can you give me some examples?**

**TRONCAR Once just hospitalized, one was undressed, bathed, was placed in a small room, properly called a cell. Now instead, talking to him, he is invited to the clinic, then he takes the pressure, he is asked where he is from, so, to make a little friendship and give him a little confidence so that he feels more at ease, feel at home, in the family. Then slowly he introduces him to his colleagues, invites him into the room where his bed is, and if there are his companions he introduces him; in short, we try to reassure him and gradually he settles down. In the evening he is invited to the department assembly, so he knows all the others, he talks, and slowly he becomes part of the**

**community of the department.**

**The remnants of the asylum atmosphere of a time are, moreover, clearly destroyed, in the cases in which it still occurs. The following interview took place with a nurse (Orlando Andrian) of the last closed ward among the male ones (the C) shortly before it opened, and indicates the conscience of the situation at the moment in which it is transforming.**

**Q I have seen that you are very actively involved in the life of the ward ...**

**ANDRIAN Yes, it is the most difficult department. It is a ward of heterogeneous patients as a disease; however, we are trying to give a better solution. We made this division which is a bit (he *points to a door that divides the department* ) a little reform. D In whatsense?**

**ANDRIAN By dividing the department in two: the most regressed on one side, the others on the other. It did something good. For some time now we have begun to do what you do in the other wards, those ward community meetings; we have seen that there is not a participation as in the other departments, but a certain interest. Something that moves, that also gives them meaning, makes them responsible.**

**D They are almost all old.**

**ANDRIAN They have been here for thirty years, the hospital has been open since '33. Some were already in patients in other hospitals.**

**D Here there are people who will be eighty.**

**ANDRIAN The average is fifty-five to sixty years. It can be said that there are several who have spent almost all their lives in this hospital or in others. Q Is it therefore particularly difficult to act on these sick people?**

**ANDRIAN There is a certain difficulty, because they are now institutionalized, they have been abandoned for a long time. Before this new direction began, community work, we limited ourselves to what was direct assistance, but we did not try to activate the sick, to make him responsible for something that would give meaning to his life. It was observed that he did not get hurt, did not hurt others ...**

**DE do you think that if this ward were opened despite the very regressed patients that exist, some results would be obtained?**

**ANDRIAN We have seen some results in the music therapy group. There was one with whom, as I recall, one could hardly ever communicate; now he answers, calls, also helps us with the internal work. In short, we see that there is something, a little, but there is.**

**From the beginning of the liberalization of the hospital until the summer of 1967, the sisters had never participated in the assemblies and ward meetings. Since the Psychiatric Hospital of Gorizia shows the visitor in detail his intense life of relationship and exchange, it was surprising in this environment to never meet the nuns, who are an inevitable character in the hospital scene in the world. They preferred to work in seclusion while maintaining their traditional role as ministers of the women's wards, charitable and authoritarian at the same time. In so doing, they legitimately fulfilled their function, without failing in their duty, always willing to work and toil.**

**The rest of the community, on the other hand, acted towards the religious according to a community logic: not to force individuals or groups, to allow maximum freedom and spontaneity to attitudes. However, an immobile situation still arises, fertile with misunderstandings to the point that when I asked the superior for a testimony of her and the other sisters, I heard her reply: «Are you sure that the rector agrees? "**

**For some time now, the sisters have been taking part in the first meeting of the day, that of half past eight.**

**Q Have they been in here a long time in the hospital? NUN Several years, thirty-two years. And this too**

**We are pleased to renovate the hospital, you see that it was actually a renovation, now we need more attention.**

**D That is, in your opinion, is it harder now?**

**NUN As far as effort is concerned, it will not be, rather a lot more responsibility now that the wards are open, once they were closed there was not so much surveillance that was needed, while now you have to keep up with it a lot.**

**SISTER The sick are less agitated, they do not have that agitation they had years ago and require less attention. We feel comfortable there.**

**Q Was there once more tension?**

**SISTER The sick were closed and there was another way of therapy and vice versa and then they had more or less agitated days, periods and now they have another way, the sick have calmed down more.**

**Q Is there a big difference between the new system and the old system, in your experience?**

**SISTER Of course there is a difference, it can also be said for good. But what one saw, once the sick when they were in themselves, conscientious, were better suited to work, perhaps they had more strength. While now they are less strong, more apathetic, less inclined to work, less willing, they put more on sleep.**

**Q In your opinion, does this also depend on drugs?**

**SISTER I think so, once upon a time when the sick person was agitated, he could be held back with somewhat strong means as was the custom at that time. But now no. Once in the good period they were beautiful, they were smiling, while now they are always a little melancholy. Q Does that mean there were more people working?**

**NUN Outside, yes, and in the workshops. Now they have dedicated themselves to those fields of work that it bears for them. But in the workshops, kitchen, laundry and so on there are fewer of them. The hospital had more help, while now it is better for the sick because they get a cash fund that later benefits the sick.**

**Q The bar has been open for three years and is run by patients. This is a good initiative in my opinion. SISTER Yes, the sick carry themselves well, for the sick**

* **even better, because before they didn't get, they didn't get that little bit of money, that little bit of reward, maybe they gave other things, men were given cigarettes to smoke, women were given a much lower salary and now they are happy with this method. Because of the trips as they do now, we sisters have already started with the sick women and then the sick were happy because once a year they saw this trip with pleasure and then it was done with those small contributions**

**also or some snacks all together. Now, to tell the truth, it has improved a lot, because also from the provincial administration they are paid more and then it is much better, to tell the truth.**

**D That is, there is some difference between once and now. Look, there used to be more old-fashioned methods, let's say, coercive methods?**

**SISTER Yes, they remained isolated for a few days in the cells; and the shirt, however like the treatment we have said that perhaps they used strong ways, this cannot be said, because when you have a knowledge of the former superiors who were indeed rigorous and the sick wanted them to be treated well, not only not with he hit something else, but not with words. They wanted the sick to be treated well, to be respected, as such, I don't know, as for the accusation, there was another therapy.**

**D According to you this therapy, that is to liberalize the sick, to make him free, to allow the sick person to go out, etc. good for the sick? I ask her from her experience, even though she is not a doctor, just as I am not.**

**SISTER There are some cases that have improved a lot, we cannot say it yet about the others, perhaps it will also be due to the quality of the disease, the tendency they have. But for some, they have changed for the good.**

**D So** **In your opinion, was this a positive experience?**

**NUN For the sick, it is good as an experiment.**

**D Do you find, however, that overall this fact, that is, evidently there is more effort to do, the departments are open, you have to follow, etc., creates a little anguish, anxiety, even a little anarchy, a little of chaos, perhaps?**

**NUN You see, now there are three women's wards open 3 And if there is one of the wards for the chronically ill, the bed, the infirmary, here the dangerous patients have been placed, at least those who tended to escape, now they are examining, they are working to open this ward, now it is not that he disapproves, but this gives a thought because knowing the sick ones and knowing that they are different that tend to be dangerous for the consequences, then it gives us a little thought, but in the end we are always willing to collaborate.**

**Q It is my feeling, also from the question you asked me this morning, is that they feel a little isolated from the rest of the community.**

**NUN No, I didn't say that ...**

**The nun does not want to record her response**  **.**

**We resume shortly after.**

**D As far as entertainment is concerned, every now and then they organize the festival. Do they also participate in the organization of this?**

**SISTER Yes, maybe in part if it happens, we go to see, several times a day, in those three days of the festival we went to see, even in the evening, we took part in the show; we also collaborated in preparing, to meet some need, we helped all the staff who were preparing and for dinner, we were full of work for the festival, we collaborate when there is something.**

**D Perhaps he also has the feeling that in a working regime, by creating obligations, a certain discipline gave more consciousness.**

**NUN We cannot pronounce on this.**

**D Because you say that you see them more listless.**

**NUN Perhaps the very fact that they see more money in hand, that they see themselves more rewarded. They have this freedom of openness, they have this bar, they can hang out there, all together, they have more trips, they have more fun and then that also makes them less willing. Once it was enough to come out of the department and for them it was already a lot, they came very willingly to the workshops, because they already calculated themselves better than the others, while now they are all free, it makes her want that one who**

**he passes through the boulevard while walking, while the other has to sacrifice himself to work.**

**D This is true, once upon a time those who collaborated, working, were the ones who went out, they were already in an exceptional situation and therefore now, since there is no longer an exceptional situation, they are less stimulated, but nevertheless there is still someone who works. Did they once also do organized chores?**

**NUN No, inside the pavilions, no ...**

**D I am sorry that you, Mother, stopped when you were about to tell me a particular point of view, but perhaps this would be beneficial to the good understanding, to the understanding of everyone, I am of the opinion that sometimes it is better to say clearly, to discuss, speak.**

**SISTER You see, we Sisters are a bit elderly, we are not like the youth, the staff at the beginning, who hardly learn the jobs, we have a practice ...**

**Q I sensed this thing here, you have been working for many years like all those who do a demanding job and this is an exhausting job for everyone and therefore also for them, but you think that for example this new situation could have better interested perhaps a young?**

**NUN No, not for us, the whole thing, I don't know how to express myself.**

**D Yes, but perhaps in the sense that like everyone else she did the**

**most of his experience with another system.**

**SISTER Yes, that's it, but we are fine, we have nothing to say, but we also don't have to disapprove in the past. The word is frank: perhaps sorry that he exaggerated in past methods, because in reality they were punished, woe betide anyone who touched a sick person, there was a very strict discipline. We love our dearly ill loved ones very, very much, but someone like this due to illness is a bit exaggerated and they report: we have been beaten, we have been touched; we would never want this to be true, because there was such a severe director that there was trouble if a doctor or a nurse touched a sick person and more, but trouble if he mistreated him, actually there were even fines. Staff caught in such an act were changed from place to place.**

**Q In my opinion, in this community the old systems of psychiatry are criticized, systems that are still generally used in many Italian hospitals, and a new fact is implemented.**

**NUN Indeed, we just have to adapt willingly, because we see that he has improved a lot. He has improved in so many things to tell the truth. When we gathered in church we once had a uniform uniform, the sick had their hair cut and were not treated**

**hair like today we have a hairdresser.**

**D They look like human beings, there is a little more order, yes, maybe modest, because this is a hospital for poor people, not a clinic.**

**NUN It's not a big province, it does what it can, anyway ...**

**Q I saw that they too are now attending the half-past eight meeting.**

**SISTER It is a great way to expose our problems, speaking we mean each other, so to speak.**

**D It seems to me too, I told you! Perhaps it is the best way to present reasons and to understand each other. Thank you.**

**The problem of the "vocational choice" is proposed in very different ways in other cases. It was interesting, in this regard, to interview some people whose work at the hospital is more specifically voluntary.**

**The "outsider" enters the hospital through the work of the social workers and with the presence of volunteers. The function of this team is to act as a buffer in the relations between the care team and the patients, between the outside world and the community. Social workers maintain relations with families, with institutions and bureaucratic bodies as regards pensions, subsidies, social security. With**

**five hundred patients, each of whom is a "case" and has a**

* **case "to be solved, the assistants' work is dispersed in the rush from one office to another of the necessary paperwork, while their presence in the departments would be so necessary to promote initiatives and activate the environment. The action of the volunteers is entrusted to the good will of the individuals and to the sincerity of their attitude. The following interview was excerpted from a recording with the social workers of the hospital and with a group of students (including Sonia Baiss) who are completing their internship here. At the time of registration, the "C men" department had not yet been opened (June 1967).**

**Q Are you a little scared, do you feel uncomfortable when you are here in the hospital?**

**BAISS No, I've never tried this. Contrary perhaps to what may be the opinion of others. I too, like my colleagues, had never visited a psychiatric hospital and the idea I had of it and what I had done through the films was something like a nightmare. Instead, here it seems to be in any place, like in any other environment where there is a community of people. Q Do you have a specific task here in the hospital despite being a student?**

**BAISS Yes, I was assigned to ward C men, in**

**beginning with a kind of excuse, that of Christmas preparations, to try to reactivate the sick a little, because the nurses could not do it for reasons of time. And then it was decided that I would stay there, and I accepted because the job seems really exciting to me, especially with the prospect that the department could open.**

**Q As ward C is the only men's ward still closed, what were the reasons that made you choose this ward?**

**BAISS I don't think I was able to choose because I didn't know the hospital well enough; I accepted the job as I am convinced that this particular job in the last male ward still closed responds to two needs at the same time. First of all, the objective need of the institution to face and possibly resolve the painful situation of over seventy patients forced to live in a climate that retains mental asylum characteristics. Secondly, I thought that working with very regressed people offered rewards not only for the sick but also for me.**

**Q What do you think the sick say about you?**

**BAIS It's not just that I think so, they tell me too. We have managed to establish a fairly straightforward relationship whereby the things we think we try to**

**tell us. At first I made them a little uncomfortable, the idea of having a female figure in the ward excited them, then they got used to and accept me as a person belonging to the ward to which they turn to for contact with family members , to inquire about pensions, subsidies, to ask me to take them out, to organize some trips. In short, they seem to have understood my role in the department quite well.**

**Q Have you already taken any trips with the patients in ward C? BAISS No; perhaps also due to the relationship that has been established with the nurses, there is a tendency to delegate these activities (trips, tours to Gorizia or even going around the hospital) to the nurses. Because they say that, since I live little in the ward, I cannot get to know the patients well. They trust themselves more also because they see me as an intern and not**

**they manage to empower me enough.**

**In short, they made sure that you feel a little freshman ...**

**BAISS Yes, a little, however, relations have also cleared up enough with the nurses; after a couple of months we were able to clarify them and now we cooperate quite well.**

**Q You spend a lot of your working time in this ward which is the closed ward, where the sick are**

**serious or very serious. Some of them do not speak or have attitudes of serious illness. What is your thought regarding these sick people, their possibility of healing, of assimilation among others?**

**BAISS Meanwhile, I would not say that the most seriously ill are found there. Because sick people with the same characteristics are also found in the other wards. These only had the misfortune of having remained in the closed ward. Because of the fact that they do not speak, I believe that she too, being for twenty years in a ward where no one ever speaks to her, would lose the habit of speaking. It's not that they don't speak because they have a particular disease or are aggressive for particular reasons. They are reduced as they are reduced precisely because the institution has made them such and I am convinced that in a little time it will be possible to change them. It will certainly not be a matter of days or months, but if we consider that a patient has been locked up for twenty years in a ward like this or in a traditional hospital, I think that in a year or two we can help him a lot, really change him like from night to day.**

**Q Have you already seen results in this regard?**

**BAISS Yes, I have seen remarkable results because we have managed to organize community meetings in which participation is spontaneous and is always quite large. On average thirty people per meeting**

**although there are about ten who speak, no more. The others listen, they comment softly because they do not yet have the courage to express themselves. Others comment when the meeting has dissolved, come to ask me for information or talk about it with the nurses. However, they have been very active. Then they start asking for things, they begin to express their needs to have money, to be free. Then a committee was organized in the department, always on a voluntary basis, and an attempt was made to administer a fund of money given to them by the Club. I believe that these can be considered results. When you consider the fact that there are ward meetings, that we have managed to set up committees, that people volunteer when they want to go out, that they complain because they have the ugliest clothes in the whole hospital and they want to go on their own to choose the wardrobe, who have taken care to distinguish their only decent dress from the others, here, all these I consider remarkable results, and also obtained in a short time.**

**The character of personal choice, which practically moves the entire hospital community of Gorizia, is particularly clear from this interview with a doctor.**

**D Doctor Schittar, you are also a volunteer, or at least you have been for a fairly long period of time: what prompted you to come to the Gorizia hospital?**

**SCHITTAR When I arrived in Gorizia I was completely "fasting" from psychiatric practice, and almost also from theory. Psychiatry had always been a big interest of mine, but I was a general practitioner: I was an assistant in a pulmonology division of an OC and in addition I had started, but without too much enthusiasm, the profession of mutual medical practitioner. D He therefore embarked on a career which is that of most young doctors; why did he interrupt her so, shall we say, abruptly?**

**SCHITTAR It is a bit difficult to pinpoint the reasons that lead us to such important choices: mine was partly an emotional reaction to the kind of role I would have had to play as a general practitioner. It seems to me that, at least in current practice, to which a newly graduated doctor must adapt, the medical profession lives day by day in bad faith. The role of the medioo is by definition that of a "superior" person; he is by definition cultured, educated, objective, "good", economically disinterested because his is "a mission"; above all he is the one who knows medicine, who**

**he knows diseases and knows how to cure them. In short, "science and conscience" are always qualities taken for granted; the evil is that they basically serve to justify the position of power that the doctor maintains, in spite of everything, in our society. relationship of authority, a relationship that covers and hides at times very serious flaws, from real scientific ignorance, to the many abuses to which patients must undergo every day. It is a very stressful situation for those looking for a different human relationship.**

**Did DE find this relationship different in Gorizia? SCHITTAR I would say yes. In Gorizia at least you want to**

**a relationship different from the authoritarian one, both between members of the medical team and in relations with patients and nurses. There is a tendency to reduce the role of the doctor to that of a technician, it's a bad word but**

* **clear enough, a health technician, not necessarily a mental health technician, of whom we can all be considered "technicians", doctors, nurses, patients. But it's not just this. The enthusiasm that this type of work arouses also derives from its voluntary and "humanitarian" aspects, but above all, it seems to me, to get out of neophytes,**

**its "political" corollaries. Here a young doctor feels that in some way, with his work, with the participation in numerous group meetings at all levels, the double intent of an activity, let's say, professional, and a daily battle of ideas, this one. the latter certainly more rewarding than the first!**

**The work opportunities of this community are not many, they are limited to a laboratory for the manufacture of chairs, another for cardboard boxes and a third where flasks are stuffed; in all they employ about thirty people, while a small team of laborers find employment on the farm. Many others work in the hospital services: kitchen, laundry, etc .; these fields of activity traditionally belong to a small group of long-term patients fully integrated into these modest tasks. In general, the work reserved for patients is not hindered, but neither is it favored, to avoid forms of colonization of the patient. From him you can get good benefits as a farmer, worker or craftsman, in the absence of normal pay, because no law defends the work of a inpatient in a psychiatric hospital. Therefore, apart from any consideration on the value of occupational therapy, the community is denying the validity of the work**

**it also starts from the consideration that the savings made by the public administration with the work of the patients do not benefit the patients themselves nor do they serve their rehabilitation.**

**The only activity organized by the community until recently, efficient and popular, was a section of music therapy based on teaching the simple rhythms of Karl Orff's "Musik fur Kinder". The music room**

* **has been closed and there is no longer talk of music therapy due to a banal trade union dispute between the administration and the nurse who was in charge of the section; the latter, having attended a specialization course in Salzburg, animated by the best intentions, after a few years of activity had asked him to be recognized as a music therapist. Except that it was a new and difficult to qualify voice, not foreseen in the bureaucratic roles of the provincial administration.**

**Until some time ago the community published a monthly entitled "Il Picchio", perhaps because it insisted (like the bird truncated it) always the same problems, or because the title wanted to be ironically allusive. The publication had three years of activity and was particularly interesting because it expressed the progress of institutional life over time. Today it is not renewed because liberalization**

**of the hospital has made the tools of mediated communication useless. The director of the "Picchio" was Furio, a patient who remains one of the leaders of the community. Furio is a man of about fifty, intelligent and evolved who knows better than any other inpatient the problems of the psychiatric hospital. The recorded conversation I had with him spontaneously and comprehensively summarizes the brief history of liberalization and the current thinking and position of the patient in the community.**

**I like those cigarettes so much there ...**

**FURIO Actually, when I returned to Italy I didn't know what cigarettes to smoke, when I ran out of Caporal I couldn't buy any because they were too expensive.**

**D By the end of the year they should decrease, because the French complain that the Italians are selling too expensive.**

**FURIO** **They are a counterpart, as in France few foreign cigarettes are sold ...**

**D As they say: the rest of us sell these here for 80 francs, you others in Italy with taxes and you can sell them all for 150 lire, but the Italians sell them for 290 lire, that's a lie. Here, however, we begin our conversation about yesterday's schemes and let's try to do, together with his testimony, the**

**history of the community, so basically starting from what year? From about six years ago?**

**FURIO Yes, six years, because we are already at the end of the year; practically here it began in '62 in July and August.**

**Q In 1962, did we already begin with what they now call the therapeutic community?**

**FURIO No, it began with freeing the patient from the constraint that was in force. We began to tear down the nets at first, the low walls in a second, then we stayed still for a couple of months, like this, to see the reactions. Because I believe that the director, even if he had the scientific conviction that certain institutional fetters from the hospital had to be removed, but for him too it was a new experience and he had to experiment with the method, if he went; since the results had been positive, then liberalization began.**

**D So the first phase was the liberalization of the hospital and this began in '62; here, this liberalization was declared, that is, the patients, I think they have been made aware, had the medical team already begun to discuss with the patients?**

**FURIO Yes.**

**DO maybe it was done only with some of you?**

**FURIO With some of us, not all, but it was done with some of us and in turn it had to be done with the others. Even today we discuss it, because many think that this is due only to the goodness of the director and instead many others are aware that if there had not been the collaboration of the sick, of the nurses, the medical team could have done very little.**

**D Well, you rule out that a first gesture can be interpreted as an act of humanitarianism in any case?**

**FURIO I absolutely exclude it, it is a matter of scientific conviction, it is undoubtedly this; it might appear that it was a gesture of humanity, because the conditions of life were not human before.**

**D Let's go back to '62 or a few years earlier. How was the hospital run before?**

**FURIO He was conducted in the traditional way, in the wards they lived closed, there was practically no participation of the patient in the life of the ward nor anything outside of material work. There was the good sick man. There was this prerogative and I believe it still exists in traditionally run hospitals. Doctors paint two portraits of the sick, that is, two roles of the sick: there is the good sick person and the bad sick one; the good sick person would be that sick person who helps the nurses**

**in cleaning and ward work, the bad patient, the bad one, would be the one who does not intend to collaborate.**

**D The patient can be used or not.**

**FURIO Yes, the sick person on whom one can rely: you take, go, etc., the sick subjected so to speak.**

**DE therefore wake-up times, retreat times ...**

**FURIO Wake-up times, times for lunches, patients spent all day in a room practically doing nothing.**

**Q Were there any means of restraint, were any means of restraint used?**

**FURIO No, I in my department would say no, at least since I came, restraints such as straitjacket or bed were not used; the most restless patients who did not sit still and had to stay in bed were tied up with the sheets.**

**D On this basis, liberalization began here. When you talked about this intention to liberalize the hospital in the wards, how were these proposals received?**

**FURIO The killing of the net was welcomed with enthusiasm: finally you can go out, now we will have the opportunity to go wherever you want, there was a tendency to escape from the closed place, in fact we had more escapes when the hospital was**

**closed, and then they could be considered escapes, today if one goes away it can be considered a removal, it is not supervised. D The setting is different.**

**FURIO It is different and then some thought: throw away the nets, we will be able to go.**

**DE doubts, fears?**

**FURIO Doubts, fears, I think there were more on the part of the nursing staff, because they said: how do we do it, how do we keep these sick people. In practice, the first days that the nets were knocked down there was a nurse in the court with the sick, who in a certain way prevented the sick from leaving the perimeter of the court with the mere presence of the nets, practically the nets were up.**

**D In the sick there was never a state of anxiety reflected, was there no joy?**

**FURIO Perhaps in some, yes, in some it reflected a state of anxiety that I believe was caused by habit, because it was the breaking of a habit, moreover, the patient was so used to it ... Many times we found this: after the killing of the net, when the nurse who guarded the perimeter of the court was removed, many sick people did not go out, the patient had become an automaton, he had become a machine.**

**D At first the presence of the nurse alone prevented ...**

**FURIO It prevented, and afterwards it was the habit that prevented them from going away, put them in a state of anxiety: but what do I find out of here? What do I see? It must also be understood that the first wards opened were those wards where a good number of patients went out during the day, for work, accompanied, etc. So he didn't shock people this way; the shock was there for the people who did not leave the ward and who had never left. In these people I was able to find thoughts and speeches such as: now there are no more walls, there are no more nets, let's go for a walk in the park! Eh, but you know, and who is there? What's over there? There was this anxiety, that one did not know what to do outside and I say that this was undoubtedly due to the habit acquired in so many years of closure: by now we no longer knew what it was outside.**

**Q Was it possible to observe an improvement in the condition of the patient in this primitive phase? Did opening immediately bring about a visible improvement?**

**FURIO It has brought about an improvement especially in social relations, the sick person has become more sociable. In fact we used to find in the closed wards at times a huge buzz in the living room, but at times there was a total silence, everyone was closed in**

**himself. But practically when there was the buzz there was no kind of conversation, no kind of contact with each other. The question ended in the acceptance department: are you here too? What's wrong? Stay cool here now, who knows when you'll come out, don't go away anymore, I've been here for a long time. And it ended there. And instead with the opening everyone felt the need to ask for the company of others to leave the ward, they began to go out in groups of two, three, four and these groups also began to dialogue, to converse with each other, they began to to entertain relationships of a social nature.**

**D So that at this point what is community action has intervened. That is, this is the liberalization phase ...**

**FURIO Yes, once the liberalization phase was reached, two wards had been closed for technical, medical and other reasons, also because I believe that there were legal difficulties, it would not have been possible to liberalize everything suddenly. It was necessary to keep a ward that still had the characteristics of the closed ward, that was really a closed ward and in fact at first those patients who in the open wards posed assistance or other problems were sent to the closed ward.**

**Q How to confinement?**

**FURIO Yes,** **if they did not behave in order to remain in an open ward, they were sent to a closed ward, separate from the rest.**

**Q So it was a very imprecise phase?**

**FURIO It was a very imprecise phase. For a couple of years, doctors have been doing everything to ensure that a sick person is not sent to the closed ward; even if a patient is in a high arousal phase, he must remain in the open ward.**

**D I mean: at this point the community phase intervened, that is, the one that solicited, through meetings, etc., the contact between the sick and the sick, the sick and the doctor, the doctor and the staff and all together. Was this phase, which was naturally characterized by many meetings that got used to contact, etc., well accepted?**

**FURIO I would say it was accepted with enthusiasm. I saw it like this; especially when the community assembly was inaugurated, which was the second initiative; previously there was only in one ward, the male ward B, the so-called "therapeutic community", the first that was opened, which held ward meetings, collective meetings in which ward problems were discussed. These meetings were very heartfelt at the beginning, because in the end the patient at these meetings felt he had to go and had to**

**to have the floor to contest, to protest against so many things that still did not go well for him, but conversations of a demanding type were not yet held; later, at a later time, we began to discuss the resignation of the partner, the problems of the partner; this is a maturity of a community character, and the community assembly had the same effect. In the first meetings there was a lot of participation even if it was almost always the same people who spoke, also because many did not know how to express themselves, they were ashamed, they have a kind of modesty. There was good participation in the community assembly as it was believed that it was the community assembly that determined the life of the hospital; this is only partially correct because the community assembly should be a dialogue, an interview, that is to examine the problems, try to study them, and solve the problems that are within our reach, that is, within the reach of the community, asking for support to doctors, nurses; but when problems arose that the community was unable to solve, that is, when the last word fell to either the administration or the outside, then the community felt that it was losing some of the power it thought it had.**

**D This misunderstanding was initially generated**

**about the powers of the assembly?**

**FURIO In fact, this phrase often occurred: but what are we doing here? Here we can never make a decision, we always argue and never decide anything. This was the dispute that often recurred. In fact, the participation began to diminish, people who went to this community assembly because they believed that by going there they could also solve their personal case, in fact the question he first asked the doctors: send me home, when will he send me home? Then they addressed it openly in the assembly and certainly the assembly tried to discuss this request, but it could not say in any way: well, go home!**

**D So there was a notable effort of education and self-education, to get to understand what were the limits and the possibilities of power of the assembly; will this phase have lasted a few years?**

**FURIO In my opinion it lasted three years and still lasts in some respects.**

**D We will talk about this later, here, according to you, the meetings also served to educate yourself, in some way to provide some kind of culture, that is to allow someone to learn to express themselves, to use a certain terminology, to have no regard even if he was wrong?**

**FURIO More than an educational factor, I believe it encouraged a lot, more than learning to converse.**

**D But the educational aspect is there in some way?**

**FURIO Yes, very very lightly, but undoubtedly there is; I have heard many express themselves in a different way than they once did.**

**Q Did the fact that you immediately built a library, newspaper, etc., also contributed to this?**

**FURIO This undoubtedly had its importance. D It is in this phase here that you began to become the leader of this editorial group, as did «Il Picchio**

**"?**

**FURIO He said something improper, it may be that today we get this impression: it is not that I try to excel and be a leader, this also happened a little because I was stimulated by everyone and especially by the director, the which he told me: "Both for your good, Furio, and for the good of all the others, you have skills, you practically throw them out, you become an active person in the community." Of course I felt that it was necessary to have someone to lead, in part; then my role was a bit the role of buffer between the nursing staff and the sick, it was a bit the role of cushioning certain discrepancies, certain things that had the way of**

**to show oneself, for example a sick person who was being treated somewhat abruptly by the nurse, would automatically turn to me and say to me: "Look, Furio, that nurse is so and so"; I couldn't go and take that nurse head on, which is very evident, but I reported in ward meetings and asked: don't use these ways, because they are ways that irritate certain people.**

**DE, however, from this phase also «Il Picchio» was released. FURIO "Il Picchio" began to come out as early as August 1962, to stimulate an acceleration of liberalization and also to empower the newspaper team, to form a guiding group; practically the guiding group arose from the newspaper, but no matter how much effort I made and how much I said and how much collaboration was sought, the collaboration of the sick was not very wide and the newspaper was almost entirely on my shoulders and friends had the tendency to identify «Il Picchio**

* **with Furio. In fact, they almost made a binomial, they said Furio to mean the Woodpecker.**

**Q This is a confusion that can happen.**

**FURIO In fact, I was making an effort to remedy this fact. D As a personal experience this act of activating**

**so intensely within the community he did to her**

**well, did you do well?**

**FURIO It has undoubtedly benefited me, because, I must say, I have had a very tormented existence both for myself and for others. And the decision to end it had matured in me, I no longer expected anything from life, now I have wasted it, I burned it, I threw it away, I said, practically what am I doing? In fact, I was hospitalized for a suicide attempt which I then repeated in the hospital itself.**

**DE, on the other hand, did these things do you a lot of good afterwards? FURIO They did me a lot of good, at least that thought**

**it wasn't as nagging as it was before. I saw that there was still a purpose; before I had a head a bit empty from the apathy that had taken over me, I was apathetic towards everything, this problem, this feeling that if I did something I could still be useful to others, this helped me enormously even if I had to be continually stimulated to overcome that phase of apathy; but the fact that in that moment I came to understand that I could be useful to others, this of course if it did not definitively get rid of the idea that it was a fixed idea, greatly attenuated it.**

**DE therefore I imagine that the same process took place in a different way, in different manifestations too**

**for many others.**

**FURIO For all the others, I would say, also because it seems to me that for many, for some people, it is a problem a little like mine. There were people who, having to go to the closed ward, had fled, had tried to escape, tried again; when the ward was opened these attempts ceased and I think that those people also made the same reasoning that I did: if I do this, this can be negative, not only for me but also for others; and this person also no longer needed to flee, since escaping from an open place makes no sense.**

**D So now we have reached a phase that practically six years later the men's wards are all open, last July there was the opening of the C and soon the last women's ward still closed will open, so basically we can say we have reached the phase of the totally open hospital. I seem to see that there is a considerable dialectic between patients and health professionals, etc. You who live from the inside and know very well, what does it look like to you?**

**FURIO Yes, undoubtedly there is a dialectic even if on the one hand there is always a certain respect that is hidden, «well, you have to respect them! "; it recurs in fact**

**very often a very indicative phrase: "the superiors", that is, when one speaks of doctors, nurses, nuns and the bursar, etc., one says "the superior" that is the person who commands, the person to whom I I must obey, to which I am subjected. One is certainly subjected, because the sick cannot do what he wants, just as no one can do what he wants, not even outside; but here we try to remove this fear. There is a difference in my opinion, between saying: "Don't do this because you go against certain rules, of good living together, of life in the community", and saying instead not to do it for fear of superiors. Many still say today: "I would not do this so as not to wrong the director"; it is a concept of dependence, which I try to smooth out; look, you must not do it not only to not do a wrong to the director, as director, but also as a person who belongs to our community.**

**D There is one thing that seems to me to be said, that is, essentially here many say: here I am no longer afraid, I am fine; I am defended, I am sufficiently free, I feel that I have a function, etc., and therefore I defend myself from the outside by being inside.**

**FURIO Yes, in fact this is a reality, but there is also the other reality, that there is always the aspiration to go out**

**from the hospital, at least in a good majority; there will be a small minority who practically, we can say, have let themselves be taken by a kind of resignation; in short, they are resigned to spending the rest of their lives here. After all, I too can understand this, especially for people who have been here for twenty-twenty-five years, and that society, represented by relatives and especially by particularly close people, has forgotten. I believe that someone has come in such a state of resignation that they say: I'm happy to be here, it's fine; but I believe that when questioned very intimately, the aspiration to go out did not disappear from him.**

**Q Why if the purpose of the community is to heal the sick and bring him back to external life, there would be no danger that the community would close in on itself, if it came to defend its component?**

**FURIO I think that many people have now reached this state of resignation; but I believe that if society comes to meet these people, the aspiration to go out returns to them. Now it is the phase of the intervention from the outside towards the inside; that is, we have obtained the internal opening, now it would be necessary to obtain the external opening.**

**D External openness , that is , acceptance by**  **the side**

**of the outside of the mentally ill. In your experience, in your opinion, is the position of the outsider still very hard with regard to the mentally ill?**

**FURIO Yes, undoubtedly, prejudices regarding mental illness and the mentally ill are very widespread and also very deep-rooted. Many times I contest certain family members who have certain expressions: but I cannot take it home, because I am afraid; and I make this challenge: look, in my opinion his fear has no reason to exist, as that person is not dangerous at all; it is not dangerous, because it does nothing dangerous, I do not think that raising your voice every now and then is a dangerous fact, this all happened, I believe that she has settled down a bit in this comfortable situation and discharges her conscience by saying : I'm afraid, that is, it's dangerous, I can't take it, we're calmer like this, me on one side and you on the other, so it doesn't face the problem. Instead we saw that when the problem was addressed, people who had been in hospital for ten, fifteen, twenty years were discharged, and it was possible to discharge them when it was possible to open up to the outside, when this problem was brought to the hospital. external, he was brought to the family, outside the hospital.**

**DE in this sense the resignations have been several.**

**FURIO They say: it's good here, etc .; but in my opinion, I repeat, they say this because they are resigned, a resignation due to the habit of being abandoned for many years from the outside, because the outside does nothing towards us, practically, because we also see people who were here, for example, before you mentioned the name of that Mila who worked for a long time at the bar and is now discharged, this person with whom I spoke before, we were very friends, also for work reasons; since she was an active person, a collaborative person, I said to her: then she is leaving ... And she said: eh, yes, if the outside does not meet me, if I do not solve my problem outside, I will not I have other possibilities; when it was possible to face the problem externally (because the problem no longer existed in the hospital, as the patient was cured and showed it with the activity she carried out) it was possible to solve it and discharge her; that is, at first this person was resigned, but he was resigned because he was removed from the outside, when he saw that the outside is willing to accept it, this person has regained the aspiration to go out.**

**D So then, once the liberalization phase has been overcome and as soon as we have entered the phase of the community with a therapeutic purpose, the problem of the therapeutic community is entirely external? The therapeutic community is a phase**

**transitory?**

**FURIO Yes, it is a transitory phase; will undoubtedly have positive sides as regards the therapy of the disease, we will say so the patient no longer has those social breakdowns that he had before in a traditional hospital, today a sick person entering here, is not isolated, always has the possibility of relationships with other men, with his fellow men, that is, there is no clear break that there was before. Only then the break depends a lot on the outside.**

**Therefore, society is denied in its conception of the sick person who is dangerous to himself and to others when the action carried out by the community proves to obtain healings, and thus demonstrates the harmlessness of the sick person.**

**FURIO I think it could also happen, but I can't see a sick person discharged from our hospital who commits an act of violence without a justified reason. And in fact we have discussed that fact of violence of a former inpatient from another city. I expressed an opinion and then I also found other people, both nurses and sick people who shared my opinion: if that patient had first been admitted to this hospital, this fact had occurred, and a sick person had been called to the site , or a doctor, or a nurse's**

**this hospital, that they had had relations with him this would not have happened. We refer to the recent news story, right? which has truly shown that the traditional method of the psychiatric hospital manages to kill a police brigadier. The news reports, moreover, leaked many truths; there was a sentence that personally struck me very much; the wife would have phoned the police station, my husband is in a state of agitation. They said: because you are afraid we cannot intervene, the person must pass concrete threats; immediately afterwards she calls back: she threatened me with a gun, is armed and threatens me. So they sent that sergeant who was killed. It seemed that as soon as this sergeant arrived, the other one shot, but that's not true. This sergeant went to the landing with the sick man's wife and daughter and entered, spoke to the sick man then managed to leave the door open, and said to the lady: now**

* **calm, but we take him away with us anyway. He said a sentence: "We take him away with us anyway."**

**Q So this exasperated him?**

**FURIO He exasperated him; therefore we thought that if instead of that sergeant there had been a nurse or another sick person, or a doctor who**

**had he had intercourse during the hospitalization with the patient, this fact, in my opinion, would not have happened.**

**D Of course, because the charge of violence he had in himself would not have been exasperated, who knows, for family reasons.**

**FURIO I do not believe that a policeman has the qualifications and the manners and the preparation necessary to deal with a sick person.**

**D But the content of the sentence also intervenes, assuming that it was pronounced like this, it will certainly have been pronounced about like this, because there is the concept that the sick person is a thing.**

**FURIO Indeed: " *we take him away with us* ." As if it were a piece of furniture.**

**D In general, in general, the image of the sick person is created as a violent person, as a person who gives in a rage, in fact those who come here for the first time, myself the first time I came here, the first wonder is that to ask: where are the sick?**

**FURIO There are some sick people who can be defined as nuisances, but I do not see sick people who are dangerous in here: they can be defined as nuisances, when they always say the same thing, when they ask for a coffee, a cigarette, but**

**I don't think this can be defined as dangerous.**

**Q In what percentage do you attribute this state of absolute non-violence to the action of drugs and the action of the community?**

**FURIO In my opinion, non-violence is about 8o% due to social relations; It is a fact that the drugs are effective in the general therapy of the patient, but the social relationship affects the patient's behavior for a good 80%.**

**Q Doesn't feeling like a thing anymore, feeling like a person, being asked to take on these responsibilities, is all this almost essential help?**

**FURIO Yes, we see that there is a kind of regress when this is done not with conviction, not with sincerity, but with a very alarming form of paternalism that is sometimes offensive; one does not notice, but many times one cannot treat an adult with paternalism as one treats a child who has a bit of a tantrum.**

**Q Do you fear this will happen sometime?**

**FURIO Yes, it certainly happens.**

**D That is, in a certain sense, there is this way of approaching the patient paternalistically: well, poor fellow, come here, let's talk.**

**FURIO Yes, this pity, many times I think that deep down we all suffer when we are treated**

**with commiseration, if there is this commiseration it means that I am inferior. Many people who do not have an openness to this problem think that in order to benefit the patient it is enough to treat him well with paternalism, which in my opinion is not.**

**Q In your opinion, in which cases does it happen?**

**FURIO It occurs in cases in which the sick person for one reason or another takes an attitude of contestation, gets irritated and says: but, why, etc ...; and then he is told: you know, I did it for you, but I ask your forgiveness ... If something wrong has been done to a sick person, we must discuss it, do not fall back in saying: you are right, sorry, I was wrong, I shouldn't have said that. Contestation on an equal footing, because otherwise the patient suffers, undoubtedly, maybe he doesn't realize; many many times it pleases to be pitied, but many times it irritates.**

**D So there is a need for an external education, in this sense.**

**FURIO Education above all, because for understanding, perhaps understanding is found, but it is an understanding made in words, not concretized by fact.**

**D Probably the current development of society in the sense of culture, etc., also leads it to a certain understanding which is of a humanitarian nature, that is: well,**

**poor people, live well, have a cinema ...**

**FURIO At least as far as I am concerned, I always strive for internal leisure to have this meaning, to be together with others; in my opinion it is not a question of going to see a film or going to the dance, to see others dance or to dance, but to be together, because the fact of going to the dance dancing does not end, but in the dance we keep relationships between person and person, between relatives and the sick, form groups, discuss, that's what I think is useful.**

**Q Has the potential for discussion that the community expresses increased in recent years, that is, is the case of debates, discussions, interventions, concrete interests more frequent?**

**FURIO Yes, but in my opinion not by much; I always keep in mind the point of view that the sick who come to these places are the product of the lower classes of society and that for the disease itself they have almost never been able to have, so to speak, a shade of education; many people have not even attended schools, especially this one, not because they have not attended schools they can neither read nor write, they may have learned to read and write, but I believe that the school teaches the child to live in society practically as well as**

**to make him learn the knowledge that is necessary for him; not having lived in groups during childhood, not having formed groups, they are a bit apathetic towards what the social relationship is, and this way of life instead stimulates this social relationship.**

**Q That this is a hospital only for poor people, let's say.**

**FURIO Yes, really a hospital for poor people, the person who has the means does not come to this hospital, or takes care of himself privately and goes to the so-called nursing homes. In part I think maybe unconsciously these people feel this minority, not having received an education, but only in certain cases.**

**Q It seems to me that we have touched on the problem well this time.**

**FURIO YES, I repeat my personal opinions; I see my experience this way, the continuous relationships I have with other friends and with other friends are relationships that at times I feel a little distorted by the fact that I am considered a person possessing skills superior to theirs , for example, they say: to do certain jobs, do Furio, do him, he is the one who is capable.**

**D Because you have now taken on a function.**

**FURIO Yes, I have taken on a function that I think is incompatible with the community, and many times I purposely withdraw.**

**D Because he feels, saying it frankly among ourselves, that his position is in some way contradictory; that is, either she is part of the community because she is a tin leader, because she is a therapist, because she is a promoter, or she is part of the community because she is a patient; now she is in fact not an inpatient by now, a therapist she is not, and her situation is a bit equivocal.**

**FURIO Right, this situation of mine makes me uncomfortable, continually uncomfortable.**

**D But** **if they gave her a specific function, would she accept it?**

**FURIO Well, a precise function, I would be a little afraid that having an official recognition, you mean this in short: you, Furio, ceases to be hospitalized from today and becomes dependent on these functions. Look, I believe this impossible, I could not accept it as I would feel that my place would always be on the other side.**

**Q Why do you think that in this sense the community does not ...**

**FURIO I saw the case of a nurse from Udine who came to me to ask for a lot of advice for sociotherapy, because according to him he saw a sociotherapist in me, and this nurse confessed to me very openly: I am uncomfortable, because many times I have to take a stand against the direction in favor of the sick and many times I cannot**

**do it by being an employee.**

**Q This would lead to a contradictory position. FURIO I also told him: I too am aware why**

**you do not have to carry out sociotherapy only for the sick, many times it is also necessary to carry it out for the staff.**

**Q You had said a very indicative sentence just at this moment, which is not a slip of the tongue: that is, you said *on the other side* .**

**FURIO Yes, on the other side.**

**D So in your opinion we have not come to express parity, there is a part and there is the other part.**

**FURIO This is felt by both sides, a sick person feels that the nurse and the doctor are different from him; on the other hand, the nurse and the doctor, even if they try good-naturedly to show that it is not true, automatically at times point out this detachment: I am the nurse and you are the patient.**

**DE then in what way do you think the medical team here failed to overcome this state?**

**FURIO The medical team makes every effort to overcome this but since I repeat many decisions cannot be taken in community, those that can be taken are made in community, the others must be the medical team that takes them. This**

**naturally validates the distrust of the patient who says: even if I have indicated this solution, in the end who decides? If you participate in our affairs you will have seen that we often find ourselves in an impasse, in a difficulty in making a decision. Now let's say it is the case for the C women's department, before it was that of the C men. We asked for an opening because we wanted the friends of this department to be on a par with us, that is, for their department to be liberalized; but it was not a decision that we could make, as it was a decision that the medical management had to make, that had to distribute the problems of the closed ward, to allow the patients of that ward the same rights as the others. And now, when we talk that C women is still closed, we say: Mr. Director, open the door.**

**D But you others, having made an analysis, actually believed that the decision to open could be taken ...**

**FURIO To our request for opening, the medical management was obliged to answer: look, there are these and these problems.**

**DE then you say that this decision-making state which is only in the hands of the medical management creates both sides?**

**FURIO Yes, it creates both sides. Undoubtedly many times it makes the sick feel part of the community,**

**but not to be that part of the community which can determine the life of the community. The community is convinced that it is not possible to do a certain thing for certain reasons, but at the same time it feels a little handicapped; then when a new problem to solve arises again, and community participation is required, naturally people do not participate.**

**D There is a kind of crisis.**

**FURIO It must never be forgotten that for the sick person, both the doctor and the nurses are always considered privileged people for the sole fact that after their shift and their work they can go out, go home, go out, because almost always this it is the background, and it comes to the surface. She is here practically eight hours and then she leaves; there is this difference in situation that creates this sense of inferiority.**

**Q But the sick person is not aware that for a certain period he has to stay here to be treated?**

**FURIO Yes, but since we have long-term patients who have lived here for several years, this period is already so long in itself, that it becomes even longer if it is planned for the future as well. Several people are aware of this.**

**DE then therefore remains the possibility of crisis and misunderstanding between patients, staff and health professionals on both sides; the crisis is always determined from the outside, that is, when the health workers are not able to give back to the outside the long-term patient who is healed, who is here and who would like to leave.**

**FURIO The fact is this, and it is disputed. Doctors and nurses are external to the sick, they are external people, this deficiency is felt and I believe that doctors also feel it, this is the real difficulty of sensitizing the outside towards the problems of the mentally ill.**

**The series of interviews and the news that link them would not be complete without adding another testimony that allows the reader to compare two situations: that of the English therapeutic community of Maxwell Jones and that of Gorizia.**

**Q You have been to Dingleton. He can therefore make a comparison between the two communities.**

**FRANCA BASAGLIA The English situation compared to that of Gorizia presents, in my opinion, less friction between what is the hospital micro-company and the external company. This may depend on several factors: the greater English availability towards**

**of technical-scientific innovations and therefore greater tolerance of the external environment; the minor political character that the English experience proposes, even in the fight against the hierarchization and structure of roles, which is limited to the institutional reality only. What differentiates, in this case, the Gorizia experience**

* **global crisis - through institutional crisis - of the structures on which a coercive and oppressive reality such as the mental hospital can be maintained. However, a point of identity between the two communities could be identified in the impasse currently common to both: that is, the danger of an involution that limits the originally "contesting" action to a level of technical perfectionism that would deny its primary meaning. This is noticeable in Dingleton, where the hospital has been open since '49, before the establishment of the CT by Maxwell Jones. The degree of stabilization of the hospital structure is such as to be able to number all the possible alternatives to the patient, within the institution, denying any spontaneity and reducing any internal contradiction. The usefulness of this comparison, if anything, is given by the example of the danger that Gorizia too is currently running: that, once the moment of institutional overthrow (with opening**

**of all departments, etc.), is unable to affect the outside, having to be reduced to an internal perfectionism, sterile and devoid of bite.**

**Q Are the British aware of this?**

**FRANCA** **BASAGLIA I would say that they do not seem to have the aim of affecting external structures, through somehow anti-institutional action. The proposals and attempts to change (eg sectorial reforms) are kept within the limits of a perfectionism of psychiatric care, tending at most to the "ideological solution" of social conflicts. In this sense, what for Gorizia would be a failure (the recognition of having to reduce the political scope of action, to limit oneself to the institution) in Dingleton is simply the reality towards which general action tends. Ultimately it is the goal that is different.**

**Q In short, would the English CT in a certain sense be more crystallized than the Italian one?**

**FRANCA BASAGLIA Overall yes, also because Gorizia is still in a phase of denial and Dingleton could be the symbol of its future, once this phase is over. Gorizia's problem will now be to see to what extent its action of negation can turn outwards, given that the objective - this time - is the social structure and not**

**plus a particular institution.**

**Q To sum up, what are the differences?**

**FRANCA BASAGLIA On the one hand, the political character of Gorizia's action, and on the other hand, a greater didactic-therapeutic commitment at the level of staff in Dingleton which, however, closes itself within the sphere of particularly institutional interests.**

**With this intervention that serves to focus on the relationships between communities and society in two different countries and in a different political, economic, social situation, I conclude the document on the therapeutic community of the Psychiatric Hospital of Gorizia. From reading the testimonies I hope it can be clearly seen that they have not been altered in any way and that, even at the risk of sometimes being incomprehensible, they are faithfully transcribed. Someone listening to the tape recorder or rereading the interviews has already asked me if the sick interviewed have already recovered or are among the less sick. In this sense, having been absolutely free to choose, I have not made any discrimination. Andrea, Margherita, Carla are sick long-term patients, that is, they have been hospitalized for many years, literally abandoned by their families. They no longer have anyone in the world to refer to and society has no interest in welcoming them.**

**It must also be said that a large part of the patients, and I am not talking about the organically damaged ones, have had an adventurous and sometimes unlikely career. From the investigations carried out by the care team, it appears that some elderly people, for whom it was possible to trace the remote origins of hospitalization, entered the hospitals with mild forms, gradually worsening due to subsequent returns to the institutions. This repetition of segregations up to the definitive one almost always depends on the attitude of families who have not been able to accept the presence of an inactive and boring relative at home.**

**Many are the derivatives of war causes, such as Carla, for example, who arrived at the hospital after the Nazi elimination camp. It matters little if Carla was Princess Mafalda's companion or not, perhaps she attributes this link with the unfortunate daughter of the king to pathetically ennoble her pain, as the accumulation of her personal sufferings were not enough; what is certain is that numbers have been tattooed on her forearm that remove any doubts about her career as an outsider. In interviews as in all meetings, the attention of those present and participation is determined by the topic. If this interests most of the participants, the assembly has a lively course; if an exciting topic does not arise, the discussion drags on as everywhere, weakly and without**

**participation. However, it is rare that there is not at least a moment of interest since the sick have understood that their opinion is listened to, requested and equalized to that of others.**

**I deliberately say "the others" because, as Furio explains in his interview, despite everyone's efforts, divisions of class, of status, exist in the community, as they exist in reality. The sick indeed note their exclusion when after a day of common life and common commitment they must remain in the hospital while the others are free to leave. This is one of the reasons for the crisis. The other critical phase, in my opinion, is determined when the patient declares that he can live only if protected by the micro-society of the liberalized hospital, that is when he voluntarily closes himself in the citadel where the movement of facts and ideas has developed. he intended to make him free, responsible and no longer the subject of public scandal.**

**Franco Basaglia**

**The institutions of violence**

**In psychiatric hospitals it is customary to crowd patients into large halls, from which no one can leave, not even to go to the toilet. If necessary, the internal supervising nurse rings the bell for a second nurse to come and pick up the patient and accompany him. The ceremony is so long that many patients are reduced to relieving themselves on the spot. This response of the patient to an inhuman rule is interpreted as a "spite" towards the treating staff, or as an expression of the patient's level of incontinence, which is strictly dependent on the disease.**

**In a psychiatric hospital, two people lie motionless in the same bed. In the absence of space, one takes advantage of the fact that the catatonics do not bother each other, to arrange two per bed.**

**In a middle school, the drawing teacher tears up the paper where a child has drawn a swan with its legs, saying that he "likes swans on the water".**

**In a kindergarten, children are forced to sit in the desks without speaking while the teacher dedicates herself to small personal knitting jobs; threaten to stay with your arms raised for hours - which is very painful - if they move or chat to each other, or otherwise do**

**something that disturbs the teacher and her work.**

**A patient admitted to any civil hospital ward - if he is not cheap as before - is certain that he is at the mercy of the mood of the doctor, who can unleash aggression on him completely unrelated to him.**

**In a psychiatric hospital an "agitated" patient is given a "loan shark". Anyone who is unfamiliar with the asylum environment does not know what it is about: it is a very rudimentary system - in use almost everywhere - of making the patient lose consciousness, suffocating him. A sheet is thrown over his head, often wet - so as not to allow him to breathe - which is screwed tightly at the neck: loss of consciousness is immediate.**

**The frustration of mothers and fathers generally results in constant violence against their children, who do not satisfy their competitive aspirations: the child is inevitably forced to be better than another, and to live his own *diversity as a failure* . A bad grade in school is punished, as if the corporal or psychological punishment were to solve the scholastic failure.**

**In the psychiatric hospital where I work, years ago he was in**

**I use a very elaborate system whereby the night shift nurse guaranteed to be woken up every half hour by a sick person, in order to be able to stamp his attendance card, as it was obligatory. The technique consisted in instructing a sick person (who among other things could not sleep) to divide the tobacco of a cigarette from the bread crumbs that had been mixed in it. Experience had shown that for this sorting work, it took just half an hour, after which the patient woke up the nurse and received the tobacco as a reward. The nurse stamped his card (it was necessary for him to testify every half hour that he was awake) and went back to sleep, instructing another patient or the same patient to start over - new human hourglass - his alienating work.**

**From «Il Giorno» some time ago: «Enough with sadness! The San Vittore prison will finally lose its gray and gloomy aspect. In fact, some painters have been at work for some days and one side of one of the rays, which overlooks Viale Papiniano, is already painted in a beautiful shocking yellow, which widens the heart. When the whole complex is refreshed, San Vittore will acquire a more dignified, less heavy and distressing face than in the past ». And inside? There are still the "blinds" in the cells, but the shocking yellow wall meanwhile "widens our hearts".**

**The examples could go on and on, touching all the institutions on which our society is organized. What unites the reported limit situations is *the violence exercised by those who have the knife on the side of the handle, against those who are hopelessly dominated* .Family, school, factory, university, hospital, are institutions based on the clear division of roles: the division of labor (servant and lord, teacher and pupil, employer and worker, doctor and sick, organizer and organized). This means that what characterizes the institutions is the clear division between those who have power and those who do not. From which it can still be deduced that the subdivision of roles is the *relationship of oppression and violence between power and non-power, which turns into exclusion from power, of non-power: violence and exclusion are the basis of every relationship that is established in our society.***

**The degrees to which this violence is handled are, however, different according to the need that those in power have to veil and disguise it. Hence the various institutions that range from family, school, prison and mental hospitals; violence and exclusion are justified on the level of necessity, the former as a consequence of the educational purpose, the others of "guilt" and "illness".**

**These institutions can be defined as the *institutions of violence.***

**This is the recent history (partly current) of a society organized on the clear division between who has (who owns in a real, concrete sense) and who does not have; hence the mystified division between the good and the bad, the healthy and the sick, the respectable and the non-respectable. The positions are - in this dimension - still clear and precise: paternal authority is oppressive and arbitrary; the school is based on blackmail and threats; the employer exploits the worker; the asylum destroys the mentally ill.**

**However, the so-called society of well-being and abundance has now discovered that it cannot openly expose its face of violence, in order not to create too evident contradictions within it that would be detrimental to it, and has found a new system: that of broadening the procurement of power to the technicians who will manage it in its name and will continue to create - through different forms of violence: technical violence - new excluded.**

**The task of these intermediate figures will therefore be to mystify - through technicality - violence, without however modifying its nature; making the object of violence adapt to the violence of which it is the object, without ever becoming aware of it and being able to become, in turn, the subject of real violence against**

**what rapes him. The task of the new contractors will be to widen the borders of exclusion, discovering, technically, new forms of deviation, until now considered in the norm.**

**The new social psychiatrist, the psychotherapist, the social worker, the factory psychologist, the industrial sociologist (to name but a few) are but the new administrators of the violence of power, to the extent that - by softening the frictions, dissolving the resistances, resolving the conflicts provoked by its institutions - do nothing but allow, with their apparently restorative and non-violent technical action, the perpetuation of global violence. Their task - which is defined as *therapeutic-orientative* - is to adapt individuals to accept their condition as "objects of violence", assuming that being the object of violence is the only reality allowed to them, beyond of the different adaptation methods that they will be able to adopt.**

**The result is therefore the same. Technical-specialist perfectionism succeeds in making people accept the social inferiority of the excluded, just as it was able to do, in a less subtle and refined way, the definition of biological diversity which, in another way, sanctioned the moral and social inferiority of the *different* : both systems tend to reduce the conflict between the excluded and the excluded by confirming**

**scientifically - the original inferiority of the excluded, compared to those who exclude him. In this sense, the therapeutic act turns out to be a re-edition - revised and corrected - of the previous discriminating action of a science which, in order to defend itself, has created "the norm", after which one falls into the sanction it itself foresees.**

**The only possible act on the part of the psychiatrist is therefore that of not aiming at fictitious solutions, but of making one become aware of the global situation in which one lives, simultaneously excluded and excluding. The ambiguity of our figures as "therapists" persists as long as we do not realize the game that is required of us. If the *therapeutic act* coincides with the impediment to the patient's awareness of his being *excluded* from moving from his particular persecutory sphere(the family, the neighbors, the hospital) to enter a global situation (awareness of being excluded from a society that really does not want it), we just have to *refuse the therapeutic act if it tends only to mitigate the reactions of the excluded against its exclusionary.* But to do this we must ourselves - thecontractors of power and violence - we become aware of being excluded in our turn, at the very moment in which we are objectified in our role as exclusioners.**

**When we outsource power (professorship competitions, I**

**primaryti, the conquest of a private clientele at a *good* level) we submit to the examination of the *establishment* who wants to guarantee that we are able to carry out - technically - our task, without shocks or deviations from the norm: that is, he wants us to guarantee our support and our technique in its defense and protection. In accepting our social mandate, we therefore guarantee a therapeutic act which is nothing but an act of violence towards the excluded, which is entrusted to us because we technically control their reactions towards the excluded. Acting within an institution of violence, more or less disguised, means rejecting its social mandate, dialectizing this denial in the practical field: denying the therapeutic act as an act of mystified violence, to unite our awareness of being simple contractors of violence (therefore excluded), to the awareness that we must stimulate in the excluded of their being excluded: this without acting in any way towards their adaptation to this exclusion.**

**The negation of a system is the result of an overturning, of a crisis of the specific field on which one acts. This is the case of the crisis of the psychiatric system, as a scientific and institutional system together, which is overturned and**

**questioned by the awareness of the meaning of the specific, particular field in which one operates. This means that the encounter with the institutional reality has highlighted elements**

**- in clear contradiction with the technical-scientific theories**

* **that refer to mechanisms unrelated to the disease and its treatment. This cannot fail to undermine the scientific theories on the concept of disease and the institutions on which they base their therapeutic actions, referring us to the understanding of these "extraneous mechanisms" which have their roots in the social-political-economic system that determines.**

**The absorption of the patient into the medical corpus has been slow and laborious on the part of science. In medicine, the encounter between doctor and patient takes place in the patient's own *body* , which is considered as an object of investigation in its bare materiality and objectivity. However, when the discussion is transferred to the level of the psychiatric encounter, it is not so simple or, in any case, it is not without consequences. If the encounter with the mentally ill takes place on the body, it can only be carried out on a body that is *presumed to be* ill, operating an objectifying action of a pre-reflexive nature, from which the nature of the approach to be established is deduced: in this case the objective role on which he will come is imposed on the patient**

**to establish the institution that protects it. The type of objectifying approach therefore ends up influencing the patient's self-concept, which - through such a process - can only exist as *a sick body* , exactly in the way it is experienced by the psychiatrist and the institution that treats it.**

**Science has *told* us, therefore, on the one hand, that the mentally ill was to be considered the result of a biological alteration, not well identified, in front of which there was nothing else to do but to accept supinely the *difference* , with respect to the norm: hence the actionexclusively custodial of psychiatric institutions, as a direct expression of the impotence of a discipline which, faced with mental illness, has limited itself to defining it, cataloging it and managing it in some way. On the other hand, the same psychodynamic theories, which also tried to find the meaning of the symptom through the investigation of the unconscious, have maintained the objective character of the patient, even if through a different type of objectification: objectifying him, that is, not more as *a body* but as *a person* . As well as the nextcontribution of phenomenological thought has not succeeded - despite its desperate search for the subjectivity of man - to remove him from the terrain of objectification in which he finds himself *thrown* : man and his objectivity are still considered as a *given* , on which there is no 'is**

**possibility of intervention, as well as a generic *understanding* .**

**These are the scientific interpretations on the problem of mental illness. But what has been done with the real patient can only be seen inside our asylums, where neither the denunciations of the Oedipus complexes, nor the attestations of our being-with-in-the-world-of-threat have served to remove it. from the passivity and objectivity of his condition. If these "techniques" had truly entered hospital organizations, if they had allowed themselves to be confronted and challenged by the reality of the mentally ill, they would have had - for consistency - to be transformed to the point of dilating and permeating every act of institutional life. This would have inevitably undermined the coercive and hierarchical authoritarian structure on which the psychiatric institution rests. But the subversive power of these methods of approach is maintained within a psychopathological structure where, instead of questioning the objectification that is made of the patient, the various modes of objectivity are continued to be analyzed: that is, they are maintained in the a system that accepts all its contradictions as an unavoidable fact. The only possibility would have been to superimpose - as has been done in some cases - individual or group psychotherapy on other therapies (biological, pharmacological therapies), the action of which would have been, however, denied.**

**from the custodial climate of the traditional hospital, or from the paternalistic one of the hospital, based solely on humanitarian bases. Given this structural impenetrability of psychiatric institutions, to any type of intervention that goes beyond their custodial purpose, we cannot fail to recognize that the only possibility of approach and *therapeutic relationship* is still, almost generally, allowed only at the level of the *free mental patient* . that is, that which escapes compulsory hospitalization, and for which the relationship with the psychiatrist retains a margin of reciprocity, closely related to his bargaining power. In this case the integral character of the therapeutic act is evident, in the recomposition of the structures and roles already put in crisis, but not yet definitively broken by the hospitalization.**

**The situation (the possibility of a therapeutic approach to the mentally ill) is therefore closely linked and dependent on the system, where every relationship is rigidly determined by economic laws. This means that it is not medical videology *that establishes or induces one or the other type of approach, but rather the socio-economic system that determines its modalities at different levels.***

**On closer examination, the disease - as a common condition**

* **it comes to take on a *concretely* different meaning, depending on the social level of the sick person.**

**This does not mean that the disease does not exist, but it does**

**points out a real fact that must be taken into account, when one comes into contact with the mentally ill in psychiatric hospitalizations: the *consequences* of mental illness are different, depending on the different type of approach that is established with it. These «consequences**

* **(and I am referring to the level of destruction and institutionalization of the hospitalized in provincial asylums) cannot be considered as the direct evolution of the disease, but rather as the type of relationship that the psychiatrist, and therefore the society he represents, establishes with him:**

**i) The aristocratic relationship where the patient has a contractual power to oppose the technical power of the doctor. In this case it is maintained on a level of reciprocity at the level of roles only, since it takes place between the *role* of the doctor (fueled by the myth of his own technical power) and the *social role* of the patient who acts as the only guarantee of control. on the therapeutic act of which it is the subject. To the extent that the so-called *free patient* fantasizes the doctor as the repository of a technical power, he simultaneously plays the role of repository of another type of power: the economic one, which the doctor fantasizes in him. Although it is a meeting of powers rather than men, the patient does not succumb**

**passively to the power of the doctor, at least as long as its social value corresponds to an effective economic value, because - once this is exhausted - the bargaining power disappears, and the patient will find himself starting the real "career of the mentally ill" in the place in which his social figure will no longer have weight or value.**

1. **The *mutualistic relationship* , where there is a reduction in technical power and an increase in arbitrary power, in the face of a "borrower" who is not always aware of his own strength. Here the reciprocity of the relationship is already blurred, to reappear - real - in cases where there is an awareness on the part of the patient of his own social position and rights, in front of an institution that should be created to protect them. Therefore reciprocity exists, in this case, only in the presence of a considerable degree of maturity and class consciousness on the part of the patient; while the doctor often retains the possibility of determining the relationship as best he pleases, reserving the right to return to the field of *technical power* when it is challengedits arbitrary action.**
2. **The *institutional relationship* in which the pure power of the doctor increases dramatically (it is no longer even necessary that it be *technical power* ), precisely**

**because that of the patient declines dramatically who, by the very fact of being hospitalized in a psychiatric hospital, automatically becomes a citizen without rights, entrusted to the will of the doctor and nurses, who can do what they want with him, without the possibility of appeal. In the institutional dimension, reciprocity does not exist, nor is its absence in any way masked. It is here that we see - without veils and without hypocrisy - what psychiatric science, as an expression of the society that delegates it, wanted to do with the mentally ill. And it is here that it is evident that the disease is not so much at stake, as the lack of contractual value of a patient, who has no other alternative to oppose than abnormal behavior.**

**This sketch of the analysis of the different ways of dealing with and living mental illness, of which for now we do not know that it does in *this* context, highlights that the problem is not that of the disease itself (what it is, what the cause, q *the prognosis), but only what kind of relationship is established with the patient.* Disease, as an entitymorbid, plays a purely accessory role given that, although it is the common denominator of all three suggested situations, in the last case always (often in the**

**second), takes on a stigmatizing meaning that confirms the loss of the individual's social value, already implicit in the way his illness was previously experienced.**

**Therefore, if the disease is not the determining factor in the condition of the mentally ill, as it appears in our psychiatric asylums, it is now necessary to examine the elements extraneous to it which also play such an important part in it.**

**Analyzing the situation of the inmate in a psychiatric hospital ( *which we insist on considering the only stigmatized patient outside the disease, and therefore the only one we intend to deal with here* ) we could beginto say that he appears, first of all, as a man without rights, subject to the power of the institute, then at the mercy of the delegates (doctors) of society, who have alienated and excluded him. We have already seen that his exclusion or expulsion from society is however more closely linked to his lack of bargaining power (to his social and economic condition) than to the disease itself. What can be the technical, scientific value of the clinical diagnosis with which it was defined at the time of admission? Can we speak of an objective clinical diagnosis, linked to concrete scientific data? Or is it not instead a simple label that - under the guise of a technical-specialist judgment - hides, not too much**

**veiled, its deepest discriminating meaning? A wealthy schizophrenic, hospitalized in a private nursing home, will have a different prognosis from that of the poor schizophrenic, admitted to a psychiatric hospital with the ordinance. What will characterize the hospitalization of the former will not only be the fact that he is not automatically labeled as a mentally ill patient "dangerous to himself and to others and a public scandal", but the type of hospitalization he enjoys will protect him from being destorified, separated from its own reality. The "private" hospitalization does not always interrupt the continuum of the patient's existence, nor does it irreversibly reduce or abolish his social role. For this reason, after the critical period, it will be easy for him to be reintegrated into society. The destonifying, destructive, institutionalizing power at all levels of the asylum organization is found to act only on those who have no alternative other than the psychiatric hospital.**

**In this light, can we continue to think that the number of patients admitted to psychiatric institutions corresponds to the mentally ill of all strata of our society, and that therefore it is only the disease that reduces them to the degree of objectification in which they find themselves? Or it would not be more correct to assume that - precisely because they are socio-economically insignificant - these patients are the object of an original violence (the violence of our**

**social) that pushes them out of production, on the margins of associated life, up to the walls of the hospital? Ultimately, are not waste, the disturbing elements of our society that does not want to recognize itself in its own contradictions? Isn't it simply a question of those who, starting from an unfavorable position, are already *lost* at the start? How could we continue to justify our exclusionary relationship towards these inmates, for whom it was too easy to define every act, every reaction in terms of illness?**

**The diagnosis has by now assumed the value of a labeling that encodes a *liability* given as irreversible. But this passivity can be of a different nature and not only, or not always, sick. It is in the moment in which it is considered only in terms of disease, that the need for its separation and exclusion is confirmed, without the slightest doubt intervening to recognize a discriminating meaning in the diagnosis. In this way, the exclusion of the sick person from the world of the healthy frees society from its *critical elements* and, at the same time, confirms and sanctions the validity of the concept of norm established by it. From these premises, the relationship between the patient and those who care for him can only be object, to the extent that the communication between one and the other takes place only through the filter of a definition, of a label that does not allows for the possibility of appeal.**

**This way of approaching the question opens up before our eyes an *inverted reality* , where the problem is no longer that of the disease itself, but that of the relationship that is established with it. But in this relationship, both the patient with his illness, and the doctor, and therefore society, which judges and defines it is involved as a party to the dispute: *objectification is not the objective condition of the patient, but resides within the relationship between patient and therapist, therefore within the relationship between the patient and the society that delegates care and protection to the doctor.* This means that it is the doctor who needs an objectivity on which he can affirm his own subjectivity; just as it is our society that needs unloading and compensation areas where it can relegate and hide its contradictions. The rejection of the inhuman condition in which the mentally ill person finds himself; the refusal of the level of objectification in which he was left cannot fail to be strictly linked to the crisis of the psychiatrist, of the science to which he refers, and of the society of which he is the representative. The psychiatrist, science, society have practically defended themselves from the mentally ill and the problem of his presence among us: but, to the extent that, in the face of a patient already raped by his family, workplace, need, we we were the holders of power, our defense has inevitably turned into an offense without**

**measure, cloaking the violence we have continued to use against the sick, under the hypocritical veil of necessity and therapy.**

**Now, what kind of relationship can be with these patients, once what Goffman 4 defines as the "series of career contingencies" extraneous to the disease is clarified? The therapeutic relationship doesn't work - actually**

* **like a *new violence* , like a political relationship tending towards integration, when the psychiatrist**
* **as a delegate of society - does he have the mandate to cure the sick through *therapeutic acts* which have the sole meaning of helping them to adapt to their condition as "objects of violence"? Does this not mean that the psychiatrist confirms in the eyes of the patient that being the object of violence is the only reality granted to him, regardless of the different modalities of adaptation he can adopt?**

**If we supinely accept this mandate, in the acceptance of our role, are we not ourselves the object of the violence of power which requires us to act in the direction it determines? In this sense, our current action can only be a *negation* which, born as an institutional and scientific overthrow, leads to the rejection of the therapeutic act as a solution to social conflicts, which cannot be overcome through the adaptation of those who suffer. The first steps of this reversal were therefore implemented through the**

**proposal of a new institutional dimension that we defined, at the beginning, a therapeutic community, taking the Anglo-Saxon one as a model.**

**The first psychiatric experiences of a community nature can in fact be traced back to 1942, in England, where Anglo-Saxon pragmatism, freed from the mostly ideological thought of the continental countries of German influence, had managed to free itself from the sclerotic vision of the mentally ill, as unrecoverable entity, by emphasizing the problem of *institutionalization* 5 , primary cause of failurepsychiatric asylum. The experiences of Main and the subsequent ones of Maxwell Jones were, in fact, the first steps of what was to become the new institutional community psychiatry, based on predominantly sociological assumptions.**

**At the same time, a large psychiatric institutional movement was starting in France, headed by Tosquelles. An anti-Franco exile from the Spanish Civil War, Tosquelles had entered the psychiatric hospital of St Alban, a small town in the French central massif, as a nurse, where he had later obtained the direction of the institute after graduating again in medicine. Here too a small hospital - not a study center, nor a new psychiatric investigation institute - is the terrain in which it is born, *in practice and on the***

***plane of necessity* , a new language and a new institutional psychiatric dimension, based on psychoanalytic assumptions.**

**The two tendencies which, on the theoretical level had two different origins, on the practical level reveal the validity of their approaches in the common overturning of an ideology, by now crystallized in the contemplation and dissertation on illness as an abstract entity, clearly separated from the patient in the psychiatric institute .**

**The German-speaking countries, on the other hand, linked to the rigid Teutonic ideology, are still trying to solve the problem of psychiatric asylums from the top, by building improved structures, in which the custodial attitude continues to dominate. Suffice it to cite the example of Gutersloh, Herman Simon's hospital, now directed by Winkler, where we only witness the technical improvement of Simon's ergotherapeutic ideology. Social psychiatry itself, now in vogue, is not here an expression of the awareness of the failure of asylum psychiatry (with consequent awareness of the objectification of the patient at an institutional and scientific level), but rather the result of a need for intellectual updating which can only lead to the construction of social psychiatry institutes, such as the one to be built - the new Brasilia of German psychiatry - in Mainz, under the direction of Haefner.**

**Even in Italy, where the official psychiatric culture has felt above all the influence of German thought, the institutional situation has moved slowly, with years of delay compared to the English and French ones. Both the "sectorial" experience of clear French derivation and the "Community" one we are discussing here, therefore, had precedents to refer to. However, as far as our experience is concerned, there was an urgent need for interventions that should be adequate to the reality on which we acted, and could not be reduced to the adaptation of already codified models, applicable to every situation. For this reason, the choice of the Anglo-Saxon model of the therapeutic community wanted to be the choice of a generic point of reference, which could justify the first steps of a *negation* of the asylum reality. However, it inevitably passed through the negation of any nosographic classification, the subdivisions and elaborations of which were ideological with respect to the real condition of the patient. The reference to the Anglo-Saxon model is therefore valid until the moment in which the field of action has been transforming and the institutional reality has changed face.**

**In the following steps, the definition of a *therapeutic community* for our institution turned out to be ambiguousbecause it could, as it still can, be understood as the**

**proposal of a resolutive model (the positive moment of a negation, which is proposed as definitive) which, to the extent that it is accepted and incorporated into the system, loses its contesting function. However, following step by step the various evolutionary phases of our institutional overthrow, the need for a continuous *breaking* of the lines of action will become clearer.**

* **inserted into the system - for this very reason their insertion must be gradually denied and destroyed.**

**Our therapeutic community was born, therefore, as the rejection of a situation proposed as a given, rather than as a *product* . The first contact with the asylum reality immediately highlighted the forces at play: the inmate, instead of appearing as a *patient* , is the object of institutional violence that acts at all levels, because every contesting action has been defined within the limits of the disease. The level of degradation, objectification, total annihilation in which it occurs is not the pure expression of a morbid state, but rather the product of the destructive action of an institution, whose purpose was the protection of the healthy against madness. However, once the patient has been stripped of institutional superstructures and encrustations, one realizes that he is still the object of a violence ^ that society has used and continues to use against him, to the extent that - before being a Mentally ill -**

**he is a man without social, economic, contractual power: a simple negative presence, reduced to being a problematic and contradictory one, to mask the contradictory nature of our society.**

**How to dedicate oneself, in this situation, to the disease as a *given* ? Where to recognize it, where to locate it if not in *somewhere else* that we cannot yet touch? We canto ignore the nature of the distance that separates us from the patient, attributing the cause only to the disease? Or do we not want to first remove, one by one, the peel of objectification, to see what remains?**

**Therefore, if the first moment of this subversive action can be emotional (in the sense that one refuses to consider the patient a non-man), the second can only be the awareness of his political character, in the sense that every action carried out in against the inhaled, continues to oscillate between the supine acceptance or the rejection of *violence* , on which our socio-political system isfounded. *The therapeutic act turns out to be a political act of integration, insofar as it tends to recompose, on a regressive level, a crisis already underway; that is, to recompose the crisis, making them retreat to the acceptance of what caused it.***

* **thus born, on practical ground, a process of liberation which, starting from a violent reality and**

**highly repressive, it attempted the path of *institutional overthrow* . By reviewing now the gradual steps of this process - through the presentation of excerpts of works, chronologically ordered, on the conceptual elaboration of the current practice - it will perhaps be easier to clarify the meaning of this action which refuses to propose itself as a solution *model* , the results of which they would just confirm the *system* .**

**In 1925, a manifesto by French artists who signed the "surrealist revolution", addressed to the directors of *asylums* , concluded: "Tomorrow morning, at the time of your visit, when without any lexicon you will try to communicate with these men, may you remember and to recognize that you have only one superiority towards them: strength ».**

**Forty years later - tied like most European countries, to an ancient law still uncertain between assistance and security, pity and fear - the situation has not changed much: forced limits, bureaucracy, authoritarianism regulate life of inmates for which Pinel had already clamorously claimed the right to freedom ... The psychiatrist seems, in fact, to rediscover only today that the first step towards the treatment of the patient is the return to the *freedom* of which he himself had deprived him until now. Thereneed for a regime, a system in the complex**

**organization of the closed space in which the mentally ill person has been isolated for centuries, required the doctor only the role of supervisor, internal guardian, moderator of the excesses to which the disease could lead: the value of the system exceeded that of the object of his care . But today the psychiatrist realizes that the first steps towards the**

* **opening "of the asylum produces in the patient a gradual transformation of his position, of his relationship with the disease and with the world, of his perspective of things, restricted and diminished, not only by the morbid condition, but by the long hospitalization. From the moment he crosses the wall of internment, the patient enters a new dimension of emotional emptiness ... that is, he is placed in a space which, originally created to make him harmless and at the same time cure him, appears in practice as a place paradoxically built for the complete annihilation of his individuality, as a place for his total *objectification* ...**

**But through the realization of these first steps towards the transformation of the asylum into a nursing hospital, the sick person ... no longer presents himself as a resigned and docile man to our wishes, intimidated by the strength and authority of those who protect him. .. But he presents himself as a patient who, made an object by the disease, no longer accepts being *objectified* by the gaze of the doctor who keeps him at a distance. Aggression that - as an expression**

**of the disease but, above all, of institutionalization, occasionally broke the state of apathy and disinterest - it gives way in many patients to a new aggression arising from the obscure feeling, beyond their particular delusions, to be " unjustly "considered non-men, only because they are" in an asylum ".**

* + **in this moment that the patient, with an aggression that therefore transcends his own illness, discovers his *right* to live a human life ...**

**Now, so that the asylum, after the gradual destruction of its alienating structures, does not have to decline into a laughing asylum of grateful servants, the only point on which it seems to be able to leverage is precisely individual *aggression* . On this aggression, which is what we psychiatrists seek for an authentic relationship with the patient, we will be able to establish a relationship of reciprocal tension which, only, may be able - currently - to break the bonds of authority and paternalism, causing up to yesterday of institutionalization ... ( *August 1964* ).**

**... The situation faced by our institution was highly institutionalized in all its sectors: sick people, nurses, doctors ... We therefore tried to provoke a situation of rupture that could bring out the three poles of hospital life from their crystallized roles, placing them in a game of tension and counter-tension in which everyone would be involved and**

**responsible. It meant entering into "risk", which alone could put doctors and sick people, sick people and staff on the same level, united in the same cause, striving towards a common goal. The foundations of the new structure to be built had to rest on this tension: by loosening this, everything would return to the previous institutionalized situation ... The new internal organization would thus begin to develop from the base instead of starting from the top, in the sense that, instead of presenting itself as a scheme to which community life had to adhere, it would have been community life itself to create an order born of its needs and requirements: the organization, instead of being based on a rule imposed from above, would have itself become a therapeutic act ...**

**However, if the disease is also linked, as in most cases, to socio-environmental factors, to levels of resistance to the impact of a society that does not take into account man and his needs, the solution to such a serious the problem can only be found in a socio-economic setting, such as to allow the gradual reintegration of these elements that have not withstood the effort, which have not supported the game. Any attempt that may be made in approaching this problem will only demonstrate that the implementation of such a step is possible, but will remain**

**inevitably isolated and therefore devoid of any social significance, if it is not joined by a basic structural movement that has to take into account what happens when a mentally ill person is discharged, the work he does not find, the environment that rejects him, circumstances which, instead of helping him reintegrate, gradually push him towards the walls of the Psychiatric Hospital. Speaking of a reform of the current psychiatric law means wanting to address, not only new systems and rules on which to found the new organization, but above all the social problems that are connected to it ...**

**( *March 1965* ).**

**... By analyzing now what forces could have acted so deeply on the patient as to annihilate him, it is recognized that only one is capable of causing similar damage: authority. An organization based only on the principle of authority, whose primary purpose is order and efficiency, must choose between the freedom of the patient (and therefore the resistance that he can oppose) and the good progress of hospitalization. Efficiency has always been chosen and the patient has been sacrificed in his name ... But after the drugs with their action have concretely made it clear to the psychiatrist that he is not facing an illness; but to a sick man, he cannot continue to regard it as an element from which society must be protected. *This company* will always tend to defend itself**

**from what scares her and to impose her system of restrictions and limits on the organizations delegated to treat the mentally ill: but the psychiatrist cannot continue to witness the destruction of the patient entrusted to him, made *an object* , reduced to a thing by a organization that, instead of seeking dialogue with him, continues to talk to itself ...**

**To rehabilitate the institutionalized person who thrives in our kindergartens, it will therefore be more important to make an effort - before building around him a new welcoming, human space that he also needs - to awaken in him a feeling of *opposition to power* that has so far determined him andinstitutionalized. From the awakening of this feeling, the emotional emptiness in which the patient has lived for years, will return to fill up with the personal forces of reaction, conflict, *aggression* on which - alone - it will be possible to leverage for his rehabilitation ...**

**We are therefore faced with the need for an organization and the impossibility of putting it into practice; faced with the need to formulate an outline of a system to refer to, in order to immediately transcend and destroy it; the desire to provoke events from above and the need to wait for them to develop and develop from the ground up; facing the search for a new type of relationship between patient, doctor, staff and society in which the protective role of the hospital is equally divided among all ...; in front of the need to maintain a level of**

**conflict such as to stimulate, rather than repress, the aggression, the individual reaction forces of each individual patient ( *June 1965* ).**

**The establishment of a community-governed hospital complex based on premises that tend to the destruction of the principle of authority, however, places us in a situation that is slipping away from the level of reality on which current society lives. This is why such a state of tension can only be maintained by a radical stance on the part of the psychiatrist, which goes beyond his role and becomes concrete in an action to dismantle the hierarchy of values on which psychiatry is founded. traditional. However, this requires us to step out of our roles to take risks in person, to try to sketch out something that, even if it already has the seeds of future errors in it, will help us, for the moment, to break this crystallized situation, without wait for the laws alone to sanction our actions ...**

**The therapeutic community, understood in this way, can only be in opposition to the social reality in which one lives because - based as it is on presuppositions that tend to destroy the principle of authority in an attempt to program a community-therapeutic condition - it places itself in clear antithesis with the guiding principles of a company, now identified with the rules that, beyond any possible individual intervention, convey it into a**

**anonymous, impersonal, conformist pace of life ( *February 1966* ).**

**... In Italy, however, we are still tied to a skepticism and laziness that have no justification.**

**The only explanation can be given in a socio-economic key: our social system - far from being an economic regime of full employment - cannot be interested in the rehabilitation of the mentally ill who could not be received by a society, where it is not resolved. fully the problem of the work of its healthy members.**

**In this sense, every need of a scientific nature on the part of psychiatry runs the risk of losing its most important meaning - its social connection - if its action within a hospital system now in collapse is not joined by a structural movement of base, which has to take into account all the problems of a social nature that are related to psychiatric care.**

**If that of the therapeutic community can therefore be considered a necessary step in the evolution of the psychiatric hospital (necessary above all for the function it had and still has to unmask what the mentally ill was considered and is not, and for the identification of *previously non-existent* roles outside of an authoritarian level), however, cannot be considered the final goal towards which to strive, but rather a phase**

**transitory waiting for the situation itself to evolve in order to provide us with new elements of clarification ...**

**The therapeutic community is a place in which all the components (and this is important) - patients, nurses and doctors - are united in a total commitment where the contradictions of reality represent the humus from which mutual therapeutic action springs. It is the game of contradictions - even at the level of doctors among themselves, doctors and nurses, nurses and the sick, the sick and doctors - that continues to break a situation that, otherwise, could easily lead to a crystallization of roles.**

**Living dialectically the contradictions of reality is therefore the therapeutic aspect of our work. If these contradictions - rather than being ignored or programmatically dismissed in an attempt to create an ideal world - are addressed dialectically; if the prevarications of one another and the scapegoat technique - instead of being accepted as inevitable - are discussed dialectically, so as to allow understanding of their internal dynamics, then the community becomes therapeutic. But the dialectic exists only when there is more than one possibility, that is, an alternative. If the patient has no alternatives, if his life is already pre-established, organized and his personal participation consists in joining the order, without the possibility of**

**Norway lobster; he will find himself imprisoned in psychiatric terrain, just as he was imprisoned in the external world whose contradictions he could not dialectically face. Like the reality that he was unable to contest, the institution he cannot oppose, leaves him only one escape: the escape into psychotic production, the refuge in delirium where there is neither contradiction nor dialectic ...**

**The first step - cause and at the same time effect of the passage from custodial ideology to the more properly therapeutic one - therefore results in the change in interpersonal relationships between those who work in the field. Change which, with the variation or the establishment of valid motivations, tends to form new roles that no longer present any analogy with those of the previous traditional situation. It is this still shapeless terrain, where each character searches for his role, which constitutes the basis from which the new institutional therapeutic life begins.**

**In the community situation, the doctor, checked daily and challenged by a patient who cannot be removed or ignored, because he is constantly present to witness his needs, cannot retreat into a space that we could define aseptic, where he can ignore the problem that the disease itself proposes to him. Nor can it result in a generous gift of self which,**

**through his inevitable transcending into the role of apostle endowed with a mission, he would establish another type of distance and differentiation, no less serious and destructive than the previous one. Its only possible position would result in a new role, built and destroyed by the patient's need to fantasize it (that is, to make it strong and protective) and to deny it (to feel strong in turn); role in which the technical preparation allows him - in addition to the strictly medical relationship with the patient, which remains unchanged - to follow and understand the dynamics that arise, so as to be able to represent, in this relationship, the dialectical pole that controls and challenges how is checked and challenged.**

**The ambiguity of his role remains, however, as long as the company does not clarify its mandate, in the sense that the doctor has a precise role that the company itself sets for him: to control a hospital organization in which the mentally ill is protected and treated. We have seen, however, how the concept of protection (in the sense of the safety measures necessary to prevent and contain the danger of the patient) is in sharp contrast with the concept of care which should instead tend to its spontaneous and personal expansion; and how one denies the other. How the doctor can reconcile these two requirements, which are in themselves contradictory, until society clarifies which of the two poles (custody or care)**

**do you want to guide psychiatric care? ... ( *October 1966* ).**

**... Every society, whose structures are based only on cultural differentiations, of class and on competitive systems, creates in itself areas of compensation for its own contradictions, in which to concretize the need to deny or to fix in an objectification a part of its own subjectivity ...**

**Racism in all its faces is but the expression of the need for these areas of compensation; how much the existence of asylums, as a symbol of what could be defined "psychiatric reserves" (comparing them to the apartheid of the negro or to ghettos) is the expression of a desire to exclude what is feared because it is unknown and inaccessible. Will justified and scientifically confirmed by a psychiatry that considered the object of its studies as incomprehensible and, as such, to be relegated to the ranks of the excluded ...**

**The mentally ill person is an excluded person who, in a society like the present one, will never be able to oppose those who exclude him, because every act of his is now circumscribed and defined by the disease.**

* **therefore only psychiatry, in its dual medical and social role, which may be able to let the patient know what the disease is and what society has done to him, excluding him from himself: only through the awareness of his having been excluded, and rejected, on**

**mentally ill will be able to recover from the institutionalized condition in which it was induced ...**

**Because it is here, beyond the walls of asylums, that classical psychiatry has demonstrated its failure: in the sense that in the presence of the problem of the mentally ill, it has resolved negatively, excluding it from its social context and therefore excluding it from its own humanity. Placed in a forced space where mortifications, humiliations, arbitrariness are the rule, man - whatever his mental state - gradually objectifies himself in the laws of internment, identifying faces. His erecting the crust of apathy, disinterest, insensitivity would therefore only be his extreme act of defense against the world that first excludes him and then annihilates him: the last personal resource that the patient, as well as the inmate, opposes, to protect themselves from the unbearable experience of living consciously as excluded.**

**But it is only on this awareness of his position of exclusion, and of the part of responsibility that society has played in this exclusion, that the emotional void in which the patient has lived for years will gradually be replaced by a charge of aggression. personal. It will be resolved in an action of open dispute with reality, which the patient now rejects, no longer as an act of illness, but because it is truly a reality that cannot be lived by a man: his**

**freedom will then be the fruit of his conquest and not a gift from the strongest ... ( *December 1966* ).**

**... If originally, the patient suffers from the loss of his identity, the psychiatric institution and parameters have built a new one for him through the type of objectifying relationship they have established with him, and through the cultural stereotypes with which they have surrounded him. For this reason it can be said that the mentally ill person, placed in an institution whose therapeutic purpose is ambiguous in his persistence in relating to a *sick body* , has taken upon himself the institution itself ashis own body, incorporating the image of himself that the institution imposes on him ... The patient, who already suffers from a loss of freedom such as the disease can be interpreted, finds himself adhering to a new body which is that of the institution , denying any desire, any action, any autonomous aspiration that would make him feel still alive and still himself. He becomes a body lived *in the institution, for the institution* , to the point of beingconsidered as part of its own physical structures.**

* + **Locks and patients were checked before leaving**
* **These are the phrases that can be read in the notes delivered from one nurse shift to the next, to ensure the perfect order of the ward. Keys, locks, bars, patients, all this is part of the hospital furniture, for which nurses and doctors are responsible,**

**without even the slightest qualitative differentiation distinguishing them ... the patient is now only an *institutionalized body* that lives as an object and that - sometimes, until it is completely tamed - tries, through apparently incomprehensible acting-out, to regain the qualifications of one's *own body, of a lived body,* refusing to identify with the institution.**

**Through the anthropological approach to the institutional world it is therefore possible to give interpretations different from those given to the modalities, traditionally recognized as typical of the psychiatric patient. *The sick person is obscene, he is messy, he behaves in an unseemly way* . These are aggressive manifestations inwhich the patient is still trying, in a different way, in a different world (perhaps that of provocation) to get out of the objectivity in which he feels locked up, to testify that he is there anyway. But is there a psychopathological reason for each event and a scientific explanation for each act within an institution? Thus the patient who could not be immediately objectified upon entering the hospital, the patient for whom the doctor could only presume a *sick body* , is now finally tamed and locked up in a label that has all the trappings of official science. . ... It is in this condition that the patient finds himself in an institution whose purpose is the invasion**

**systematic of space, already restricted in him by sick regression. The passive modality in which the institute forces him does not allow him to experience events according to an internal dialectic. It does not allow him to live, offer himself, and be with others by having**

* **together - the possibility of safeguarding oneself, defending oneself, closing oneself up. The patient's body has become only a point of passage: a defenseless body, moved as a ward object in the ward, which is prevented - concretely and explicitly - from the possibility of rebuilding *its own body* that is able to dialectize the world, through the imposition of a single body, aproblematic, without contradictions of the institute ... A highly anti-therapeutic community, in its persistence in presenting itself as an enormous envelope, filled with so many bodies that cannot *live* and that are *there, waiting for someone to take* it and let them live in its own way: in schizophrenia, in manic-depressive psychosis, in hysteria. Definitely cosified ... ( *March 1967* ).**

**... If therefore the asylum situation has revealed the substantial antithetical-therapeutic nature of its structures, a transformation that is not accompanied by an internal travail that calls them into question from the base, is completely superficial and apparent. What turned out to be anti-therapeutic and destructive in psychiatric institutions**

**it is not a particular technique or a single instrument, but the entire hospital organization which - as it is aimed at the efficiency of the system - has inevitably objectified in its eyes the patient who was to be the only purpose of his existence. On this basis, it is evident that the introduction of a new *therapeutic technique* into the old institutional terrain is hasty, if not downright harmful, in the sense that, once the institutional reality is laid bare for the first time as a problem to be faced, there is a risk of covering it up. as fast as a new dress that presents it in a less dramatic light. Even "sociotherapy" as an expression of psychiatry's choice of the path of integration risks - at the present moment - to be reduced to a simple covering of problems, revealing itself**

* **like the clothes of the Emperor in Andersen's fable**
* **a cover that does not actually exist, insofar as the underlying structure cannot but deny and destroy it ... ( *April 1967* ).**

**... No longer being able to exclude the mentally ill as a problem ... in fact we are now trying to *integrate him* into this same society, with all the fears and prejudices towards him that have always characterized it, through a system of institutions which, in somehow, you keep it from**

***diversity* that the mentally ill continues to represent ...**

**Now there are two paths to follow: either we decide to look him in the face without trying to project the evil we don't want to be touched on him, considering him a problem that must be part of our reality and therefore cannot be evaded; or let us hurry - as our society is already trying to do - to quell our anxiety by erecting a new diaphragm that increases the distance, just bridged, between *us and them* , and immediately build a *beautiful hospital.* In the first case the problem cannothowever, to remain within the narrow limits of a "science" such as psychiatry, which does not know the object of its research; but it becomes a general problem that has a more specifically political character, implying the type of relationship that the present society wants or does not want to establish with a part of its members ... ( *January 1967* ).**

**... However, when traditional psychiatry is called into question which - in having assumed the parameters on which its system is based as metaphysical value - has proved inadequate for its task, there is a risk of falling in a similar impasse, if you immerse yourself in the practice, without maintaining a critical level within the practice itself ... This means that, wanting to start from the "mentally ill", from the hospitalized person of our institutes as the only reality, there is the danger of approaching the problem in**

**purely emotional way. By overturning, in a positive image, the negative of the coercive-authoritarian system of the old asylum, we risk saturating our sense of guilt towards the sick in a humanitarian impulse, capable only of confusing the terms of the problem again ... for this reason the need is felt for a psychiatry that constantly wants to find its verification in reality and that in reality finds, however, the elements of dispute to contest itself ...**

**Asylum psychiatry therefore recognizes that it has failed in its encounter with reality, escaping the verification that - through that reality - it could have implemented. Once reality escaped him, he only continued to make "literature", elaborating his ideological theories, while the patient found himself paying the consequences of this fracture - locked up in the only dimension deemed suitable for him: segregation. But in order to fight against the results of an ideological science, one must also fight to change the system that supports it.**

**If, in fact, psychiatry - through the scientific confirmation of the incomprehensibility of symptoms - has played its part in the process of exclusion of the "mentally ill", it is to be considered, together, the expression of a system that has so far believed to be denying and canceling one's own contradictions by distancing them from oneself, rejecting their dialectic, in an attempt to recognize oneself**

**ideologically as a society without contradictions ...**

**If the patient is the only reality to which we must refer, we must face the two faces of which this reality is precisely constituted: that of his being a sick person, with a psychopathological problem (dialectical and not ideological) and that of his being an excluded, a socially stigmatized. A community that wants to be therapeutic must take into account this double reality - illness and stigmatization - in order to gradually reconstruct the face of the patient, as it should have been before society, with its numerous acts of exclusion and the institution of invented it, acted on him with their negative force ( *June 1967* ).**

**... In the real field of praxis, the so-called therapeutic relationship in fact releases dynamics which - on closer examination - have nothing to do with the "disease", but which, nevertheless, play a considerable role in it.**

**I am referring here, in particular, to the relationship of power that is established between the doctor and the patient, a relationship in which the diagnosis of illness is a pure accident, an opportunity for the creation of a power-regression game that will instead be decisive in the ways of development of the disease itself. Whether it is the almost absolute "institutional power" of which the psychiatrist is invested within an asylum structure, or a power**

**so-called "therapeutic", "technical" power, "charismatic" power or "fantasy" power, the psychiatrist enjoys a situation of privilege vis-à-vis the patient which, in itself, inhibits the reciprocity of the encounter and therefore the possibility of a real relationship. After all, the patient, precisely because he is mentally ill, will adapt all the more easily to this type of object and aproblematic relationship, the more he wants to escape the problematic nature of the reality which he cannot cope with. He will therefore find, precisely in the relationship with the psychiatrist, the endorsement of his objectification and de-responsibility, through a type of approach that will feed and crystallize the level of regression ...**

**The psychiatrist therefore has a power that until now has not helped him to understand something more about the mentally ill and his illness, but which he has instead used to defend himself against them, using - as one of the main weapons - the classification of syndromes and psychopathological schematizations ... This is why psychiatric diagnosis has inevitably assumed the meaning of a value judgment, therefore of a labeling, since - faced with the impossibility of understanding the contradictions of our reality - all that remains is to download aggression accumulated, on the provocative object that does not allow itself to be understood. This means, however, that the patient has been isolated and placed in parentheses by psychiatry for it**

**could deal with the abstract definition of a disease, with the codification of forms, with the classification of symptoms, without fearing any possible denial by a reality that, in this way, was denied ... The psychiatrist therefore makes use, in the diagnosis, of a power, of a technical terminology to sanction what society has already implemented in excluding from itself the one who has not integrated into the game of the system. But this sanction of his does not have the slightest therapeutic character, it is limited to the sorting between what is normal and what is not, where the norm is not an elastic and questionable concept, but something *fixed and strictly linked to the values of the doctor. and of the company of which he is the representative ...***

**The current problem of the psychiatrist is therefore only a problem of choice, in the sense that he finds himself once again in the possibility of using the tools in his hand to defend himself from the patient and the problematic nature of his presence. The temptation to quickly quell the anxiety that this real relationship with the patient causes is constant, and nevertheless it is itself a sign of the reciprocity of his relationship ...**

**So this is the present danger: psychiatry has entered a real crisis. Beyond the rift created by this crisis, it would now be possible to begin to glimpse the mentally ill, stripped of the labels that**

**they have so far submerged or classified him in a definitive role. But psychiatric reformism is already ready to go on the attack with a new solution, which can only be a new label that is superimposed on the old psychological structures. Language is easily learned and *consumed* , without the word necessarily corresponding to the action performed or to be performed ( *May 1967* ).**

**... Psychiatric crisis, then, or institutional crisis? The one and the other seem so closely linked that it is impossible to glimpse what is a consequence of the other. In fact, both have a single common denominator: the type of object relationship set up with the patient. Science, in considering it an object of study which can be dismembered according to an infinite number of classifications or modalities; the institution, in considering it (in the name of the efficiency of the organization, or in the name of the labeling confirmed by science) as an object of the hospital structure with which it is forced to identify ... It would not be - at this point - necessary to destroy that what has been done, for fear of being entangled in something that preserves the germ (the psychopathological virus) of this science, the paradoxical result of which was the invention of the patient in the likeness of the parameters in which it defined him? Reality cannot be defined a priori: at the very moment in which it is**

**it defines, disappears to become an abstract concept.**

**The danger, at the present time, is that we want to solve the problem of the mentally ill through a technical improvement ...**

**In this case the psychiatrist would only perpetuate, in highly equipped and modernly built organizations or in perfectly logical conceptualizations, a relationship that I would define as *metallic* , from instrument to instrument, where reciprocity would continue to be systematically denied.**

**What emerges from the analysis of the crisis is the absolute incomprehensibility on the part of psychiatry of the nature of the disease which - still unknown in its etiology**

* **it intuitively requires a type of relationship exactly opposite to the one adopted up to now. What currently characterizes such a relationship at all levels (psychiatrist, family, institutions, society) is the *violence* (the violence on which a repressive and competitive society is founded) with which the mentally disturbed is attacked and quickly shaken off. What is it if not exclusion and violence that pushes the so-called healthy members of a family to channel the aggression accumulated by the frustrations of all to the weakest? What is, if not *violence* , the force that pushes a society to remove and exclude the elements that are not in its game? What is it but exclusion e**

***Violence* is the basis on which institutions rest, whose rules are established for the precise purpose of destroying what remains of the individual's personnel, to safeguard good performance and general organization? ...**

**Let us also analyze *the world of terror* , the *world of violence* , the world of exclusion, if we do not recognizethat we are that world - since we are the institutions, the rules, the principles, the norms, the legal systems and the organizations - if we do not recognize that we are part of the *world of threat and prevarication* by which the patient feels overwhelmed, we will not be able to understand that the crisis of the patient is our crisis ... The patient suffers above all from being forced to choose to live in an aproblematic and adialectic way, since the contradictions and violence of our reality can often be unsustainable. Psychiatry has only accentuated the patient's aproblematic choice, pointing to the only space that was allowed to him: the one-dimensional space created for him ( *June 1967* ).**

**But it is not the therapeutic community, as an organization given and fixed within new schemes, different from those of asylum psychiatry, which guarantees the therapeutical nature of our action. It is the type of relationship that is established within this community that will make it therapeutic, insofar as it is able to focus**

**the dynamics of violence and exclusion present in the institution, as well as in society as a whole; creating the conditions for a gradual awareness of this violence and this exclusion, so that the patient, the nurse and the doctor - as constitutive elements of the hospital community and of global society at the same time - have the opportunity to face them, dialectize them and fight them, recognizing them strictly linked to a particular social structure and not as a fact that cannot be eliminated. Within the psychiatric institution, any scientific investigation into mental illness itself is possible only after having eliminated all the superstructures that refer us to the violence of the institution, to the violence of the family and to the violence of society and all its institutions ( *October 1967* ).**

**The reconstruction made on the documentation of the overturning process still underway in our institution, does not want to be the description of a *technique* and a work *system* that is more efficient or more *positive* than another.The reality of today is not that of tomorrow and, when it is fixed, it is already distorted or outdated. It is only the conceptual elaboration of a practical action that has been maturing as the system of concentrational life gave way to a more humane way of relating between the members of the institution. The problems and the**

**ways of dealing with them have gradually changed, with the gradual clarification of the specific field in which one was acting, and with its gradual expansion into a vaster terrain. This is what interests us in our daily action.**

**However, according to normal practice - insofar as the institution in which one acts is a therapeutic institution - we are usually asked whether the new community management is the solution of psychiatric institutions; what the statistics say about the results; if, in short, *the sick get better* . It is difficult to answer in quantitative terms and, although classically *positive* data can also be referred to in this sense, this does not seem to us the way to set thequestion.**

**A general look at psychiatric hospitals can tell us that, roughly, drug therapy has produced surprising and disconcerting results everywhere. Medicines have an undoubted action, the results of which have been seen in our kindergartens and in the reduction of the number of patients "associated" with the hospital. But - a posteriori - we can begin to see how this action of theirs moves, both at the level of the patient and at that of the doctor, since they act simultaneously on the *sick anxiety* , as on the anxiety of the one who treats it, highlighting a paradoxical picture of situation: the doctor sedates, through I**

**drugs that he administers to her, his anxiety in front of a patient with whom he cannot relate, nor find a common language. Therefore, in a new form of violence, he compensates for his inability to handle a situation that he still judges as *incomprehensible* , continuing to apply the medical ideology of *objectification* , through a perfectionism of the same. Through the "sedative" action of the drugs, the patient still remains fixed in the passive role of the patient. The positivity of the situation that is created is given only by an openness to the relationship that now proves possible, even if this possibility is subordinated to the subjective judgment of the doctor who may feel or not feel the need for it. On the other hand, drugs act on the patient by attenuating the perception of the real distance that separates him from the other; which makes him assume a possibility of intercourse, otherwise denied him.**

**Ultimately, what is changed through the action of drugs is not the *disease* , but the apparent attitude (apparent insofar as it is always a form of defense and therefore violence) of the doctor towards him. Which, moreover, confirms what was pointed out earlier on the fact that the *disease* is not the objective condition of the patient, but that what makes it assume the *face it has* lies in the relationship with the doctor who codes it and with society. which denies it.**

**That in 1839 - before the pharmacological era - Conolly succeeded in creating a completely free and open psychiatric community, testifies to what is being said here. The action of the drugs has made clear what we doctors had not intuited, more concerned with the disease as an abstract concept, than with the real patient. On closer examination, it sounds like a challenge to the doctor and his skepticism, beyond which there is the possibility of starting a subsequent discussion that can understand and not understand the action of drugs.**

**Aware of this, when our practical action is looked at and judged by the public who is directly involved in it, we are faced with a fundamental choice: either we emphasize our working method which - through a first destructive phase - he managed to build a new *institutional reality* and we propose the model as a way of solving the problem of psychiatric institutions; or we propose *denial as the only modality currently possible within a political-economic system that absorbs every affirmation into itself, as a new instrument of its own consolidation.***

**In the first case it is evident that the conclusion would be just another face of the same reality that we have destroyed: the therapeutic community as a new institutional model would result in a technical improvement**

**within both the traditional psychiatric system and**

**the general socio-political one 6 . If our action of denial was to highlight the mentally ill as one of the *excluded* , one of the scapegoats of a contradictory system, which in them tries to deny its own contradictions - now the system itself tends to show itself understanding towards this clear exclusion: the therapeutic community as a restorative act, as a resolution of social conflicts through the adaptation of its members to the violence of society, can fulfill its therapeutic-integrating task, playing the game of those against whom it was originally born. After the first period of clandestinity, where this action could escape the control and codification that would crystallize it into what was only to be a step in the long process of radical overthrow, the therapeutic community has now been discovered as a new product: heals more as OMO washes whiter. In this case, not only the sick, but the doctors and nurses who have contributed to the realization of this new good institutional dimension, would find themselves prisoners of a prison without bars, built by themselves, excluded from the reality on which they presumed to affect; waiting to be reinserted and reintegrated into the system, which hastens to plug the most blatantly evident leaks, opening them**

**others more underground. The only possibility that remains is to preserve the patient's bond with his story - which is always a story of oppression and violence - keeping clear where the overwhelming and violence comes from.**

**For this reason we refuse to propose the therapeutic community as an *institutional model* that would be seen as the proposal of a new conflict-resolving technique. The meaning of our work can only continue to move in a *negative dimension* which is, in itself, destruction and at the same time overcoming. Destruction and overcoming that go beyond the coercive-prison system of psychiatric institutions, the ideological one of psychiatry as a science, to enter the terrain of violence and exclusion of the socio-political system, refusing to be exploited by what one wants to *deny* .**

**We are perfectly aware of the risk we are running: being overwhelmed by a social structure based on the *norm* it has established itself and beyond which we enter the sanctions provided for by the system. Or we allow ourselves to be reabsorbed and integrated, and the therapeutic community will remain within the limits of a dispute within the psychiatric and political system without affecting its values (which means having to resort to a psychiatric-communal ideology in order to survive one's projects. as a solution to the partial and specific psychiatric problem);**

**or continue to undermine - now through the therapeutic community, tomorrow through new forms of contestation and rejection - the dynamics of power as a source of regression, disease, exclusion and institutionalization at all levels.**

**Our position as psychiatrists places us in the need of a direct choice: either we accept to be the *contractors of power and violence* (and then every action ofrenewal contained within the limits of the norm will be enthusiastically accepted as the solution of the problem); or this ambiguity is rejected by attempting (as far as possible, given that we are well aware that we ourselves are part of this power and this violence) to address the problem in a radical way, demanding that it be incorporated into a general discourse that cannot be satisfied of partial, mystified solutions.**

**We have made our choice which obliges us to remain anchored to the sick, as the result of a reality that cannot be avoided calling into question. This is why we force ourselves to continuous checks and overcoming which, too superficially, are interpreted as signs of skepticism or inconsistency towards our own action. Only the verification of the contradictions of our reality can save us from falling into the *communal ideology* , to destroy the schematic results andcoded of which we should wait for a new one**

***overthrow* .**

**Meanwhile *, the psychiatric establishment* defines - albeit unofficially - our work as lacking in seriousness and scientific respectability. The judgment can only flatter us, since it *finally unites us* to the lack of seriousness and respectability, which has always been recognized in the mentally ill and all *excluded* .**

**An oriental fable 7 tells of a man to whom a snake crawled into his mouth while he was sleeping. The snake slipped into his stomach and settled there and from there imposed his will on man, so as to deprive him of freedom. Man was at the mercy of the serpent: he no longer belonged to himself. Until one morning the man felt that the snake was gone and he was completely free. But then he realized that he did not know what to do with his freedom: "In the long period of the absolute dominion of the serpent he had become so used to submitting his own will to the will of this, his own desires to the desires of this, his own impulses to the impulses of this one who had lost the ability to desire, to tend towards something, to act autonomously ». "In the place of freedom he had found emptiness", because "together with the snake his new" essence ", acquired in captivity, had come out of him" and he had no choice but to gradually regain the previous human content of his life.**

**The analogy of this fable with the institutional condition of the mentally ill is surprising, since it seems the fantastic parable of the incorporation by the sick person of an enemy who destroys him, with the same acts of prevarication and violence with which man of the fable was dominated and destroyed by the snake. But meeting with the mentally ill also showed us that**

* **in this society we are all slaves to the serpent and that if we do not try to destroy it or vomit it, there will no longer be a time to regain the human content of our life.**

**Lucio Schittar**

**The ideology of the therapeutic community**

**A discourse on the therapeutic community 8 today implies not only a historiographic perspective or, more simply and with less effort, bibliographic, but also the attempt of a critical analysis of the origins and developments of this new modality of psychotherapeutic approach. This analysis appears all the more necessary today, when "community therapy" tends to be indicated as the solution to the problem of psychiatric institutions, while it can appear (if it is not seen as a "situation" liable to disintegration and palingenesis, as a point of passage, perhaps necessary, in the process of institutional renewal) only a new "scientific" instrument for controlling deviance.**

**The therapeutic community seems to be today the "last cry" of psychiatry, the structure in which the contradictions in which institutional psychiatry struggles, continually uncertain between its therapeutic vocation and the proclaimed social need for exclusion and control of individuals who exhibit pathological behavior.**

**That the therapeutic community resolves these contradictions is desired or believed to be true by many, but a study of its origins and its developments, what we intend to conduct, can make one very doubtful about the possibility of such a resolution.**

**The therapeutic community is a typically Anglo-Saxon "invention", indeed English, because England is the country that has the longest tradition of attempts at psychiatric institutional renewal 9 since the times of the Tukes, Conolly and the "moral care" of the sick of mind.**

**Conolly himself, with the surprising ability to put into practice his intuitions on the therapeutic need for the liberalization of psychiatric hospitals (think that in 1839 he completely abolished the methods of restraint for Hanwell's 800 patients) can be considered the first of that thread that from the first half of the nineteenth century unfolds up to Maxwell Jones and the current therapeutic communities.**

**But other factors, in addition to those of the reformist tradition, of essentially religious origin (the Tuke were Quakers), certainly contributed to the rise in England of social methods of treating the mentally ill. The influence of the war events (World War II) seems to have been important, with the enormous number of cases to be treated and the relative shortage of psychiatrists and nurses that they provoked, and therefore with the necessity, which the psychiatric institutions, to do more work with the assistance of fewer people.**

**It may be added (Clark) that the war "tore the**

**psychiatrists from the closed world of psychiatric hospitals and the tranquility of their psychotherapist studies and threw them into the magma of the recruitment camps, field hospitals and combat units: in short, it forced them to make them aware of the enormous power of social factors in influencing the thoughts and feelings of individuals ", confirming in practice the theories of the new Sullivanian psychiatry.**

**The reasons for the rise of sociotherapeutic methods were, however, to a large extent "political".**

**In the war and immediately post-war period there had been a decisive modification of the political-cultural schemes of English society with the assumption, by the community, of previously ignored social responsibilities. Labor participation in the country's government led to the approval of important social security measures, such as the organization of the National Health Service, and laws such as the Disabled Persons Act of 1944, which marked a turning point in society's attitude. towards the mentally ill, for the first time included in a rehabilitation program outside the hospital and therefore outside a situation of social exclusion.**

**Politics in a broader sense were also the reasons that led, for example, Maxwell Jones to try to unmask, even in external manifestations (the**

**white coat, the "aggressive" gavel, etc.), the real and fantastic power that the psychiatrist exercises over the patient entrusted to his care.**

**In hospital practice these attempts to challenge the authority and medical power, as a social mandate and as a residue of magical-witchcraft anthropological elements, found the form of the group discussion of the problems that arose from community life, discussions to which patients, doctors, nurses, social workers should have participated in the same capacity, with the same rights, with the same decision-making capacity.**

**These were, in short, the "theoretical" presuppositions; in fact the notion of therapeutic community arose in 1946 when TF Main 11 in a special issue of the "Bulletin of the Menninger Clinic" devoted to a review of the progress of postwar British psychiatry, speaking of the work of the British psychiatrists of the "Northfield group" (Bion and Rickman, and later Foulkes), described the Northfield hospital under the title: *A Therapeutic Community.***

**Bion and Rickman had organized in 1943 their group of patients from Northfield Hospital, who were soldiers with neurosis, in a communal way, with discussion groups and patient participation in governing the ward.**

**The same had done Maxwell Jones at the division for**

**Stress Syndrome at Mill Hill in 1941-44, then at the former prisoners of war hospital in Dartford in 1945, then in 1947 at the Industrial (later Social) Rehabilitation Division of Belmont, which became, under the name of Henderson, the psychopathic hospital where Maxwell Jones worked until 1959 (he is now the director of Dingleton Hospital in Melrose, Scotland).**

**Maxwell Jones himself quickly became the most representative of psychiatrists interested in the therapeutic community, and his approach to the institutional problem was soon received and imitated by many Western psychiatrists.**

**On the other hand Stanton and Schwartz, Goffman, Barton, the Cummings, Caudill, Belknap and all the other scholars of microsociology of the Psychiatric Hospital, showing in their investigations the effects of the formal and informal organizational structures of the institution on the life and course morbid itself of the patients 12 contributed in a decisive way to setting up an institutional psychiatric reform, which often took place in the sense of a "community therapy".**

**In 1953, at the conclusion of a study on the psychiatric organizations of the states adhering to the World Health Organization, the Committee of Experts stated 13 that the Psychiatric Hospital had to be *in its entirety* a therapeutic community. It**

**it had to be based on principles such as the preservation of the patient's individuality, the belief that patients are trustworthy and have the capacity to take responsibility and initiative, the regular engagement of patients in some kind of occupation, etc.**

**These "fundamental principles", once implemented in practice, would have come to structure the Psychiatric Hospital in a certainly new way, but they would not necessarily have led to the formation of a therapeutic community as it is understood by most today and as it was developed by the English authors. , by Maxwell Jones in particular.**

**This last type of therapeutic community (the "proper" therapeutic community) is based on certain principles which have been defined as revolutionary and which are basically subversive of the traditional type of doctor-patient relationship. Although it cannot be reduced to rigid schemes, it finds its first essence in the declared exploitation, for therapeutic purposes, of *all* the resources of the institution, conceived as a non-hierarchical organic set of doctors, patients and auxiliary staff.**

**Martin states: "A therapeutic community is one in which an effort is made deliberately to use, to the greatest extent possible, in a broad therapeutic plan, the contributions of all, staff and patients."**

**Without prejudice to these general characteristics of multipolarity of the therapeutic approach in the institution, with the implicit rejection of the exclusively dual doctor-patient relationship, it must be said that there is no model of therapeutic community, rather there are more ways of implementing it, than for the their very nature of continuously evolving structures are difficult to formulate schematically.**

**According to Clark, however, some common characteristics could be extrapolated in the various ideologies:**

1. ***Freedom of communication* : every effort is made to ensure that communication is possible at all levels and in all senses, not only in the descending sense of the hierarchical pyramid as occurs in traditional institutions.**

**2) *Analysis of everything that happens in the community in terms of individual and, especially, interpersonal dynamics.* This takes place more properly in thegroup meetings and with the greater intensity and frequency the more psychodynamic oriented psychiatrists are. At the limit, community ward meetings can slowly turn into group psychotherapy sessions (Mack).**

1. ***Tendency towards the destruction of the traditional relationship of authority* with a flattening of the hierarchical pyramid, at the lowest rung of which**

**traditionally the patient, on whom the tensions of the whole hospital are discharged. This horizontal movement, with the necessary subdivision of the decision-making power that it entails, would undoubtedly constitute the most significant innovation of the therapeutic community.**

**4) Possibility of enjoying social re-learning opportunities 14 both spontaneous and structured in the institution (dances, film screenings, theatrical performances, parties; individual or group outings, etc.).**

1. **Presence of a meeting (usually daily) of the whole community (community meeting) e. of frequent regular smaller gatherings, at all levels, which are the natural place in which all the processes mentioned above take place.**

**Other constants can be identified in the study of the structural characteristics of community ideology and practice. The sociologist Rapoport, investigating the ideological basis of the therapeutic community of Henderson Hospital in *Community as Doctor , pointed out four fundamental themes:***

***Democratization* :** **everyone's opinion was taken into account equally.**

***Permissiveness* : Community members exhibited a high**

**degree of tolerance for the acting out of the most disturbed patients.**

***Community* of intents and purposes.**

***Confrontation with reality* , to which all members of the therapeutic community were continually reported.**

**Rapoport pointed out that these themes of communal ideology were dialectically mixed with hospital practice, which sometimes required, *in response to the threat of a possible disorganization* of thecommunity, a suspension of the atmosphere of permissiveness and the re-emergence of the external community. The use of a term as acculturation (which historically has been realized as acceptance of the culture of the "lord" by the "servant", and can therefore be considered equivalent to "colonization") by insisting on the difference between a culture " healthy "and a" sick "culture, seems to re-propose in a socio-psychiatric key the recovery of a fundamental bourgeois Manichaeism that finds precisely in the alienity that separates the sick from the healthy the justification for the relegation of the" mad "out of social commerce.**

* **on the other hand, exclusion from social commerce is the cause, and not the effect, of deculturation: the subhuman culture of the "long-term patients" relegated to an asylum for years is the natural outcome, but after the studies on institutionalization we have learned that this has well**

**little relationship with mental illness.**

**So for example. ideological democratism also underwent an "oscillatory process" in its practical implementation so that from the initial phase (phase A) of "participation of all", due to the mounting anxiety of the staff, it ended (phase D) with the imposition of leadership of the nursing staff. 15**

**In addition to the Henderson studied by Rapoport, other important English therapeutic communities, almost all of which have sprung up in psychiatric hospitals, are those of the Claybury Hospital of D. Martin (who in Adventure in Psychiatry gave a lucid description of it), the Fulbourn Hospital of DH Clark , Maxwell Jones Dingleton Hospital, etc. 16**

**Numerous therapeutic communities have sprung up in North America, some in private clinics, others as part of university psychiatric facilities, still others in psychiatric wards of general hospitals, and finally as intermediate structures of Community Psychiatry (day hospitals, night hospitals, hostels for recently discharged patients, etc.) 17 .**

**The problems that continually arose from the application of the community method to the psychiatric field have been the subject of numerous writings.**

**For example, the topic of efficacy was debated**

**of the community situation as a therapeutic tool: Does it really "heal" the therapeutic community (Lethe-mendia)? Does it really want to heal individuals in the traditional sense of the term (Rapoport)? The community situation is really more suited to the "neurotics", the "psychopaths", the "schizophrenics", than the "depressed" and the "manic" (Kole and Daniels), or not**

* **rather necessary for everyone (Jones): patients, doctors, nurses who are they?**

**There has been talk of the possibility of reducing or abolishing traditional therapeutic tools: insulin therapy - ES therapy - the same drug therapy (Klerman, Rubenstein and Lasswell, Sanders, Wilmer). Tensions between members of the therapy team (Band and Brody, jones, Zeitlyn) were highlighted.**

**Rarely has there been an attempt to discover beyond ideology what the real decision-making capacity and real participation in power on the part of patients was.**

**Those who did this (Rubenstein and Lasswell) concluded that *"the patient continues [in the therapeutic community] to be deprived of certain freedoms, and the hospital staff remain the expert agents mandated by society to exercise extraordinary power over patients. entrusted to them. The director continues to be authorized to deprive patients of the rights and privileges usually considered their prerogative as citizens of the***

***democracy ".***

**Not only that, but the patterns of social exclusion that have been considered characteristic of the asylum can be reproduced in the therapeutic community, both with the presence (Wilmer, Cone and many others) of programmatically closed wards (which depriving the patient of freedom of movement the possibility of making primary choices) both (as Zeitlyn notes) with a selection of the most "suitable" patients and the referral to other closed hospitals of the most disturbed individuals, considered not to be integrated into the permissive environment of the therapeutic community.**

**The response of other British and North American psychiatrists to the problem of authority and real power in the therapeutic community has often been peremptory, with the affirmation of the need for a power, not only ghostly but also real, of the doctor . The problem was found using the forms of false consciousness, both with justifying the patient's subjection to his illness, and with affirming that the patient's participation in community power was real, even if it was carried out according to the techniques of consent and whether his "participation" took place in closed wards.**

**To illustrate the attitude that some psychiatrists have taken in this regard, a few quotes will be useful:**

**For Denber and Rajotte: «... hierarchical distances must be reduced while maintaining them: the fragility of the schizophrenic's inner world must be able to rely on a structure external to him».**

**According to Patton "the doctor is the leader [of the therapeutic community]"; for Sarwer-Foner "medical authority must be paramount in the ward".**

**For Stubblebine, “another principle [of the therapeutic community] is that relationships of authority must be openly recognized and accepted. The therapeutic community is essentially an expression of confidence in people's ability to examine their immediate social situation with all its authority complexes. In order for the group to discuss authority issues openly and profit from this discussion, it is essential for the *physician to* be calm in the exercise of his authority. *He must be as free as possible from feeling threatened when his statements or contributions are scrutinized, criticized or distorted, he must be so safe that he hardly has to defend himself, thus acting as a model of objectivity "etc.***

**Let us try to realize at this point the reasons why the therapeutic community does not seem to have kept the promises of a substantial change in the institutional situation in its development process.**

**With the cultural presuppositions on which it had arisen and developed (social psychology, mainly in the Lewinian lesson), it could not maintain them, and therefore often ended up by revealing itself as only a new "therapeutic" tool in the hands of doctors, at the peer of Simon's medications, ES and ergotherapy. It does**

* **made an instrument when the socio-psychological technique of "problem solving", fundamental in teamwork in all fields in which it is used, was smuggled into it as revolutionary: industry, bureaucracy or psychotherapy. 19**

**These are the group techniques of social psychology, which have been so strongly influenced, especially in North America, by Kurt Lewin's theory of the 'social field'. The Lewinian way of solving**

**social conflicts 20 has been applied in the therapeutic community as it had been applied for greater efficiency of bureaucracy and industry. 21 For it, conflicts can all be resolved, through the "participation" of all, with discussion; the points of the contrast can be smoothed, by means of group "manipulation", with a tolerant and understanding attitude; the outcome of the group discussion is the integration of all the participants into the group itself, under the guidance of a wise and enlightened leader, in an effort to reach the "good" end**

**common: this is the orderly unfolding of the bureaucratic mechanism, that a regular production, and the healing-rehabilitation-integration of the mentally ill.**

* ***efficiency* assumes, from this point of view , which alone will be able to achieve the "good" end.**

**If the "good" goal is the care of the mentally ill, then the organization must be led by the psychiatrist, who in the new organization, the therapeutic community, will be called " *administrative " psychiatrist* (Clark) or, as better and better with moreconsistency propose Levinson and Klerman, clinician-executive, clinician and manager at the same time, thus realizing on the one hand the panoramic-organizational ideal of the neo-capitalist society, on the other the psychopathic aspiration often present among psychiatrists themselves.**

**Evidently, the exercise of activity and power by the psychiatrist is no longer contested at this point, it is no longer a problem: "The clinician must deal with the behavior of his patients as well as with their private fantasies and feelings . He must be able to establish and maintain limits and take decisive action at the crucial points of his clinical direction. The joke about the therapist giving an interpretation as the patient throws himself out the window is**

**the caricature of therapeutic passivity and permissiveness, but that's not what a good therapist would do. Firmness and initiative are less emphasized but nonetheless essential virtues of the clinician. On the other hand, the clinical part maintains its importance for the executive psychiatrist. Proper concern for the personal feelings and needs of members of the organization will help, not hinder, his efforts to build the organization. His professional ability to listen will help him in his efforts to increase communication and to negotiate disagreements »etc.**

**The cycle seems closed; what has arisen as a need for a fundamental renewal of psychiatric institutions has revealed itself mostly in practical implementation and theoretical speculation, only a new type of institution, more modern, more efficient, but in which the power relations seem to remain same.**

**The "third psychiatric revolution" would seem nothing more than a belated adaptation of the methods of social control of pathological behavior to the methods of production, perfected in the last forty years by the intervention of sociologists and mass communication technicians. It seems that the sociologists and psychologists of the organization have found a way to apply to the institutional psychiatric field, under the pretext of healing the fundamentally dehumanizing structures of**

**asylum, the techniques (first of all group techniques) that have proved so effective in neo-capitalist economic management, while leaving the oppressive power schemes of society intact.**

**This conclusion would appear to be a confirmation of Marcuse's words « *To the extent that operational sociology and psychology have helped to alleviate subhuman conditions} they are part of intellectual and material progress. But they also testify to the ambivalent rationality of progress, which satisfies in the meantime it exercises its repressive power, and represses in the meantime it satisfies* ».**

**However, the balance of the therapeutic community cannot be a failing balance. The problem of the transformation of psychiatric institutions has found in the therapeutic community a type of solution that can lead to subsequent developments and certainly it cannot be denied that for the first time all the fundamental contradictions of institutional reality have posed themselves as problems in it.**

**Its merit is that of continuing day by day to highlight these contradictions, removing them from the Manichean and aproblematic schematization of the traditional psychiatric hospital. Even if, as we have seen, there is a serious risk of involution in its presuppositions, it is the merit of the community situation to allow**

**to run this risk every day, and to arouse the patient's daily protest against it, which certainly does not take a "democratic" form, in the various assemblies and meetings, but is implemented, for example, as a control (that the free movement of patients allows) on the use that the doctor makes of his power.**

**The contradictions remain, the important thing is to become aware of them: the debate that follows, stimulated by the considerations that emerged in this study, can give an idea of how this awareness takes place.**

**Team meeting of November 27, 1967.**

**JERVIS I think we must be aware of the fact that there is a danger in doing as Schittar does the criticism of the mystification of the therapeutic community: the danger, that is, of concluding that since it is all a mystification, we might as well go back.**

**SLAVICH This is basically the speech that many make also in Italy: yes, so much is said about the power of the patient, but in the end in the institution the power of the doctor stands out continuously and nothing can be done about it. In short, everything is postponed to the distant future, when and if out-of-hospital assistance will be implemented.**

**JERVIS It is also interesting the interpretation given by someone to some of my positions. Having also criticized on more than one occasion the mystified aspect of the therapeutic community, it was me**

**said: then you, who make this speech as a politicized speech, refer everything to the revolution: since the external society imposes this mandate on you and infiltrates through your reforming action to the point of continually mystifying it, you try to correct yourselves, but in the end accounts postpone everything to a future in which a new society will be able to bear this too. This seems to me to be a problem that needs to be addressed thoroughly; we should have the courage to make a fairly severe self-criticism, that is, not only a criticism of the Anglo-Saxon therapeutic community, but also a criticism of our work; however, we should do it in such a way as to indicate a possibility of overcoming, without proposing psychiatric-regressive arguments.**

**SCHITTAR** **As for the self-criticism that we should do, I would say that it is very different to programmatically reject the discussion on medical power (as we have seen done by many Anglo-Saxon psychiatrists), from discussing the power that is entrusted to us and making us and others continually participate , in practice, of the contradictions of this power, even if it can be said that it still remains in the hands of doctors.**

**SLAVICH So it is understandable that someone, aware of these weaknesses of our criticisms of the dangers**

**of the therapeutic community, at a certain point take the situation in hand and say: We must lead, we must have the courage to say that the community must be led. If everyone says, even the pseudo-advanced ones, that in the end it is under the power of the doctor, we might as well say clearly that the therapeutic community must be guided.**

**JERVIS It ends up being an appeal to "reality confrontation": given that the therapeutic community must continually confront itself with reality, if reality is an oppressive reality, not only outside the hospital, but also, in spite of everything, inside of the therapeutic community, this oppression must be recognized as existing and thus be institutionalized in some way.**

**PIRELLA** **What then is opposed in our situation for these oppressive behaviors to be exposed? - I would like to ask a provocative question, that is, I would like to know what is opposed in our situation to this oppressive conduct being exposed and denounced. At some point the transformation of a traditional situation into another guided and paternalistic situation, according to some, both from the right and from the left, both from the right and from those who are careful not to mystify their work, is considered the translation of an oppressive power e**

**manifest to more bland and soft and in some niode unmasked. So the power in the traditional situation is manifest and oppressive and the power and authority in the situation instead of the therapeutic community would be more masked and muffled, softer. In my opinion the provocative question may be this: while we know what prevents the denunciation of this oppressive power in the old situation (and it is the structure of oppression itself), in the new situation what prevents by each of those who work in the field (patient, nurse, doctor, social worker, etc.) What prevents these people from denouncing openly in all instances and in all places this masked power, always oppressive, but hidden and muffled? That is, if it is true that the accusation we make against Maxwell Jones is that of transforming the Psychiatric Hospital into a situation in which the techniques of social psychology are applied as techniques of consent, if this is true, in our situation, or in the situation of Maxwell Jones what prevents everyone from denouncing, unmasking, demystifying this power? Is there anything preventing this? Is the system so perfect in which consensus is reached in every way, without any stretch, no contradiction?**

**SLAVICH It would seem that it was really perfect. After all, ideal communities are made up of many Giovannas, meaning by "Giovanna" for example an integrated position of consensus to the phantasmatic leadership of the community (whether Maxwell Jones or others) for which the needs of the therapeutic community are met without shock. I have the impression that in this sense the therapeutic community is working very well. Once the principle of the reform of authoritarianism has been established, I have the impression that an already complete system without stretch marks emerges, which does not allow a denunciation of the "latent authority" which lies beneath.**

**JERVIS I think this pessimism of yours can be discussed, I don't know if I would accept it as a whole. It seems to me that even the revisionist-integrative therapeutic community of the well-articulated psychosociological type, with this engineering of consensus so perfectly functioning, ultimately creates contradictions. And I have a bit of the impression that there are still some residues of dissatisfaction, of non-integration, of rebellion; or even residues of open authoritarianism. I have a bit of the impression that the existence of an integrated, paternalistic therapeutic community, in which everything happens with well-ordered consent, is not possible; that is, it always leaves areas not recovered from**

**system. All in all, the therapeutic community as we see it, of the neocapitalistic type, must always oppress something in order to function, it must always somehow crush a margin of non-integration.**

**SLAVICH** **I'm perfectly agree. I had forgotten to mention the need for a small, partial, "enlightened" closure within the field of the therapeutic community. Certainly, for example, the integrated therapeutic community cannot do without measures that in crisis situations safeguard its integration, for example it cannot do without a closed ward. Here the integrated therapeutic community proves to be a hybrid system that still maintains in itself, in order to exist, residues of explicit as well as latent authoritarianism. Integrated therapeutic communities must foresee some repressive possibility. If the bridges with the material possibility of exclusion have been cut, only then will the discourse probably become dialectical.**

**PIRELLA To my earlier question: "What prevents us from clearly denouncing the still present and oppressive power? We can then give this answer: the possibility that a repression mechanism will be triggered at any moment commanded from above; real possibility, not hypothetical. It's possible**

**that is, for example, that at Maxwell Jones those who make serious acts of rupture go to a closed hospital in Edinburgh, or there is the presence of a closed ward in an open hospital, or again, there is a possibility that at some point the "Latent authority" to effectively prevent a manifestation, a deviant behavior. At this point, to deepen our investigation, I would return to the question that Schittar basically poses: are we a therapeutic community in this sense?**

**SLAVICH We can also do the reverse: what keeps a community from integration? I believe basically that it is the threat deriving from the irreversibility of the situation that has arisen. For example, the non-existence of a closed ward certainly keeps the situation hot and prevents it from crystallizing into a "perfect" model. The pressure of the patient's mass contestation allowed by his free movement (which may have been donated at the time but which is now firmly in his hand) is the real guarantee, as the patient's power of control towards us and towards the situation institutional. The patient controls the doctor and avoids that in some way he can take the opposite path on the path of community formation, and summarize authoritarian attitudes or build**

**artificially communal situations.**

**PIRELLA Does this control of the patient exist? SLAVICH I am convinced of that. I am convinced that you do not**

**thus expresses verbally and "politically" in assemblies, or with majority votes, but is expressed as a power of pressure and control in the "fluidity" of the situation.**

**JERVIS I have the impression that in theory we could also envisage a therapeutic community in which all power is controlled or even exercised from below, that is, which functions, for example, through committees in which everything is "democratised", "but I don't think this is the ideal solution, because when the base introjects the need to keep the community as a functioning community, in practice it ends up introjecting the need for power. In my opinion, the guarantee of not falling into a new mystification does not lie in delegating a power to the base, but in risking at any moment the possibility of the community falling apart. Because if we delegate the power to the base when the base guarantees us to know how to manage it, in reality we are delegating the mystification.**

**PIRELLA I disagree; I disagree for the reason that this statement does not take into account that by definition the inpatient in a psychiatric hospital**

**can't run the hospital. When the inmates run the hospital, they make an act of enormous contestation of power, because they contradict a fact that power justifies: their exclusion in a situation of dependence. So it seems to me that in your sentence there was a confusion, which sometimes we ourselves do, between the power inside the hospital and the power outside. If we are the contractors of external power, we are to the extent that we keep the situation under control. If the situation escapes our control, and is self-managed in ways that partly escape us (in part, or in whole: there are some situations that can completely escape us, as we have also seen), at that moment a profound contestation of external power. The difference between our community and communities, let's say in the classical sense, lies in the dynamics of the contestation, which we have spoken about many times. The new fact is that our community is characterized by a position of contestation at all levels. Therefore, the control over the doctor by the patient, over the doctor by the nurse and then by the doctor over the nurse and the patient, in short, the mutual control and also the reciprocal dispute, all this leads, in a contradictory and even disordered way, to to contest the external power in a global way, that**

**power that instead would require us to keep the situation totally under control in a guided community, which we do not do.**

**JERVIS I fully subscribe. That power is no longer managed by those who are the official agents but is controlled and put in crisis by those who are the official rejected, is already a truly revolutionary fact.**

**BASAGLIA It seems to me - even if I have not followed the whole discussion - that the problem of CT and its future is all in the awareness of the danger of falling into a simple psychiatric reformism. But if we want to recognize a dialectical dimension in the situation, we must also identify the second possibility which may consist in the very contradictory nature of the situation: the institution is simultaneously denied and managed, the disease is simultaneously placed in brackets and treated, the therapeutic act is simultaneously refused and acted. In this sense, denial is simultaneous with management and vice versa. The presence of the so-called "norm" within the psychiatric institution could be, to a certain extent, challenging, given that the explicit function of the institution is to contain what is outside the norm. Until the system determines that**

**the psychiatric institution is a new institution of the norm, this could indicate a subsequent contesting use (with respect to the system) of CT, if it places itself in an attitude of denial of the functionality of the system of the psychiatric institution, as a place of the abnormal in the norm. This also means that the presence, within other institutions (family, school, factory, etc.) of disturbing elements discharged from a psychiatric institution that no longer wants to be the place of discharge of external contradictions, could serve (as well as there**

* **norm "is contradictory in the place of abnormality) to highlight the true contradictions in the terrain of the so-called" norm ". The "discharged" person can play his role as a person integrated into society, through the use of a re-integrating institution, but he can also fulfill a challenging function, in the sense that his mere presence in the external world would negate in a way the one-dimensional world desired by the system is revealed and, at the same time, confirms the action of an institution that refuses to exist only as a place of non-contradictory discharge of contradictions.**

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**Myth and reality of self-government**

**Self-management, self-government, community decisions: these are words that recur more and more often in the reformed language of the new psychiatry, to the point that one might think that a new, freer way is taking place in what until recently were institutions of care and custody. and more democratic "than the management of power, and to the point where the mentally ill participates. A seductive hypothesis; enchantingly cancels the fundamental contradiction that contrasts the institution with the patient in an adialectic relationship of object subordination, the only relationship that is capable of seconding the possible ends of the institution - social exclusion or even, on the contrary, rapid productive social reintegration - and to ensure the conservation of the institutional mechanism itself; it is a hypothesis that manages to put violence in its various shades in brackets, violence that alone manages to manage such a contradictory relationship; it is, above all, a hypothesis that removes those who officially manage power in the institution from the embarrassing accumulation of contradictions in which they find themselves, in spite of themselves, immersed.**

**Neglecting this fundamental contradiction, whoever proposes the hypothesis of a "community self-government" on the part of the patient can only formulate abstract and vague models. However different the ideological matrices of the hypothesis of such "self-government" are, it always results in the presentation of a**

**adialectic facade; mainly, in this regard, the following three positions can be identified:**

1. **A perspective that sees the resolution of all internal institutional contradictions with the simple reversal of the situation, and therefore with the assumption, in principle, by the patient of a high and rational decision-making capacity, in a sort of "psychiatric republic »Whose dimensions are strictly circumscribed in a micro-company context, and therefore arbitrarily detached from the determined social reality, from which every institution is primarily expressed.**

**b) A second perspective represents the** **possible advent of a "self-government" of the mentally ill as a threatening antagonistic contradiction: this "sick power" is colored with the dark tinges of irrationality and chaos; and the hypothesis is therefore useful to justify, ex contrary, the authoritative conservation of institutional power, in official hands, according to the most sincere asylum tradition.**

**c) The third way of envisaging self-government, currently increasingly widespread, is that which requires a spontaneous settlement of internal contradictions by means of an enlightened *external intervention* , of *technical guidance* (medical or sociological) which serves as a support to**

**an orderly and rational management of some portions of institutional power by the patient " *made collaborative "* .**

**These three positions, perhaps arbitrarily rooted here (and which continually tend to overlap, by virtue of changing shades of false consciousness), end up configuring a real community metaphysics. However, if they do not seem acceptable to us, in their more or less interested abstractness, this does not mean that, in the act of rethinking the possible meanings of a reversal of the characteristics of the asylum institution, we should not place ourselves on different bases. problem. In fact, one cannot speak of self-government on the part of the patient without explicitly asking at least two questions; one on the actual nature of the power possessed by the patient, the other on the historical modalities of the transfer of this power from the traditional seats to his hands, in the course of a determined process of overthrowing the asylum institution; this possible transfer of power cannot be hypothesized, but must be verified in a concrete analysis, before in any way we can speak of "self-government". Thus abandoning any temptation to make community metaphysics, and sticking to an attempt to analyze the contradictions as they manifest themselves in a**

**concrete institutional situation - as the Gorizia experience of these six years can be considered - a schematic analysis of the process of redistribution of institutional power can be attempted, to see if, and in what forms, possibly alternative to those of the so-called "community democracy" or "Self-government", the power acquired by the patient has had a real weight in putting the structures of the asylum institution into crisis.**

**In the typical situation of a traditional psychiatric hospital - such as that of Gorizia in 1961, at the beginning of our experience - the patient is not usefully placed in the hierarchy for the exercise of institutional power: he is therefore openly "out of the game" even under this regard; the logic of the institution does not allow for deviations, and therefore there is no mention of self-government on the part of the sick. However, the physical presence of the sick to some extent still affects, and is not negligible. First of all, they still constitute the very reason for the existence of the institution, and are therefore an obligatory point of reference for every organizational activity and for anyone who is instead usefully placed in the hierarchy; secondly, the weight of this presence, albeit only in the form of a numerical prevalence, is also measured as a result of the hardness of the coercive reaction and**

**serializing that the institution must put in place to reduce, schematize, simplify the problem that derives from the mass of objects of care. This total deprivation of power of the patient is obviously not contradicted by the granting to individuals of fringes of personal power, in the form of privileges to be exercised exclusively within the restricted limits of the permissiveness of the system.**

**The fundamental contradiction between the institution as a mechanism and the patient as an object of care therefore means that power is totally localized in the first of the two terms; the characteristics of its distribution are however - and they were in Gorizia - quite complex, and themselves contradictory. First of all, however articulated and stratified the hierarchy of internal authority is, it exists and**

* **a *homogeneous solidarity* between the various levels is in place, based on the objective concordance of the institutional operational purposes: doctors and assistance staff, all consenting recipients of the same social care and custody mandate, and an integral part of the same functional mechanism, act in solidarity and compliant - each with its own technical module - for the achievement and conservation of the institutional purpose. The common possession of the same object of exercise of power - the mass of patients - facilitates the distribution of hierarchical roles among the various professional categories, and**

**within each of them: the patient becomes the only passive means of operational communication between the different categories, doctors, nurses, religious and administrative personnel, etc .; otherwise they remain closed in the circle of the respective corporatist interests, and in the socio-cultural parameters of the respective caste.**

**This formally homogeneous solidarity between the different hierarchical levels is facilitated by the characteristic of the social mandate of being always and continuously delegated in a chain that is resolved only in direct contact with the object of the mandate (the patient). The delegation to the management of power for the purposes of the institution comes to the top hierarchical from outside the institution itself, after a long series of steps that gradually involve the underlying structures of the external society and its constituted powers (the family, the natural social environment, the workplace of the patient; then the Judiciary, public security, etc.). The proxy becomes an embarrassing witness who, as soon as he arrives in the hands of the doctor inside the hospital, is immediately sorted through the hierarchy to the assistance staff, once compliance with the law is formally respected, and the "scientific" needs of the address of care by formulating the "general rules" for the treatment of the patient. The assistance and administrative staff are delegated the**

**direct power over the sick person; a broad delegation with a wide margin of discretion, which allows the exercise of real direct and personal authority over the patient. It follows that, in the traditional psychiatric institution, the doctor holds only a formal and abstract power, while substantially and concretely it is exercised by the auxiliary staff. The hierarchical subordination of this subsystem of personal power to the formal authority of the iiedic is still and only ensured by the theoretical possibility of the sanction; but there is no doubt that the center of gravity of authority, for the patient in his daily life within a closed ward, lies in the nurse: it is the nurse who decides and revokes, grants and denies, formulates the image of sick - good or bad - which will be communicated to others (and among them the doctor), etc.**

**This mechanism of delegation of powers in a closed hospital can also be used to explain how the doctor always manages to maintain respectability in the eyes of the patient; his absence from the field - justified by the impossible ubiquity and multiplicity of his other professional commitments, and in any case surrogated by the wide delegation that he distributes for the practical details of the assistance - removes him from the embarrassment of decisions concerning, face to face, the sick; he can thus present to them a severe and distant but just and uncompromising "facade", and be recovered as**

**ghost of the technician who knows and can, and in any case the only antagonist (usefully placed in the hierarchy of power) of the nurse, who instead at any moment of the day constitutes an impending presence that really decides and acts. Even the fact that, in the eyes of the patient, it is the doctor, ultimately, who keeps him in the hospital, is reabsorbed in the mechanism of delegations: and the patient ends up accepting, in most cases, the interpretation that the responsibility of the his protracted hospitalization goes back "upstream" of the doctor.**

**Compromised in inverse proportion to the doctor, burdened by the delegation of personal power over the patient, the nursing staff still and always performs their duty. Whatever the personal motivations of each person to commit their work in the institutionalized and frustrating conditions typical of the psychiatric hospital, it is certainly not a vocation of the class of nurses to institutional violence, but a violent function, within the limits set by the organization. The contradictions deriving from a more mature class consciousness - especially among nurses - remain inoperative or in any case well controlled. The contradiction concerning the inequality between formal power and real responsibility on the part of nurses remains internal and secondary to functional solidarity with other professional categories, and**

**in any case within the limits set by the rigidity of the hierarchical roles.**

**A particular position in this power structure for the government of the institution is assumed by religious personnel, when they are at the top of a closed subsystem (a ward or a hospital "service"), in an intermediate position between the doctor and the nurse. . The religious fully accepts, like the other categories, functional solidarity with the aims of the institution, on the basis of the social mandate that she accumulates coherently with that derived from the Rule of the religious Order; only that he tends *not to delegate* further personal power over the patient, preferring instead to manage it on his own, with his continuous presence in the ward. It thus becomes the seat for the delegation that gives the doctor the greatest trust; and manages to impress a personal style, particular for each subsystem, with a type of power management over the patient with which he manages to reconcile the institutional purposes with those of the religious Rule; in order to do so, it must however put out not only, as is obvious, the patient but also all the remaining subsystem assistance personnel, with antagonistic tensions that are continually dormant and skilfully controlled**

**.**

**This, very schematically, is the situation as for**

**distribution of power for the "government" of the institute, from which one moved to Gorizia six years ago; a similar situation, probably, to that of many other psychiatric hospitals, due to the characteristic of total institutions that they always repeat themselves. A situation in which, with all evidence, the decision-making power of the patient was absolutely null.**

**At the end of 1961 a new director, followed shortly after by another doctor, began their work in the hospital; their refusal of the simple mandate for the conservation of the institution and the orderly formal management of the delegation for the social exclusion of the mentally ill, produced a *sharp break in functional solidarity* between a part of the doctors (among whom, however, thetop management represented by the director) and the remaining care and assistance staff. The consequence of this rupture of solidarity was an interruption of the chain of delegations of institutional power: it was hired and managed on its own by a part of the doctors, who constituted themselves as avant-garde in the name of a denial of the asylum structure, of its conditioning norms. , and related institutionalization.**

**The work, in this first period, often assumed aspects declared to be breaking with the pre-established norms: thus, for example, the continuous and "ubiquitous" presence in the departments; the renewed medical approach e**

**psychopathological to the patient, in an attempt to grasp his presence through the screen of serialization; the abrupt abolition of all physical means of restraint and active vigilance in avoiding violent measures of coercion; the research and denunciation of the numerous institutional rituals now deprived of any sense, even if only theoretically therapeutic; the restoration of some traditional means of rehabilitation, such as ergotherapy; the large-scale and non-discriminatory distribution of privileges, hitherto limited to a few patients particularly useful to the institution; the reconsideration of a large number of external socio-environmental situations relating to patients, with the consequence of numerous discharges of long-term patients; the solicitation of numerous administrative measures aimed at improving the primary living conditions of the patients, etc. If even in the course of 1962 the base of the avant-garde had been expanding due to the arrival of new doctors and above all due to the consent of a certain part of the staff, there is no doubt that this initial action - on a level that involved the structure as a whole of the institute - it was possible only for the non-delegated exercise of power by the top, in a still hierarchical structure, forced to maintain itself in order to deny itself. However, such an extensive and vast attempt to overthrow the asylum structures could only result in a profound one**

**crisis of pre-established positions of power at various levels, in the various professional categories and in the various subsystems; in particular the nurses, deprived as a homogeneous and autonomous group for the exercise of personal power over the patient, deprived of the coverage of the delegation by the doctor, were abruptly recalled from their institutionalized condition, and lived the crisis of a first and fundamental choice, that he had to define for each one the meaning and the value of his individual presence in the field of his work; a choice for which they lacked new norms and predetermined values to refer to (other than the rejection of pure custodialism and the voluntary donation of a vaguely therapeutic meaning to their work). Any choice**

**collaborative was not paternalistically exploited for inscrutable higher ends, but contributed to broadening the base of the avant-garde; and each refusal strengthened the tendency towards conservation of the asylum institution; for a long time this fed with tension and anxiety the strongly antagonistic contradiction between the previous power structures (which were regaining their solidarity) and the new power group that was forming.**

**In all these dynamics the sick still had a very marginal and reflected part, and were still the object of the decisions and actions of the avant-garde; far from-**

**expressing a decision-making possibility they risked being exposed to a new form of power, more hidden but no less insidious. The paternalistic temptation was in fact immanent insofar as it was taking place; and formally this voluntaristic "donation of therapeutic sense" could in fact present itself in the form of paternalism: it freed itself from it only to the extent that the practice, in the rapid succession of organizational phases, formulated and immediately denied dialectically, precluded the will to preserve the institution by manipulating a stable reform, and instead tended to subvert its presuppositions. Certainly, the decisions and actions of the avant-garde were based on the patient, and not on the institution itself; but they were still decisions in favor of, and the fruit were gifts from above, or concessions of privileges, and as such they were enjoyed, at least initially, by the majority of the sick.**

**A decision - which also came from the medical team**

* **which differed qualitatively from the previous ones, with regard to a possible redistribution of decision-making power, was that of opening the first long-term patient ward (November '62). That was the test of the avant-garde's real determination to restructure the therapeutic institution on a new basis. In fact, if we consider that the main form of exercising power over the patient proper to custodial ideology is**

**represented by the coercion of the freedom of his movements, and by his visual control in a limited space, the irreversible break with that ideology was achieved with the opening of the departments, and above all with the restoration of the possibility of a movement not subject to the control of view of the patient inside the hospital. Amid numerous reservations and resistances, with temporary compromise precautionary measures, in 1963 another four departments were opened.**

**In the early days, when an increasing number of sick people came to have freedom of movement in an ever less conditioned way, the majority of them continued to remain on the sidelines of the active process of renewal of the institution; some in possession of a freedom given from above, which still showed they did not know what to do, if not to use it to respond to the predetermined solicitations of traditional sociotherapy; the others, many, still confined to the numerous asylum-like pockets of the closed subsystems. The process of re-identification, which albeit slowly arose from the constantly changing dialectical situation, allowed some leaders to emerge among the patients who, with real collaboration, went to flank the avant-garde. This is the period ('63 -64) of some initiatives managed by the sick and facilitated by the care team, which for the formal modalities "**

**autonomous »management, for the possession of a means of internal communication and propaganda (the internal newspaper**

* **Il Picchio "), and above all because of the contrast with the still traditional framework in which they came to place themselves, partial forms of self-government on the part of the sick were proposed as" revolutionary ". As such, at least, they were used outside the hospital (especially by virtue of the opinion created by the "Picchio"): in reality it was an open group of long-term patients numerically limited (fifteen to twenty people at most) compared to the mass of patients, with a recognized leader (Furio); the initiatives of this group were perfectly aligned with the aims of renewal of the avant-garde. The contribution of these patients was very important in this phase (with the establishment, for example, of the "Club help us to heal", the first organized group of patients from different sectors of the hospital; or with the organization and animation of the time free, with the still traditional means of parties, trips, the internal library, etc.); but this contribution was perhaps not indicative, as it might seem, of an effective redistribution of decision-making power; This is also proved by the fact that the resistance on the part of the conservative instances to these initiatives by the patients has been almost nil (with the exception of some polemical positions in the**