**comparisons of the "Picchio"), if compared with those aroused by the free movement of the hospital of a part of the patients, for its disorganizing consequences the institutional "quiet". Even in this period the idea of the necessity of the "collaboration of all" and of the dimension of the group as a way to overcome certain institutional or interpersonal contradictions was taking shape; even if confidence in the new liberalized climate increased at all levels; even if the primary purpose of the hospital resumed officially, in the culture that was being formed, the "therapeutic" one and structures (such as the "Club", the various "Committees", etc.) began to express themselves formally "Democratization" of institutional life: even the patient still lived the experience of his hospitalization either as a collaborator in the decisions and suggestions dictated by the avant-garde, or as the object of therapeutic initiatives and sociotherapeutic "analysis"; his margin of freedom - even if he was in possession of it - was slowly built up in the possibility of personally managing, free from visual control, his own space and his own possibilities, even of contestation, on an individual level.**

**In this phase (autumn 1964) characterized by the progressive opening and internal liberalization, with the**

**irreversible donation of physical freedom to the patient and the slow reappropriation by him of a margin of psychological freedom *within* the hospital; in this apparently chaotic and shapeless movement of renewal, in search of an organized form, the establishment of the first "therapeutic community" in a long-term inpatient ward is situated. Also originating from a medical decision (opening of the sixth ward, transfer of a large number of patients between wards, choice of staff and of the fifty-four patients called to participate in the community experiment) the initiative took on a new meaning, because it called to the active collaboration not only a few leaders already supporters of the avant-garde, but a significant mass of patients from all male wards. On the occasions of the ward assemblies - which then began their prolific existence in the hospital -, in the daily coexistence in close contact with the treating team, the patient came to have a decisive part in the common organization and in the management of the day of the ward, in the constitution of its norms, in the formation of its culture, in the critique of residual institutional mechanisms; and if the organizational "decisions", the resolution of certain internal problems without the necessary intervention of the hierarchical opinion, represented the most sensational aspect**

**of the experiment - given the context in which it was located -, it seems to us that its value for the hospital as a whole was rather sought elsewhere: in the possibility that in the ward assemblies, in discussion groups, in daily coexistence to a more real and direct communication between *all* the members of the department; that the hierarchical verticalization could be concretely subverted in the continuous attempt to establish, on a level of precarious equality, a collaboration of all for the same therapeutic purpose; that + interpersonal problems and tensions could be ventilated without the exclusive and resolving intervention of the doctor's technical authority.**

**This first community experiment proposed an ideology, formulated slogans, deliberately intended to spread certain formal principles of a therapeutic organization to the rest of the hospital; the part played by the 54 patients called to participate in the initiative was relevant to the extent that they actively, in direct contact with the hospital mates of the other wards, in the spontaneous groups that were formed in the alternatives to ward life (at the same time as the therapeutic community the internal bar entirely managed by the sick had been opened in October 1964) were promoting the opportunities and advantages of the "new" type of community management. Do not**

1. **it is doubtful that this first large group developed a consciousness and a culture of its own very quickly. However, it must be borne in mind that the expectations underlying this active collaboration were still conditioned by the decision-making power of the doctor; the experiment was in fact seen by these patients as a big joint effort, which was a prelude to the discharge of each one from the hospital. And it was on condition of maintaining these expectations and this possibility of becoming futuristic that the department maintained its cohesion and spontaneously activated those dynamics which, from the outside, appeared as a "democratic" and community management model.**

**In the course of '65 and '66 the "community culture" gradually extended to most of the subsystems of the ward. In particular, each ward began its assemblies, each ward care team met weekly, and organizational meetings and "committees" were held and unraveled in continuous attempts, which often found their negation in themselves. It is no coincidence that the beginning of the collaboration of new doctors, in this period, coincided with the progressive activation of all**

1. **ward subsystems, with their complete opening, with the increase in the number of meetings. In November of '65 the need for an assembly arose spontaneously**

**general, which would allow the meeting and communication between all the people who, present in any capacity in the hospital, wished to participate. The decisions regarding the beginning of each of these initiatives still started from the vanguard; however, many of these initiatives fell when, being spontaneous participation, they were denied by the patient, who thus denounced the lack in them of a valid motivation for him. The intensification of communications and the broader participation of the base in alternative occasions of daily institutional life has also spontaneously led to the release of certain services - especially for the management of free time - from control and organization, with "socio-therapeutic" intentions. by the healthcare team.**

**This description of the process of widening the basis of collaboration between doctors, patients, nurses, which seems to admit a homogenization of the entire hospital field on an advanced "community" basis, with a real and active participation of the patient, would be mystified if present some of the most striking internal contradictions that seem in part to deny this community process. Thus, for example, the relative displacement in the timing of the process that occurred in the female open wards is significant, compared to**

**the male ones. The presence, in each of these departments, of the usual "decision-making" seats (assemblies and discussion groups) did not prevent a relative persistence of the verticalized hierarchical structure, which in many cases also heavily influenced the real availability of the margins of freedom of the sick. The reasons for this are certainly many, the last and most negligible of which seems to be that, often invoked, of female "passivity", which would also reveal itself among the sick; there are other reasons, probably, for this lack of penetration in depth of the action of overthrowing the asylum institution; in the first place a less active intention on the part of the vanguard, and also the resistance of the hierarchical top of the ward, represented by the nun, to give back the delegation for the personal management of the personal power over the patient.**

**A further important contradiction was represented until very recently by the presence of the last two closed wards. If these too had not been used for a long time as a means of sanctioning and controlling deviations, there was still the fantastic possibility of sanctioning, which acted as an internal counterweight to the progressive granting of freedom of movement to the patient. Recently these last two departments have also been opened; with two further actions**

**of "rupture" that have gone beyond the power of the internal "decision-making" offices (largely controlled, in these two closed wards, by subgroups of the nursing team) currently *all* patients have the theoretical *possibility of freeing themselves from the custodial system and managing* own, using or not the alternatives that institutional life makes available, one's personal freedom of movement.**

**This historical outline has been delineated intentionally keeping in mind only the possibility that the patient has had and still has to confront and oppose the positions, old and new, of institutional power. At first, the conclusion would seem completely negative: in the progressive formation of an ever wider vanguard for the overthrow of a traditional asylum condition, the "officially" sick person seems not to have played a large part. The doctor seems to have succeeded in imposing his power, even if he intentionally tried to deny its traditional function: thus showing his persistent and contradictory compromise in the social mandate; the other professional categories have benefited from the opportunity to reactivate their work in the institution with meaning, largely by actively participating in common action, and in any case actively experiencing internal contradictions with the doctor and with**

**the sick. The sick person also enjoyed first of all, *within the institution* , the *possibility* of rediscovering himself, in the margin of personal freedom that his condition of exclusion granted him. He has re-appropriated freedom from coercion (not, for example, freedom from need); was able to make use of interpersonal contacts, manage his day on his own, individually or in spontaneous groups, choose between certain alternatives, etc .: all this, however, always within the system, within the limits, not only spatial, set by the institutional mechanism. In two distinct periods, during these six years, the activities of the patients have shown a tendency to formalize in an apparently orderly, calm, reassuring way. A first time (1962-**

1. **in the passive enjoyment of the "sociotherapeutic" privileges distributed en masse from above; a second time, more recently, in the conformist acceptance of the formal "democratic" rules, in the "committees", in the groups of activities, or in certain moments of the assemblies. A part of these activities, as has been said, has fallen into disuse, denied by the patients themselves as their artificiality and pure functionality were manifested to a new institutional control system.**

**The patient therefore has the power, now, to deny some wishes of the treating team; only that it does not do so with a majority "decision", but rather by denying,**

**individually, his collaboration. Here emerge the contradictory functions that coexist in assemblies, discussion groups, and in general in all those meeting occasions in which active participation seems to mean the achievement of a high "community maturity".**

**On such occasions, in fact, the encounter and confrontation with the small and large problems of institutional life allow for real communication between anyone who takes part, even in silence; they allow a non-formal discussion in which the positions, motivations and coverage of each are committed; an awareness is made possible that, at the limit, can concern any of these problems and contradictions, including that, therefore, of the limits imposed by the condition of exclusion, and by the objective impossibility, on the part of the patient, to take a decision that is valid to force these limits.**

**The orderly formal appearances of discussions in assemblies easily evoke parliamentary models; and in the face of the complex system of assemblies, the image of a patient's "self-government" in the institution is re-proposed. However, together with this image, the other aspect of the contradiction concerning the assemblies also emerges. A "self-government", as it was said at the beginning, presupposes a power, and this must**

**being able to translate into decisions that confirm the power of those who make them. Looking at the formal parliamentary appearances, it is legitimate to ask: what are the real decisions that are made in a psychiatric institution, and how much part does the patient have in each of them? An answer perfectly in line with the community ideology could be this: "Everyone decides, all decisions are important"; but in reality in an institution that continues to base its legal foundation on the fundamental contradiction between itself and the patient as the object of the care and custody mandate, the decisions cannot all be equally important, as there are some that affect, others that do not affect. this fundamental contradiction. Similarly, these decisions cannot be taken by everyone indifferently, since, at least as long as such a fundamental contradiction remains in place, there will always be participants in different capacities.**

**What are, for example, in concrete terms, the different types of decisions that can be faced in the assemblies? The following groups can be identified:**

1. **In an institution closed to the outside, in which the doctor has the mandate to forcibly detain the patient, and therefore continues to be in solidarity with the institution in the fundamental contradiction, the**

**basic decisions are those concerning the patient's discharge, his transfer elsewhere, his possibility of leaving the hospital field while maintaining the link with the institution (family leave, walks, etc.): on these decisions the patient has not some power; group or individual pressure in this sense can only be effective if it expresses a position that conforms to a consent that the doctor has already decided to give.**

1. **In "therapeutic" decisions, which in itself are the prerogative of the doctor, the patient can have a certain margin of dispute; however, he can usually oppose only with the global denial of a specific type of therapy, because he lacks any technical power that can validate his arguments on the details of the therapy.**
2. **In internal administrative decisions (individual and group benefits, improvement measures, etc.), the patient may have a part, albeit limited, by making certain strongly contesting opinions weigh in the assemblies, when these put the official offices of administrative decisions in real embarrassment; however, these are very rare occasions, around facts and arguments that manage to mobilize mass participation; on the other hand, there is no doubt that it escapes any sick person**

**possibility of controlling the timing and methods of implementation of these decisions; and in any case this type of decision tends rather to strengthen the "new" institutional way of life, to consolidate the patient's integration into the hospital micro-society, than to undermine its contradictory bond.**

1. **Decisions concerning coexistence, within the hospital, the organization of certain activities and free time: these are certainly real possibilities in the possession of the sick, especially since the treating team seems to have renounced its sociotherapeutic power, and therefore to his "far-sighted" organizational interventions. It is this last type of decisions that mainly shows itself in the assemblies; However, for this reason it certainly cannot be said that they reflect a power of the patient: they contribute, even in a decisive way, to the formation of *community superstructures* which, however, have a meaning only until they are denied, and in any case do not affect the fundamental contradiction. Any of these decisions can in fact be taken outside of any intervention of technical guidance: but this fact alone should make them suspect, and should reveal the subtle mystification constituted by calling all this "**

**self-government ".**

**If we overlook the fundamental antagonistic contradiction between the institution, charged by mandate with the exclusion of care and custody, and the patient, the object of this treatment and this exclusion; if we try to make the patient accept this exclusion in fact by suggesting to him the possibility of re-appropriating his "civil rights" within the institution by collaborating in a formal and orderly management of all the contradictions within the institution, one ends up by mount a strange playful mechanism, which does not laugh at itself. Each game, on the other hand, has its own rules, pre-established norms that do not allow for variations or "excesses": every mistake in the rules of the game is paid for. It follows that every institution that decides to play the formalistic community game must at the same time provide, for compensation, valid and strong mechanisms for the control of deviations. He has at least two safe ways ahead of him; the first, to become a "guided" therapeutic community, which explicitly accepts the sanction with the rules of the game, and is consequently based on the persistence within it of closed institutional pockets capable of ensuring the sanction, under penalty of nullifying and mocking the guide. The second way is to allow the inherent tension**

**the institutional contradictions may grow in a conditional way only up to a limit beyond which a non-coercive, persuasive and interpretative authority intervenes, which otherwise does not reveal itself. At the basis of this second way is a clear medical technical power that trusts only in itself, and in its own interpretative and resolving capacity. If even this security appears antithetical to the insecurity of those who, following the first "community" model, are still required to admit violence as a counterweight to permissiveness, yet, from the point of view of the power of the patient, the result appears identical.**

**It has been seen that not even the Gorizia hospital has been able to avoid all the rules of this institutional game; indeed, on closer inspection, there would be all the formal conditions for it to have refined over the years to the point that the treating team could always and in any case be in possession of the axes; only that, in the course of the process of overthrowing the asylum institution, the action of the avant-garde parallel to the (intermittent) rediscovery of the community game intentionally laid the foundations for its negation as well. In fact, at the moment in which, albeit by virtue of a "gift" from above, the patient has regained possession of his freedom of movement, when the opening of the wards is**

**intentionally pushed to its extreme logical consequence of the opening of the whole hospital, the traditional custodial control mechanisms are effectively put out of action; at this moment also the call to community collaboration of the mass of patients demonstrates its objective limits, and is self-questioning. Perhaps this may be the real margin of power acquired individually by the sufferer. Faced with the possibility of contestation, even individual and regressive of the single patient, when it multiplies by the numerical mass of hospitalized patients, the logic of the fundamental antagonistic contradiction between the institution and the patient, and all the mechanisms of coverage with which the institution can try to reform itself, they enter to some extent into crisis. The limits of permissiveness can no longer be fixed once and for all, and above all the rules that strictly ensure compliance with these limits can no longer be dictated. The power for the formulation of real decisions remains, as we have seen, even in the open situation in the hands of the institution, now represented by the vanguard; only that it is no longer possible for it to delegate to the patient a "self-government" that conforms to his decisions and purposes, and is instead controlled to a considerable extent in the management of the institution's "governance". Of course, everything remains in a condition of**

**dialectical possibility; the complaint of the patient remains almost always unorganized, individualistic, sometimes regressive, sometimes even "sick"; but it is from the *sum* of these possibilities that the mass pressure arises which tends, with its echo also outside the institution, to undermine the fundamental contradiction. Only when *all the possibilities* are open within the camp does a community management of the margin of freedom and personal power acquired by the patient in the institution begin to make sense. In this case one cannot even be surprised if the sick, accepting some conventional rules of community coexistence, do not use this margin of power at all to confirm the threatening hypothesis of the advent of a "sick power" that is exhausted in the sterile regressive contestation and in anomie.**

**To the extent that the patient comes out of his institutionalized conditioning, he can also grasp the meaning and purpose of the institutional overthrow of the avant-garde; and he can therefore use his margin of power in pursuing, together with it, that *common purpose* , which is spoken of elsewhere in this volume. The reality of this common purpose is perhaps able, also by virtue of the share of power brought to it by the patient, to shift the terms of the fundamental contradiction; this, in a sense, not**

**arises more between the institution and its object of care, but between the institution (which finds within it, in a precarious balance, the common purpose of overturning its asylum characteristics) and the social context (which would tend instead to express an institution with a reformed face but with unchanged purposes). The main contradiction shifts in this sense when the institution, also due to the participation of the "threatening" share of the protest expressed by the patient, begins to become a problem for the society that expresses it. In this perspective, the internal contradictions that manifest themselves in the institution subordinate themselves in a secondary role to the new main contradiction. Within the institutional field, the dynamics between the different roles and the different positions of power that tend to dialectically compose such contradictions can now be played out. The patient has a real part in it, even if he does not "govern himself". It is also probable that from this participation he may derive a benefit which the doctor will call "therapeutic"; but in the face of this possibility of mass participation and contestation by patients in institutional dynamics it will now be very difficult for the technical-medical power to feel reassured to the point of believing that it has found in the "self-government" of the mentally ill a new, more modern , final solution.**

**Agostino Pirella**

**The denial**

**of the traditional psychiatric hospital**

**At a recent conference organized by a US Foundation that brings together graduates from all universities on the west coast, psychiatric profiles of current Chinese political leaders who described them as paranoid were given in confidence. In this way, on "scientific" grounds, one can only expect fear and threats from a paranoid. There were some observations regarding the fact that the presence of US military all around China could not demonstrate a friendly will of the Americans towards that people. This was rejected as propaganda.**

**Is this an episode (the source of which is serious and totally reliable) 23 which is valid both as an example of the self-foundation of science and as an automatic and sensational exploitation of science for the purpose of political stabilization. While the profile of Chinese leaders is passed off as "scientific", the obvious observation about the presence of US armed forces in Asia is labeled "propaganda". The problem is degraded to an indisputable fact.**

**On the other hand, the "scientific" management of problems holds up until the contradictions between scientific power and society, that is, between the possibility of really serving the citizen in his needs and the concrete result that arises as a response to these needs, become very sharp, and explode dramatically.**

**At this point there are two possible positions for "scientific operators". They can continue to ignore the new problem opened up by these contradictions, continuing with their usual management and trying, if anything, to cover with difficulty the cracks that continually open. Someone else, on the other hand, may begin to raise the urgency to intervene decisively because they realize that all knowledge and all the usual practices risk collapsing definitively after entering a crisis. In both choices there is a response to the crisis, an attempt to overcome, but by means of the maintenance at any cost of the old structures in the first case, through a response of renewal that is presented as positive and reabsorbing the contradictions. , in the second case.**

**Psychiatry has simultaneously become, in the course of its short history, a branch of medicine (and as such a presumed field of diagnostic and therapeutic operations), a theoretical-practical science of certain individual deviant behaviors, management of the same in institutes called Psychiatric Hospitals or Centers of mental hygiene. This fact has helped to gradually explode growing contradictions which I believe have been muffled and muted for a long time by collateral disengagement operations in Italy, in connection with**

**the lack of development of the post-fascist society. There is no doubt, for example, that the possibility of avoiding confinement in an asylum for those who could afford a stay in a private nursing home has helped to keep the dramatic failure of psychiatry in almost absolute silence. The mentally ill was for many years, and still is, the one who can be brutally oppressed, the citizen deprived of his rights. He is the one who can be deprived of his personal freedom, of his things, of his human relationships for an indefinite period, and who asks himself with pain: "What have I done wrong?" »He is the one who has broken a rule. He is a "deviant". For years, psychiatry has indulged in building a castle of criteria and labels around it, and has, in turn, established itself as a norm. The functionality of social norms and scientific norms for the purpose of stabilizing the political system is demonstrable at any time. Is there a need to recall again the example of the psychiatric profiles of Chinese leaders?**

**One of the toughest and most self-defensive norms is that which refers to the fate of the mentally ill in our society. The mentally ill cannot be tolerated in society. His way of appearing and living must be hidden and repressed. Although the generous distribution of the new sedatives could help suppress the most obvious appearances of "madness", the attitude**

**towards the mentally ill has not changed. The infringement of the norm of "civil life" must be punished with a particular form of imprisonment, and with terrifying or unpleasant therapies. The asylum reality constituted and still is, to a large extent, a very efficient punitive structure, with peaks of horror that are not always remembered. It can be said that this is the first great contradiction between scientific optimism and practical reality. The naked violence, the manifest oppression of psychiatric institutions do not reconcile with the scientific purposes of therapy, of rehabilitation. Since the places where the mentally ill are hospitalized are called "hospitals", the medical evidence of interventions aimed at the "treatment" of deviant behavior tends to contradict any openly oppressive situation. The gross and dramatic limit of this attitude, which passes off as a doctor what is often vulgarly terrorist, is found above all in the punitive use of certain "therapies". It is known that the punitive intention can be grasped in the transaction between those who are active and those who are passive in the treatment. For example, the fact that in psychiatric hospitals it is said: "if you are not well I will give you a shot" (or electroshock, or similar) means, with full legitimacy, the presence of a real oppressive dynamic that is covered by a naive medical ideology. The fall into disuse of some**

* **therapies », such as pyretotherapy, cardiac shock, etc., demonstrates, among other things, the openly punitive meaning that is no longer acceptable by those who intend to replace it with another attitude in which violence is more subtly and grossly masked.**

**Medical ideology continues to mystify. In fact, an Italian psychiatrist stated verbatim at a congress about the efficacy and goodness of a drug, which, due to its lack of flavor, can be administered secretly in food: this drug solves**

* **the problem of persuasion, let's even say sometimes of the necessary enticement to the shelter of resisters or protesters, the rebel becomes docile, sometimes even becomes a little lamb! And in the most fortunate cases, if he gets a spastic torticollis from medication, he is the one who asks for the work of the neuropsychiatrist! Therefore, in some cases, neurodysptic syndromes are also welcome! »Where there is, above all, a sort of evident racism that tends to use even the unpleasant side effects for the purpose of oppressive power. The need to take into account the contradiction leads to ever more accentuated forms of mystification. The hospitalized, after having been**
* **lured, deceived, oppressed, they are now entertained with performances, dances, various activities, jobs, all passed off as therapy. So that they are ready for the two solutions prepared for them by the institution: forced rehabilitation, or**

**the habit of the place that must now be their home 24 In both cases through the loss of their personality and the emergence of a deep dependence on others.**

**The infringement of the norm of "civilized living", the inability to "play the game", the anguish of living in a world that rejects and oppresses, is paid for with this transition to total institution.**

**The doctor who tends not to let himself be captured by the mystifying ideology discovers this contradiction at his first contact with the world of institutional violence. He entered this world with instruments that proved immediately useless and poisoned: in front of him there were not sick people, but an institution of violence.**

**However, to discover and make violence evident he must begin to deny it. That is, he must take back that power which he delegated to the institution and which he no longer wields in order to "not get his hands dirty". In fact, there are nurses to tie up, to immobilize, to lock the security rooms. The division of labor, the separation between intellectual and manual labor becomes here too a reason for privilege. The doctor who denies ideology denies violence in its practice. In reality, he also wants to bring out, from the darkness of his own**

**masking, hidden oppression. He begins to manipulate his power to reject physical strength and the closure of the confined space of the room, the refectories, the wards. His movement of denial begins.**

**Denial of closure immediately implies the rejection of the corporate mandate. A mandate that the company delivers so that the hospitalized are "guarded" so that they cannot harm and therefore definitively lose the possibility of making autonomous and responsible choices. The psychiatrist who refuses is a man who becomes aware of the permanent but hidden contradiction of medical ideology, whereby a person reduced to an object against his will should be considered "a sick person like everyone else". That is, the psychiatrist tends to reject both the social mandate and the medical ideology that covers its degrading aspects. This refusal, which has matured in close contact with the reality of the institution, is built both against ideology and against the concentrationary reality that this ideology tends to hide or justify. Rejection of ideology and denial of the reality of violence are thus combined to foster awareness of what must not be done, what must be denied in the concrete situation.**

**With this it appears evident that the initial positions and the subsequent "transformation" of the hospital have arisen**

**essentially as negation and rejection, and not as proposals already concluded and tested. The reference to Anglo-Saxon models is seen as a simple point of support and not as an exercise in guided restructuring. Denial does not imply a "positive" to be referred to as a model, but the simple refusal to perpetuate the institution, the attempt to change it by continually putting it in crisis. This act of systematic denial involves not only the traditional role of the doctor (who thus appropriates himself before power), but also the roles of the nurse and the patient. The value of the role of the "good sick man", that is, of the docile servant always ready, the role of the regressed sick man, of the authoritarian head nurse is denied and contested. Denial then invests relationships, institutional rites. Why does every initiative have to be taken from above? Why should the sick person be "given" what he receives? Starting from the negation of violence, which is thus unmasked, we arrive at the radical negation of the institution, as a place where everyone never decides about himself.**

***Authority, the first contradiction.***

* **easy, in a tenacious denial of violence, of manipulation, of the objectifying-distancing relationship, that**

**the sense of the denial of authority progressively matures. The denial of dependence, the enhancement of the dispute, both in the relationships with the patients and the members of the treating team among themselves, have opened up modalities of relationship that posed the need for continuous verification, for a global and detailed participation in the choices of the various collectives (departments, groups, etc.). With this, beyond the traditional hierarchical development of power, already widely denied, even the simple relationship of authority, even if purged of oppressive dross, was lost.**

**The hospital therefore found itself in a first contradiction, historically understandable, given that the denial of authority was initially carried out with an act of intense authority on the part of the director and the doctors. In other words, everything began with an act of power, with what in another text of this volume is defined as the re-assumption of power, previously delegated to the staff and to the institution, by doctors. The doctor began to deny through an intense authoritarian act, and the contradiction arises from the fact that the denial also tends to affect the relationship of authority. While the oppressive meaning of a whole series of pseudomedical behaviors was being unmasked, and therefore the norm was affirmed that oppression, violence and blind authoritarianism are an "evil", it was emphasized**

**also, in fact, that the authoritarian use of power for the purpose of negation could still be a "good." The norm, born of negation, was simultaneously affirmed and negated in reality. In this the denial of violence appeared to "deviate" from it with respect to a previous institutionalized norm and to the expectations of the society of**

* **healthy ". This deviance expresses all the real possibilities of contestation that the institution retains, evading an automatic sanction, but not even crystallizing itself as a new norm. While this type of contestation in fact escapes the institutional condemnation (which the sick have been forced to), the institution continues to live by placing itself every moment as a norm and as a sanction. A contradictory rule and therefore always open to discussion and challenge, but also a sanction, at least to the extent that it continues to segregate. This contradiction affects all institutional relationships and occurs with equal intensity in all three significant poles of the hospital: patients, doctors, nurses. Examples will be seen later.**

***The norm, second contradiction.***

**The denial of violence has radically put the hospital in crisis, but has therefore not been able to establish itself as**

**norm: the norm of negation has no power or meaning. Denial cannot become a norm. From time to time, each one says that a gesture, a movement, a choice is "good" or "bad" or that it is "therapeutic", but in the end one realizes that the institution is a norm in itself, and that if we begin to deny, we must go as far as the global denial of the institution. Between denying the institution and denying the possibility of contestation there is often a very acute contradiction. Indeed, it is "good" that is posed as the possibility of contestation, of putting itself in crisis, but it is "evil**

* **what appears as a major inconvenience, as a hindrance for everyone, as a paralysis of associated life. A typical institutional example is the infringement of rules by some patients, such as leaving the hospital without permission, getting drunk, or behaving in a way that puts the situation in crisis. The discussion that opens at this point often demonstrates that these attitudes express a critical response of contestation to the institutional system, forcing everyone to take a stand, to redefine relationships, roles, the very meaning of being in hospital. On the other hand, this disruption also means, on the level of reality, a risk of "death" for the life of the institution, an example of "evil" that each one tries to hide, to reject, to exclude from himself. The critical assumption of**

**these destructive gestures is not just a theoretical fact but a practical way of choosing and determining oneself in reality. Evil and good, not as an ethical norm, but as a social and "scientific" norm, present themselves at every moment as proposals for modeling. On the other hand, the real clash between the various members of the community cannot open the discussion on what can be understood as a norm, except for the very general norm of the denial of violence, physical oppression, closure. On the other hand, it is precisely the real conflict that directs the situation to totally new choices, such as the continuous contestation, for example, of nurses by some patients and doctors by some nurses. A traditional aspect of culture is denied in the crisis of the "scientific" decision-making power: the sapère deposited in the minds of a privileged few. What it was called**

* **medical thought ”(Tosquelles) presupposes a guiding process by which everything that takes place in the field can and must be critically evaluated and arranged in value models. The denial of this passes through a phase of intense disorder, but it can be practical verification through the contribution of all present to the elaboration. Criticism does not remain the privilege of those who have the deposit of science. The possibility of collective verification is what the (social, scientific) norm proposes as a norm to be sought, to be invented, in the rejection of "technicality", of**

**schematic defense of one's beliefs. The contradiction here is again both that of the division between intellectual and manual labor, and that of the clash between the real need, for the hospital, to respond to a service requested by society, and a negative way of responding from within, a practical invention. which tends to reject the mystified medical ideology.**

***The sick as inpatients, the third contradiction.***

**The role of the sick has been challenged both by the re-appropriation of hospital space and by the contrast between this "internal" re-appropriation and external exclusion. The mentally ill as irresponsible, dangerous to himself and to others, instead regains the possibility of control in the community. Participates in debates, moves within the hospital, loses its traditional connotation as the institution transforms itself, as the patient, together with doctors and nurses, works to transform. All this seems to many a kind of technical device for rehabilitation. The decisive fact is instead that the new freedom gained internally, while demolishing in reality the myth of the dangerous mentally ill, collides with the barriers that society maintains, psychological barriers,**

**social and economic. We begin to realize that society produces the sick not in a banal causal sense but as products of exclusion, that internal freedom can become an alibi for a more tenuous, muffled closure. When he can leave the hospital on leave only accompanied, the patient is forced to verify that literally "he is no longer a man", he is not held responsible for his actions, and therefore reveals the contradiction between internal freedom and external oppression. The reference to the current legislation can only make the alibi of considering "sick" what is only the object of exclusion more clumsy. The "sick" are therefore patients, inpatients, capable of practically verifying, together with the doctors and nurses, the contradiction in which they are forced to live.**

***Doctors and nurses, fourth contradiction.***

**As it is also said in other parts of the volume, the choice of the medical team is a choice that is at the beginning of the movement of denial and that is posed in terms of an institutionally legitimate leadership, even if every moment questionable. The socio-political, scientific, "humanitarian" motivations underlying it can also be discussed. What, however, is highlighted**

**more clearly is the constitution of nurses, as opposed to the medical team, as a group or caste with specific interests, common fate and common problems. This fact can only be obvious in an institutional situation such as a psychiatric hospital. But the obviousness of separateness implies a whole series of differentiations that place the staff in a difficult oscillation between participation in the choices of the medical team (with the socio-cultural implications that this involves) and pure contestation of the team (with partial mimesis of the role of the patient, and request for autonomy). The discussion that is published in the volume on the problem of opening the wards poses very clearly the problem of the relationship between the avant-garde that opens and the personnel who may or may not be involved in it. It would be quite easy to say that the staff recognize themselves as a group for an attitude of defense against the anxiety of the new situation. In reality, things cannot fail to be more complicated, also because the writer is a doctor and cannot fail to perceive the risk of acting as an external judge. This contradictory aspect seems essentially to be part of a wider contradiction between autonomy and dependence, contestation and freedom, which finds its partial "solutions" in the constitution of a homogeneous group, and, at the limit, of a class. The example that will be given, on the personnel strike, will be able to contribute to**

**clarify this point.**

***Contradictions and institutional reality.***

**The end of the closed institution, capable of concealing its contradictions, of suppressing any protest against the good conscience of the establishment, has "produced" the manifestation of what we have somewhat schematically grouped in the previous four paragraphs. In them we have framed, so to speak, the conceptual aspects that refer to realities experienced daily in the hospital, discussed in the various meetings, interpreted several times, and not only by the members of the medical team, as a crisis, as a contradiction, sometimes as a defeat, never judged with scientific detachment and "serenity", but participate from within, and act as situations in which denying the institution means denying oneself as representatives of oppressive power and of the ideology that justifies it.**

**We will therefore examine some institutional issues that seemed to us to be the most significant, and the closest to these crises, most affected by them.**

***The transfer of the ward* . Usually, in traditional hospitals, the ward transfer is ordered by the**

**doctor or nurse on the basis of organizational (availability of places), technical (need for special "treatments"), medical (type of illness), punitive or "safety" needs (agitated ward, disturbed ward), etc. The wish to be transferred to another ward expressed by the inpatient is rarely taken into consideration, but even more rarely is it expressed, as the inpatient soon gets used to the idea that his wishes are not meaningful.**

**The denial of the agitated department, in the Gorizia hospital, led to the focus of everyone's attention for a certain time. 25 on the only two closed wards, one for men and one for women. They had remained seriously institutionalized inpatients, along with a number of those who had presented behavioral problems in the past. In the course of the assemblies, in the course of the hospital's very life, "going to ward C" meant a sanction from time to time, being "mad", being unwelcome. Ward C, the only one closed, became like the place of exclusion inside the hospital. At this point it became clear that the hospital had to undertake not to transfer anyone to these wards, to transfer vice versa from these wards to the other open wards, and finally to reach the opening of the last two closed wards. It was so clear to everyone that no "medical" attitude could mask it**

**violence of closure, that no infringement of the law could justify the closure in a degraded ward.**

**This type of commitment did not take place without a crisis, and there was also an episode that meant a sensational contradiction. The crisis corresponds to the tension of each one so that the problems created by living together in a ward are dealt with in the ward itself and are not masked by the removal of the patient; to the point that today nurses, doctors and patients are often in agreement in bringing into question the problem of disturbing behavior, for example, without resorting to the regressive measure of transfer. If a patient is disturbing, it is now obvious to ask oneself why he disturbs and deepen the question not so much because it is "resolved" but, in the beginning, because it is "understood", approached and not distant. The main argument that seems to have made its way is that it is absurd to make another department put up with a person who disturbs; it is much easier for the sending ward to deal with the problem than the sending ward, even if the patient in question wants to move there. Typical in this regard is a discussion about a patient who had made some act of impulsive violence against objects, and who seemed to undergo a fairly clear process of exclusion. The ward suddenly realized that it didn't know anything about this patient, who basically**

**he had already been excluded from the ward even before making this gesture. If the tact of violence had contributed to put the ward in crisis, the absurdity of the transfer could not fail to appear evident. Only by taking care of this distant friend would it be possible to arrive at a real (and not mythical, fantasized) judgment on him. In this case, the level of tension of the department could be considered useful for the purposes of the practical verification described in the previous pages.**

**It is clear that if the level of tension increases beyond a certain limit, you risk falling into a panic situation. This happened only once, in the men's acceptance ward (after the decision not to transfer anyone to ward C), for a patient whose seriously anxious situation was punctuated by destructive dumping against people and things. The opportunities for discussion and participation were seriously compromised by the relationship with the institution. The plan to destroy community relations and to significantly damage cohabitation was expressed by this patient with sufficient clarity. The absolute necessity of obtaining a short period of rest in the chaotic and regressed protest movement advised the transfer to the closed ward, which was also provocatively asked in a loud voice by this patient. This opened a long debate, in all**

**locations; there is a partial testimony of it in the documentation of the community assembly published in full in this volume.**

**The problem is contradictory because it involves, among other things, the image that the patients have of themselves. For many years, and according to age-old stereotypes common to the so-called "normal", they have with them an image of**

* **crazy "as someone who cannot live like others, who breaks all relationships, who responds in a destructive way to anxiety that he cannot tolerate. The aforementioned inpatient reported in an interview to the doctor the nostalgia of the good old times, when, moved to the restless ward, he could go around naked, masturbate in front of others, regress in an unbridled contest. And he also denounced the persistent closure of a ward (at that time in fact ward C was still closed) as the doctors' conviction that after all a closed ward was still necessary, that cases like his had to be foreseen, that the mechanism of exclusion, the punishment had yet to be triggered.**

**The patient in question has now been discharged, having overcome the crisis in about two months. The opening of the last department has today made a "solution" of this type impossible. Does the institution need to invent new ways of relating, or does the opening of all departments also mean the fall of the regressed protest?**

**The existence of a highly specialized department for alcoholics has also raised the problem of transfer criteria several times. An essay in this volume is dedicated to this. It remains to be said that only a personal choice of the patient could have cut the knot of the medical authority that overlaps the institution. In reality, it became very clear that the specialist department in our hospital is intimately contradictory. The denial of the transfer criteria has become a denial of the transfer. The transfers carried out in the last year were all transfers requested by the inpatient and discussed at length among all the interested parties (ward of origin, ward of destination). It is clear that this can lead to blocking situations, such as the one that occurred once in an admission ward, where the temporary and exceptional overload of inpatients had placed the need for disposal (at least for the night) in another ward. . After a long discussion, a certain number of people were chosen according to non-medical criteria (young age, for example) to be designated by drawing lots. It is obvious that this does not mean that a convenient norm has been found for the solution of the problem in case it should reappear. Problems exist and are addressed to the extent that there are no preformed institutional solutions that become (or risk becoming) oppression again.**

**Thus the hospital departments differ today on the basis of two fundamental elements. The first is the distinctive fact of whether or not the first admission patients are accepted. The difference between short-term and long-term patients, which will be discussed later, is one of the most lively characteristics of the current institutional dynamic. The second is given by the internal characteristics of the ward: the greater or lesser comfort, the number of patients, their greater or lesser social "respectability". The two C wards, recently opened, are less "respectable", for example, and less equipped with amenities. Internal exclusion also passes through these elements.**

***Short-term and long-term patients.* Another element of internal exclusion is given by the presence, in the hospital field, of patients who know they will remain in the hospital (and**

1. **remain in fact) a few weeks. Some of them were hospitalized don the mutual, others, a few, pay**

**the straight line 26 The confrontation, in the various occasions of community life, with the other patients, who have been in hospital for years, initially created a situation of clash, of opposition, which has its roots in profound reasons for discomfort in the face of "diversity" institutional. Just the presence of two closed wards posed, until recently, the delimitation, justified**

**in fact. "Let's hope you don't have to go to C," he said to himself jokingly, as one says, from the outside, "you're a madman." The C as a "madhouse" was denied at the moment of its opening. But other oppositions remain, one of which is socio-economic, another is predominantly cultural. The short-term inpatient, with his mutual, with his intimate and close link with the outside world, marked even more crudely the state of abandonment and loneliness of the long-term patient. The availability of money is rather large for the short-term resident, very scarce for the others. The clothing of the former is refined, almost elegant, of the latter less lively, less similar to that of the "outside world", particularly for women. The exceptions, in this sense, among long-term patients, have progressively allowed a rapprochement which today appears to be growing. The moment of assimilation seems to be more the feeling of common social exclusion than that of illness. We quote from a community assembly.**

**BRIEF-DEGENT A Look, now I am saying something that you may not be convinced of. Last night someone said: you see, the gentlemen who are in here, they come on vacation, it is no longer the asylum of the past, they come on vacation for so and there, they are fine in here.**

**BRIEF-DEGENT B Something has been done, what could not have been done twenty years ago has been done.**

**SHORT-DEGENANT Look, I'm from Venice, I don't know if I'm a difficult patient or not, I don't know, the doctors have to say this, but they advised me ... we can't escape, because it's ridiculous, they take us inside right away. But there are many people who do not like to go out, some people are sorry to go out, precisely because society rejects them, society rejects them, why? Who trusts a sick person who has been ten years, even fifteen years? he has always been in an asylum. Yet mental illness is like another disease, of the heart, of the lungs.**

**BRIEF-DEGENT B And do you find this understandable or not? You find it understandable that Mr. X tomorrow, wanting to employ a person ...**

**SHORT-DEGENANT A You must take it with a certain reserve, this is logical; but I know it is so, it will also be like this ...**

**The common condition is therefore not illness, but being or having been hospitalized in a psychiatric hospital and undergoing or having undergone a process of exclusion. Social exclusion, in general, but family exclusion, in many cases, to which the short-term patients are also sensitive.**

**SHORT-DEGENT Why**  **were they sent here? Why**

**they could not stay outside, because outside they harmed the society in which they lived, and so they came here.**

**LONG-WELL-WELLING It's not true what she says, there are many who bring them here to get rid of them.**

**SHORT-DEGENT So why do they want to get rid of it, you say. Because they annoy, they weigh.**

**The short-term patient begins to realize that one of the reasons for the hospitalization is "annoying". And it is significant that the long-term resident was able to counteract his feeling of exclusion in terms of which results were acceptable.**

**On the other hand, for a long time, and perhaps still today, the short-term resident tried to defend himself from the annoying presence of the long-resident in the various occasions of community life (bar, dance, meetings, trips) trying to distance him from himself, to constitute him as the one who must remain excluded. From the debates this dynamic appeared similar to that of family members towards the short-term patient. This analogy led the latter to reflect on his condition and to confront himself, in a more dialectical way, with the long-term patient. With regard to external society, there is no doubt that the short-term resident feels (and is felt by others) closer, less excluded. On the other hand, he is also the closest to the crisis of detachment, to the problem of critical relations with the outside world, the**

**further away from institutionalization. To deny the institution of violence he seems to be the most suitable, the closest to the possibility of empowerment. In reality, precisely in order to exclude the others, the short-term learner tries to place for himself the privilege of the "good" institution, and at times he tries to disengage himself from the involvement that the institution operates in him. But he soon realizes that there is no "good" institution that is not also "bad", that does not oppose the second side, that of violence, to those who do not adapt when a difference between "good" and "bad" is required ". The contradiction opens precisely at the moment in which the norm of this distinction is advocated by the short-term patient to his exclusive advantage. Each one then claims this advantage for himself, he fights so that the norm "is on his side". The long-term patients say that "those in ward A" are selfish, "they come on vacation". The others reply that they need treatment and that "they too are sick". That is, they feel the need for a similar condition. As we have seen then, in subsequent levels of study, a common dynamic of a different type emerges.**

***Medicines and medical denial.* The denial of the traditional hospital has passed, as we have seen, through the denial of violence and oppression**

**which preceded and accompanied the administration of certain "therapeutic" treatments. Even today, after the rarefaction or disappearance of certain somatic treatments, a place of great importance occupies the administration of drugs. There is no doubt that medical power passes through this modality of relationship, even independently (to the extent that this is possible) from institutional conditioning. Stand in front of a patient and tell him: «you need this drug**

* **it means acting as a power and not as a simple consultant. In the limit, this tends to make the fight against oppression mystified or useless, if I, as a doctor, retain this enormous power of domination and control mediated through psychotropic drugs. At this point a question arises which represents a precise real, practical contradiction. Denying violence means denying the nuances of violence that the psychotropic drug brings with it: sleepiness, difficulty concentrating, asthenia, unpleasant side effects, but does it directly mean denying the prescription of the drug? Does denying the traditional hospital mean denying the hospital *tout court* ? There were moments in ourscommunity history, which seemed to have to give a positive answer to these questions. Questioning these problems has sometimes meant arriving at responsible choices on the part of patients who have refused the**

**drug. In the debate it has been said by more than one that the possible need for an administration would emerge as a fact that could be checked collectively and no longer for an exclusive judgment of the doctor. The general anxiety about this rejection remained. But if the staff accepted this anxiety, it was because they wanted to try to share the patient's anxiety as possible, find a new point of contact with him, be available and free from cultural and scientific conditioning. On other occasions, yes**

* **decided that the medicine would still be offered to the patient, without insisting, and accepting the discussion after the refusal. This obviously opened, on the medical side, the question of the necessary medication for epilepsy sufferers, who cannot leave it out, and this**
* **appeared as a case of the institution being put in crisis.**

**In other words, the use of medical authority enters an oppressive dimension if it is inscribed in a rigid and non-contestable institutional framework; but, on the other hand, if she agrees to be challenged she must accept the risk of certain consequences. The waiver of responsibility does not appear to be an acceptable alternative to the oppressive mode of relating.**

***The staff and the institution.* During a community assembly, the organization of a trump match was discussed, a proposal started by a department, by a group of**

**patients and nurses of a ward. It was decided, in this department, that the registration fee for the competition would be different: the nurses would pay double. Here we give some lines of the discussion.**

**NURSE A Now I don't criticize the difference in altitude, but this has never been discussed with the nurses as to whether it is okay or not.**

**DOCTOR A Excuse me, but there is a committee, a group of people who organize something, who organize by setting rules, so that others can participate or not participate.**

**DEGENTE A But it is right that other people can make observations.**

**DOCTOR A Yes, because what Nurse A meant was this, it seems to me, that this group could discuss, and thus hear the opinion of others. It is a group of people who organize something and then question it. It is clear that if there is something to change, it must be changed.**

**DEGENT** **In the trump race or otherwise, if the entry fee is unique, that is, all on the same level, there have been people who have said: no, it's not fair.**

**DOCTOR A It seems to me that Nurse A wanted to know if nurses also participate in this group.**

**DEGREE B Can nurses also participate? DEGENT C Doctors too. There are also nurses.**

**There is Nurse B who is on the organizing committee. I brought it here fresh, the proposal, to discuss here; no decision has been made so far.**

**DOCTOR B This seems to me an important thing, whether or not the possibility of a group of people in the community taking the initiative is questioned. It seems to me that this initiative, this possibility of initiative by a group of people, including doctors, nurses, patients, is being discussed or criticized in some way. I was saying that it would be interesting if nurses A and C who criticized, clarify whether in their opinion this initiative, before it was born, had to go through a series of checks, even if it was a legitimate thing. According to nurses A and C, if a nurse participates in \* an initiative he should hear the other nurses first. So, at this point, it seems to me that the thing needs to be clarified. Because then a patient who participates in an initiative should hear all the other patients first, the doctor who participates in an initiative should hear all the doctors.**

**During the debate it was then clarified**  **that \_**

**Nurse A's intention was to investigate the matter, "to hear what the community is saying"; however, the problem remains that nurses tend to respond to the new situation with a growing personal availability linked, however, to a profound need to establish themselves as a class. A key episode is represented by the personnel strike.**

**The abstention, decided autonomously by the union in its modalities, provided for the absence of half of the ward nurses and all of those of the general services. This, while risking to radically put institutional work in crisis, was experienced by the other members of the community in a contrasting way.**

**A majority of patients did not express dissent but rather, at certain advanced points, an active solidarity, even expressed in an assembly as a refusal to carry out postponable substitute work. Other patients showed impatience and discomfort; in uri case even with vibrated protests. The same contrast could be traced to the medical team. Even if the right to strike was absolutely not questioned by anyone, it was pointed out that its modalities could have been less rigid, and that moreover it was unfortunately possible an active exploitation of the agitation not so much against the employer, as against the new institutional system. On this question they opened up lively**

**contrasts, but one point was obvious. The staff found a moment of identification and strength in being able to differentiate themselves from the patients, largely powerless in the face of need, deprived of any right to strike, unable to go in front of the Administration headquarters with signs and whistles, as they did. compact nurses. It was actually an unusual and unusually large protest. A trade unionist, a politician, would have spoken of "worker maturity". There is no doubt, at least, that it was an anti-institutional example, an example of protest. The sometimes passive acceptance of the new situation was redeemed with an act of active presence, of choice, which suddenly put in a state of tension the relationships with the patients and the medical team. While compared to the former it was, as has been said, a choice of differentiation, towards the latter the dynamics were less clear, basically placed in an area of challenge to medical power, always seen as oppressive, even if not on a bureaucratic level. -disciplinary. In this regard, we consider it useful to quote the words with which a "free" staff representative (that is, not particularly linked to the internal commission or to the union) intervened during a community assembly that was to take stock of the respective situation at the three poles significant of the hospital.**

* **Responsibility increases our professional efficiency and creates a greater initial availability which, however, tends to regress in the long run, finding no compensation and even arriving in certain situations by means of exploitation. The union leads to a team work which is the most desirable there can be in a community like ours with therapeutic purposes. However, to be such a community must recognize the same rights to all those who are part of it, but when our opinions and decisions are discussed and accepted only if they agree with programs previously made by medical staff, we do not feel part of it, but useful to it; so we find ourselves facing ever new situations that often create states of anxiety in us, accepted because we are convinced of the goodness of the system, but difficult to overcome precisely because we feel the little consideration in which we are held. However, we would like to clarify the concept that for us the system is not identified in any person, so that the relationship difficulties, while naturally affecting performance, have not jeopardized the aims and essential purpose, that is, the improvement and reintegration of the patient in the society, which is what we all want ”.**

**It seems to be sufficiently clear that the dialectic between availability and contestation places the staff in a contradiction that is not easy to overcome. To be available**

**without falling into institutional dependence, in other words**

* **being able to be autonomous "puts the problem at its highest level.**

**Faced with the many open questions and contradictions unmasked by the denial process, it may seem insufficient to affirm that the life of the hospital continues through these knots, with the awareness of not being able to overcome the contradictions because they are nothing more than one of the manifestations. of incurable antagonisms in "external" society. On the other hand, going through the knots does not mean solving therapeutic problems or social problems *tout court* that find their reference in the planning of global political solutions. The design therefore seems to become either too ambitious or ineffable, getting lost in utopia or everyday banality.**

**However, the denial of the traditional hospital, which takes place day by day, accumulating experiences, sometimes marking time, making the tension last, involving an increasing number of people (patients, relatives, technicians, politicians), becomes significant precisely because it succeeds to transform in a qualitative sense what is opaque, elementary quantity: the number of open wards, the number of those who begin the confrontation of ideas, the number of patients who participate in the various activities**

**regardless of any direct paternalistic or pseudo-technical solicitation, etc. What is felt from time to time as a "conquest", the opening of the last ward, the increase in the number of patients staying in the mountains, the increase in the number of those who leave on leave, the frequency of permits, and so on, it develops as apparent reformism, but it connects precisely with the initial act of negation.**

**Another issue that should receive clarification is that which refers to the denial of authority. The denial of violence without denial of authority - it is said - can only lead either to a good-natured but equally oppressive paternalism or to attitudes of a scientist brand that pretend to foresee everything and clarify everything. Both can only be the mystification of confrontation and mutual contestation. It should be noted, however, that there is also an attitude of negation which passes through this problem, namely that of the negation of exclusion. Denying exclusion (and therefore the violence and oppression which are its immediately effective tools) does not mean not being authoritarian. Engels wrote that «a revolution is certainly the most authoritarian thing there is**

* **27 Authority may be prevarication but it is not identified with prevarication. An example can be seen in the doctor-nurse dyad, in which authority**

**of one can from time to time, as a prevaricator, unleash unresolved tensions on others, usually the patients. The bureaucratic-disciplinary attitude used in traditional hospitals is authoritarian and institutionally violent, even if masked by cold, courteous or even good-natured appearances. Exposing oneself with authoritarian attitudes to the contestation of others, to the limit to the contestation of the entire institution, is the most important experience that a person who wants to pass from institutional leadership to real leadership can have. This does not mean that a situation of totally shared leadership is being built which cannot fail to be utopian 28 but to fight for the denial of institutional violence through a phase of transition, in which the supine acceptance of the prevaricating role is replaced by the rejection of this role and the use of power for social transformation and awareness.**

**The risk of this not happening is enormous. We must be aware of this, and never tire of accepting and asking for a confrontation with reality.**

**Letizia Jervis Comba**

**C women: the last ward closed**

**Q Doctor, have you been working here for many years?**

**DOCTOR Since 1945. I had the B, C and D women. For fifteen years I have had all three departments.**

**Q Was there a difference between C women and other departments in the past? Was it a department with particular characteristics?**

**DOCTOR There was a characteristic for each department: that is, at B they were the most agitated, at C they were physically ill, and at D they were the so-called workers.**

**DE since when did the ward look like it does now? How has it changed over the years?**

**DOCTOR After Professor Basaglia came, things changed. Before, the sick who were agitated were sent to B, and if they calmed down they could go to the other wards, C or D: they were not sent to B as a punishment, but because the staff and all of them were better equipped to look after them. . There were also more cells, at B. C was done as now when B opened: naturally all the patients of B had to sort themselves out, and they had to choose the best ones to leave them at B. But they went almost all away from the B, because they were the worst.**

**DE did they come to C?**

**DOCTOR Almost all of them came to C: those who had a tendency to flee, those who had**

**some erotic tendency. The physically ill, those who were already at C, remained there. As the D opened, some from that department also came to the C.**

**DE in these five years, have patients been sent to C who stayed there for a short period of time?**

**DOCTOR.How punishment? Well, there was a long time when sick women were threatened with being sent to C.**

**D So ward C has taken the place of ward B. DOCTOR Yes, of course without restraints, they are**

**immediately eliminated all the bodices, and after a while also the restraint beds. The mesh beds lasted another year, it seems to me, and then they were no longer for the agitated but for the epileptics or the old ladies who kept getting out of bed. But it was very ugly, even if it was not a cruel restraint: to see it was ugly, above all.**

**Q Since when has C no longer been used as a, say, "punishment" department?**

**DOCTOR For about two years. Until two years ago there was still this habit of saying "I'll send you to C". And it was done. But it was more of a threat than anything else: then there was often an excuse not to send them, but it was a kind of sword of Damocles.**

**Q But this has happened since the C was the last closed ward, right? Then the characteristics of the department took on a pejorative connotation!**

**DOCTOR Yes, but the characteristics have worsened because the worst elements have been placed at C. So, actually, it was thanks to the C departments that the other departments were able to open.**

**Q Do you think that there was a big difference between the two C wards, male and female, apart from the different number of patients? In other words, why did the C men open when the C women was still closed?**

**DOCTOR First of all, in men there is no problem of erotic tendencies. Then there are more women, in my opinion, who have a tendency to flee, or who seem to have a tendency to flee. While like violence, it seems to me that when a fight happens, men are more violent.**

**Q But, given that there was this tendency on the part of women to flee, how come in recent times it has been seen that almost none of them wanted to leave the closed ward to move to an open pavilion?**

**DOCTOR Well, first of all because they are women. They have more tendency to remain in their own environment, in their own home: and then, perhaps they have also been treated better by the nurses than the men by the**

**nurses. You may hear that sometimes the nurses raise their voices, but deep down they always love their patients. In the past, the nurses gave the sick people something, biscuits, chocolates, and took them home, even for lunch. After all, women have never expressed the desire to go for a walk, like men, who have this great desire to go out. The women mostly asked to go home, but not to go out to the garden.**

**Q Do you think that the nurses' attachment to the sick played a role in determining this fact?**

**DOCTOR Of course, the sick are more institutionalized by us than by men: after all, the nurses too. Eh, the continuing habit of doing the same thing for years and years remains.**

**The history of the C women's ward can be written, like all stories, with dates, numbers, indication of events: the "facts". Perhaps, less coldly, it can be experienced through the eyes of those who have worked on it for years. But why are we trying to trace this past?**

**The last closed ward of the hospital contained one hundred inmates in October 1967: and no "fact" will be able to give us the measure of the violence that has marginalized**

**these people from the new hospital history. Institutional efficiency froze on this island**

**without history the invalids in the infirmary, the serious oligophrenics and the elderly demented, some "well-known fugitives", the women with sexual problems, and he has framed them with some "good" patients, who can help effectively in the internal work of the ward.**

**On the way in which they have gathered here, medical intelligence can only provide us with some explanations, groped for a justification: invalids in bed are often only the result of a lack of assistance, an unconsolidated fracture of the femur, the amputation of the legs, a hemiplegia not re-educated and for which it is not possible to have a wheelchair. And they say: what difference would the open door make for them, bedridden as they are. For the severe oligophrenics and the demented, the need to protect them is confused with the desire to do it with minimal effort. And they say: what sense would it be to open the door for them, they don't even know how to open it, and besides, they don't know where they are going.**

**To this nucleus of people thus consigned to the closed space, "physically unsuitable" for freedom, were added the others, rejected by the departments that were opening up or that had opened up, or not removed from the place they had lived for years. "Psychologically unsuitable" for freedom? Other than this generic label, very little there**

**medical intelligence can say about them, if not by resorting to nosographic classifications of coverage; or psychological intelligence, rich in subtle objectifying methods of quantification. But we can try to analyze this institutional violence otherwise.**

**The removal from one closed space to another closed space has followed, perhaps for the last time in a gross and blatant way, the laws of institutional efficiency. In order to open the other departments, gradually, the "problems" (real or phantasized) that seemed to seriously threaten the "success" of the opening were handed over to the closed space. Those who had fled once, perhaps five years earlier, or remained standing and looking at the door for whole days, were turned away and locked up, so that the opening of a ward was not delayed by a burden of anxiety that was too serious for the staff ( nurses, doctors, director); so that the "operation" could succeed in being repeated; because a total questioning, immediately, would have been ideologically perfect but not real. For the hospitalized, this transfer was the umpteenth confirmation of their total availability for the institution, of their ahistorical objectivity.**

**It would be interesting at this point to analyze how this availability occurs: Goffman's "moral career of the mentally ill" indicates the stages. But it is realized through a body - the body of the patient - which is denied in its individual characteristics and finally assumed by the institution (and this process is described by Basaglia, in *Body and institution* ). In our opinion, the stages traveled by men and women are not identical to theirs**

**entry into the institution, because the dispossession process follows cultural models differently adapted to the different bodily experiences. But this is not the place to deepen the discussion: in different ways, both are led to the same final condition of being institutionalized.**

**The removal from the open to the closed ward had another meaning: the exclusion from the "best part" of the hospital, open, which rejected the disturbing elements on its own, and used the residual asylum structure of the closed ward to create a distance between oneself and others, worse (the real crazy?) For more than five years, that is, since the liberalization of the hospital began until a few months ago, ward C has performed this particular function: women who fled , or who had sexual problems, the inpatients who were the source of acute coexistence disorders ("the problems" as it was said later, also dehumanizing people linguistically) were sent to the closed ward, both temporarily and permanently.**

**What significance did these measures have? There is a first alternative: whether the transfer to the closed ward was a simple organizational measure, due to the insufficient "management" of certain difficult cases by the open wards, or whether it was a *punishment* , that is a sanction with a value that , starting from a sort of hospital "new ethics", helped to strengthen it by example.**

**The second alternative proposes that the transfer to the closed ward be considered, on the one hand, a purely prison-type provision: while on the other hand it could have been a repetition of a mental hospitalization within the hospital field.**

**In each of these alternatives, the first horn of the dilemma considers the possibility of "purely" technical solutions: in any case they have taken on wider meanings, and their "purity" has been contaminated with violence.**

**Finally, we must consider the third group of people who are today at C women: the patients who have settled in this ward, of which they have always been a part without there being a specific reason to keep them there. For years there has been no talk of them, they have been inextricably mixed with the others, confused in the indistinct closed "residue": institutional violence has taken on the aspect of forgetfulness towards them.**

**Even at this point we could look for organizational explanations, and often the aspect of functionality would be revealed to us: patients who "have always" been cooking, or helping to care for the elderly, are kept in a ward by all the other members, their importance is emphasized, and privileges are granted such as to mask objective "forgetfulness" and objective "closure". The first among them is precisely the freedom to have the door opened whenever you want.**

**In all its modalities, in the different origin or in the various justifications, the career of the patient in the closed ward confirms the modalities of *violence* and *exclusion* : punished for real or ghostly "faults", or simply forgotten, they have been actively, constantly, separated from the movement of the hospital.**

**In recent months, almost all women in C have been offered the opportunity to move to another ward:**

**these people, faced with the possibility of leaving the closed space for a larger, new, "free" dimension, preferred not to move.**

**The difficulty of detaching oneself from the ward finds its first explanation in the analysis of the internal relations of this sort of "total institution" which is the closed ward: but this is highlighted differently according to the relations existing between the ward and the rest of the 'hospital. It does not seem necessary to remind us of the tenacity of the bonds that are formed between patients and staff, and the nature of disguised violence that they cover: the small favors, the privileges granted (or withheld) from time to time, and often essential to the patient's life. , have their most chilling aspect in the fact that they are only apparently the result of exchange ("a box of biscuits to clean the corridor", "you can stay in this bed if you don't get upset", etc.). Behind this appearance, there is always the possibility that the pact will be dissolved: in the relationship there is a stronger part, which has the power to decide if the pact is good, if it must be respected. There is no longer a norm that is the same for everyone: the relationship of the weak with the stronger other takes place at the cost of the subversion of the general conception according to which "power" descends and is regulated by "moral values". Here the opposite is true: and the nurse not only possesses the norm, the value, but is the custodian of it to such an extent that it becomes the norm or value itself. In**

**this total dependence of her own being, the patient cannot decide.**

**In the completely closed hospital, the change of ward is therefore situated in the gratuitous sphere of favoritism, for which the adhesion of the transported object is purely accidental. But what sense does this have in the framework of a hospital that is opening or that is all open except the C women? In other words, what real choice, what "decision-making power" is available to the patient of a closed ward in the context of an open hospital? Or, again, what are the relationships between these two realities?**

**When we initially spoke of the C women's ward as "a frozen island with no history" we fully stylized the analogy that exists between the asylum-society relationship on the one hand, and the closed ward-hospital relationship on the other. The asylum is, in society, an island cut off, which is used, exploited precisely in its function of "final station" but precisely because of this function it cannot be assumed in the living and real context of the things that change and cause to change. The asylum is a world without history. Time stops at the gates. Inside, the days follow each other indistinguishable, identical and empty, and every evening one would have to make a cross on the wall to give measurable dimensions to this indistinct duration.**

**The last days, the last hours before admission are a "present day"**

* **(even if the date is correctly quoted, and dates back to twenty or thirty years ago): the child is crying, she is two years old, has never grown up, and the twenty year old daughter who comes to greet her mother cannot be the same person and his presence does not cancel the present anguish of that abandonment. Many people don't know their age or date, even if they know the year of their birth, and they can do simple math. A salient event that happened "inside" (yesterday or ten years ago) is remembered identically: it is not history, it is legend.**

**The hospital begins to have a history - we can also say: history enters the hospital - when society enters the hospital, it breaks its isolation. And the way in which this happens is mediated by the people who, so to speak, "bring in" society, no longer being only the custodians of the custodial mandate. In fact, a "pure and simple" entry of this capitalist society, founded on the division of labor and the hierarchization of roles, has already occurred and has already taken place where and when paternalism (or soft institutionalism, as Basaglia says) has taken the place of the old authoritarian regime (harsh institutionalism) and has hidden the same power relations under the humanitarian mask. And if this modification has not yet taken place, it will be society itself to ensure that the "island of backwardness" disappears (see Gilli, in this same volume).**

**There is therefore a relationship between the social system and the institution that tends to introduce into the institution as much as it can**

**serve as confirmation of the social system: how then can new relationships be established?**

**Basaglia finds in "anti-hierarchical voluntarism" (see *Body and Institution)* the only way in which relations within the institution can be modified and, ultimately, modified (basically: overturning or destroying) the institution itself. It is therefore no longer a question of getting rid of one role at the gates in order to assume another; nor of "having the same role" inside and out.**

**The "society" that entered was full of contradictions. At the top (hierarchical) of the holders of institutional power - director, doctors - the**

* **anti-hierarchical voluntarism ": by accepting, indeed seeking and provoking, the confrontation with others" without taking into account "the institutional roles, it has been made possible precisely to become aware of the meaning (of violence) of these traditional roles. Simplifying, we could say that they have always been kept alive and denied at the same time: but this does not always mean only an acute awareness of the problematic nature of the situation. It means that choices have been made in daily practice: from which, over the course of the days, a different availability of contestation opportunities has arisen.**

**Some wards were opened earlier than others, meetings began with some groups of patients earlier than with others: some initial "privileges" are**

**often been lost or acquired by others**

**The C women's ward was closed longer than all the others: the similar C men's ward opened on 14 July this year. Now the opening of the doors is a forced passage point. It is a question of providing a physical freedom that strips the staff of the prison attributes - concretely expressed by the key - and forces them to a new relationship with the patient: the possibility of escaping gives everyone a margin of individuality that is "threatening" . "Control" can no longer be exercised over passive objects ("locks and patients"), it can no longer take place "without taking into account" this new aspect of people.**

**But for this availability of opportunities for contestation not to be ideological proposed by doctors, to safeguard their own identity, and instead be a reality for the sick, the latter must have appropriated their own reality, their own body.**

**If we retrace the steps in the liberalization of the hospital, we encounter (as we say elsewhere in this volume) the moment in which the doctor regained "real power" over the patient, taking it away from the nurse (who, in fact, managed it): in this way, the doctor at the same time "freed" the nurse from his prison role and intended the patient.**

**In making him the object of care and attention, he made him a body: a sick body. But the sick body is there for the doctor. It comes out of serialization, of transparency, and becomes an opaque object, acquires a thickness: when the doctor recognizes it. When the doctor leaves, the patient remains under the gaze**

**of the nurse: and he happens to change his form of existence, because he is no longer recognized as the same.**

**Its objectivity is confirmed by the interchangeability of the roles (of the forms of existence) that are attached to it and are always decided by the other. It is not yet subject to anything. The contradictions of the institution have opened up before him - within him, in his own body: they can once again be reabsorbed by the institution.**

**And, on the other hand, the "liberation" of the nurse coincides with his ability to leave the anonymity of his hierarchical role to take personal initiative in the relationship with the patient. It can be placed, in the wake initially indicated by the doctor (perhaps, more correctly, included within the initial indications of the doctor), and, underlining the generic professional qualification, address the "sick body" and treat it humanitarianly, with attention, without obvious violence. This is a necessary step: but not a sufficient one. If the nurse (and the doctor) stop there, the contradiction is once again resolved in a new objectification, which transforms the "mentally ill" into a**

* **sick like all the others ». The meeting will take place in the patient's body-object, making any other relationship irrelevant, making the subject of this body-object irrelevant. Once again, the re-appropriation of the body**

**precisely it will be made impossible for the patient, since he will only be occasionally allowed to have a *body* - the object phantom of his body - and the opportunities will escape his control, depriving him of the possibility of making them his own in a temporally lived context.**

**Leaving the anonymity (the reassuring normativity) of one's role without immediately seeking the new anonymity (the new reassurance) of another normative role, means - for the nurse (for the doctor) to recognize the contradictions and ambiguities that arise - due to the fall of hierarchical normativity - between his being in society and his being in the institution: often, the way to contain the anxiety that derives from this awareness is to re-propose models and "external" values, and use *them tout court* (without the mediation of hierarchization).**

**It is no longer forbidden for nurses to read the files of the sick, in the absurd claim to treat them all - anonymously - in the same way: on the contrary, behind these skeletal pages in the data, monotonous in the exposition, an indication of a way of be characteristically individual, the story of a person.**

**It is no longer absurd to address the patient to say something that is not an order: and one realizes that after years of silence, of "mutacism", the answer comes, and the more it is listened to, the more it is enriched with personal contents.**

**But even more meaningfully: the nurse is no longer forbidden to talk about himself. And in identifying the nurse as a person who offers himself to the relationship, the dimension of reciprocity is present, albeit in a very initial way.**

**Within the framework of an assumed and denied institution (not yet overturned, perhaps not yet emerging from the technical timelessness of history) these individual, different positions, not summarized in a pre-established plan, disordered and contrasting, represent a *real contradiction* . And the sick person is reflected in it. Andit proposes in these margins of dysfunctionality its own presence, 'involved in contradictions, no longer purely objectual. He proposes the urgency of emerging from reification (to accept, Sartrianly, his own *fact* ) by looking at whoever is in front of him, in search of *the real limits* of his own body. It is finally possible for him to reflect narcissistically in the nurse and collect from him the contents of the cultural determinations on which the social model of the body is articulated.**

**To make this journey, the women of ward C found a particular obstacle, linked to the structure of the women's confinement ward: permissiveness.**

**At C women everything is allowed. There are those who eat with their hands throwing on the ground what is not of interest, there are those who make obscene gestures at the address of the staff or other patients. There are those who use a colorful profanity. There are those who take advantage of the slightest distraction of the staff to perform, behind the window grates.**

**Nobody is scandalized.**

**The *gestures* have been stripped of their provocative content. Frozen under a gaze that *does not see them* , the sick have become disordered, inconvenient, obscene.**

**Thus obscenity is not the provocative filthy gesture but the distance at which those who tolerate it place themselves, taking away all meaning from it, indeed using it to objectify those who perform it, exploiting its regressive module for a reduction to the heaviest reification.**

**Permissiveness is, indoors, linked to distance.**

**The hierarchy that exists among the sick is a testimony of the effort that is made to avoid being continually invaded by the obscene: but in this "recovery" of distance, by itself, the objectification of the other is reconfirmed. And the game is reproduced, because there is always another, hierarchically superior, who can objectify the patient: once again the nurse becomes the custodian of values (of power).**

**But even among the nurses hierarchical relationships are reproduced, power is subtracted from common management, we are witnessing the mortifying training of the "freshman" and the recognition of leaderships to those who have best contracted the sub-government of the ward.**

**All this serves to remove from any relationship a character of encounter between people: it serves to convey a particular conception of the -institutional-asexual woman whose body is, in the limit, present only in the dimension (no longer fearful, because closed and destorified, sterilized ) of the obscene. Beside this, moreover, yes**

**already at C women, as "infirmary", the attitude of medical objectification of the "physically ill" through their body (even poorly cared for, as the body of the poor is cared for), inextricably linked with institutional detachment: and therefore not usable , albeit as a first step to then be denied, for the recovery of a different relationship.**

**Against these obstacles (which perhaps, as such, are not profoundly different in a male department) we find the social model, culturally determined, of the female body: which has been proposed, over the years, both through the free put on of the nurses, both through other institutional changes. In fact, as the nurses and the sick emerged from the walls of the closed ward, albeit on limited occasions, into the wider field of the entire hospital now liberalized, the first opportunities for confrontation allowed the first contradictions to emerge. Some nurses felt the discomfort of the constraint of their hierarchical role and maternalism which was not separate from it, and they found themselves in the contradiction between this reality and the need to place themselves in a more conscious way, which did not deny them the specificity, the historicity , of their being women. And the inmates found other signs outside the ward: the introduction of the hairdresser's shop, the importance given to tailoring, the very way to move**

**of the women of the other wards (the fruit, in turn, of the free attitude of the doctors, the director, the other nurses, all those who moved in the field) indicated new possibilities of re-approaching a lost identity. And in the ward, then, the patient reflected in the nurse: she collected her values and ambiguously referred them to herself, and did not propose, in two stages, her relationship with the nurse and her identification with it, but it has grasped the margins of reciprocity that have become available and made them its own, and with them it has left free entry k a contradictory and heavy baggage.**

**In this situation, which allows an initial incoative emergence of one's own body, cultural determinations do not overlap as subsequent learning, intimately connected as they are to conduct, to behavior referring to the world. On the contrary, they enter into the dialectic of relationships, qualify them, make them accessible (often also: inaccessible) to reciprocity.**

**Now the cultural determinations of our society have proposed the model of a "deuxième sexe" woman (with S. de Beauvoir), for whom objectification no longer occurs only in the individual, in the individual relationship, which is then exposed to the dialectic of the encounter: but it is generic and generalizing, and as such it underlies the ways of the individual encounter. The woman**

**perpetually "Other", he cannot recognize himself as a person in the same title as man, but always defines himself in terms of man. (The historical stages of this process are the historical stages of the process resulting from the division of labor, in which there is no room for egalitarianism).**

**We can schematically look for the models that society offers us. The woman-female, culturally re-proposed through the "cheerful housewife" is well described by Betty Friedan (in *Mysticism of Femininity* ) as the product of an advanced consumer society: happily engaged in motherhood, slave-mistress of a thousand appliances, self-esthetician itself, in order to "conquer" man, is the greedy consumer of the product that capital must place. Although far from our socio-economic level, it presents itself to many workers as a mirage of freedom.**

**For others, the achievement of dignity in the world of work corresponds to a higher level of women's emancipation. But "emancipating", like freeing oneself from slavery, is still a movement included in the same dialectic, and the woman-man who says she wants to overthrow a system finds herself contributing to its functionality: not only does she enter the world of production how and when he wants capital, but theorizes this integration as "liberation" by mystifying its meaning.**

**This also happens in the temptation of omnipotence that presides over the synthesis of the two figures: a woman capable of keeping home and work, capable of "listening" and ready to "discuss", skilled director of her own masculine and feminine qualities, whose continuous tension becomes availability continues to the world of consumption and that of production, without the possibility of finding the common reasons for this double alienation.**

* **In the consumer society, women are brutally objectified: profound hypocrisy of a structure that offers women more and more frequent opportunities for**

**"Emancipation" and at the same time incites her to sell not only her workforce but to sell herself as an object of consumption. Female "qualities" such as beauty, shamelessness, unscrupulousness are modified, and at the same time categorized in dialectical opposition with other "qualities" such as honesty, modesty, virginity, "style", which in turn are nothing more than instruments of commodification of woman as an "object" "(G. Pirella, *Private property* ," What to do ", n. 3). The female body is commodified, urged to sell itself in the exchange value that it assumes for man. And (the way in which the woman lives this total objectification is called passivity. "What is recognized as a natural attitude (passivity in fact) cannot be the result of an unnatural balance that forces her to create a distance between herself and one's own body, such as to be able to live it as an object for oneself and for others? "(Franca Basaglia Ongaro, *Woman-man* ," Che fare ", n. 3).**

**In living her own body, the woman therefore encounters her own commodification, beyond the mystifying facets that seem to propose themselves through apparently different social roles; the division of labor entered the individual man-woman relationship, brutally detaching the "most fragile of all perceptions" (Merleau-Ponty), the experience of one's own body, from**

**subject-woman to which she should have belonged in order to deliver her to the system.**

**The very possibility, for the woman, of *being her own body* seems to elude her indefinitely asit seems to miss the possibility of getting out of its own exclusion.**

**Adding the exclusion of women to the exclusion of the mentally ill has given, as a conspicuous product, the backwardness of the female wards compared to the male ones, the protracted closure of the C women.**

**But today these women also look out over the entire space of the hospital: from 22 November also a door of the C woman is open. In the field thus expanded, new points of reference emerge, new opportunities for meeting: alongside the female models available within the ward, alternative figures take shape (among which the inpatients of long-open wards who have taken on the role of leaders). Often, these models refer directly to those proposed by the external company, whose indications they accept. The most coherent is certainly provided by the religious, in the rejection of the body through which their being-in-the-world is realized, and in the oblativity that denies the individual role to be only a social role (and regains authority at this level " sterilized**

**»). In another way, however, the nun re-proposes the values of "honesty, modesty, virginity": and connects them with the matriarchal role, traditionally female, which recovers justification in protective oblativity, in the farsightedness of savings and order. of their own existence. But also in the secular world “the maternal role, towards man, can partly compensate the woman for her having to live in mediation. It is a dangerous game of mutual weakening, in order to be able to protect each other: the man in determining the regressive level in which the woman is forced; her, in defending himself from it by circumventing him with “maternal” care that tends to make him regress »(Franca Basaglia Ongaro, *loc. cit* .). In this context, the traditional models of domestic cleaning and of the kitchen, combined with obedience and order, are proposed to the inpatient.**

**Thus Antonia, an elderly patient mother and happy grandmother, proposes her good-natured but solidly authoritative matriarchy. Its greatness rests together on age, on the ancient wisdom that comes from experience, on the awareness of one's own intelligence; he places himself at a level of dialogue with the authorities, of which he recognizes the indisputable goodness and from which he asks for confirmation. She does not consider the traditional values of the housewife - knitting, cooking - to be negligible when she can carry them out independently; but it naturally faces organizational and managerial tasks when they are "works of peace". Many were made under his enlightened conservative rule.**

**But the exit from the institutional greyness does not happen only through this path: since the opposition**

**dialectic between "modesty" and "beauty" enters the hospital every day, with visiting girls, young nurses or social workers, new patients in the observation wards who propose the other face of "modern" femininity, which has appropriate of one's right to sexual pleasure paying it with the need to always appear as a seductive object in the eyes of man. The mirror, the lipstick, the graceful T-shirt: see your own body, retouch it, decorate it, find it "beautiful". All these acts stop at the boundary of personal identity and fail to reach it, because the male world (in the individual and in the social) holds its confirmation.**

**This issue inevitably leads us to a dortianda: does it make sense for the hospitalized patient to regain possession of a sexed body, which she is not allowed to enjoy in sexual intercourse? We could answer with the words of Merleau-Ponty: "a show has a sexual meaning for me not when I represent to myself, even confusedly, its possible relationship to sexual organs or states of pleasure, but when it exists for my body, for this power always ready to amalgamate the stimuli of an erotic situation and to adapt a sexual behavior to it ». There is therefore a sexual behavior - there is a sense in re-appropriating one's sexual body - which is placed only in the social relationship, and for which the individual relationship has a crucial meaning (and crucially suffered in the absence), but it is not necessary. (while its absence may be necessary).**

**But these people who bring the values of external society "inside" with their work, are not housewives: and in active participation in the world of work**

**testify to another feminine dimension. Some undergo it out of necessity; others have appropriated the characteristics of "emancipation", and masquerade as the "masculine" values of career, freedom from family, competitiveness (and exploitation).**

**Always rebellious, Ada refused to be integrated by the institution into the classical canons of the good working and industrious sick woman, being judged first "agitated" (she was very often kept in a bodice) then "impulsive". Today, like a girl seeking confirmation of her need for independence outside the home, she spends a small part of her day in the ward: she is very often at the bar, always at general assemblies, and on all "social" occasions (dances, parties, trips) of community life. Her participation in discussions is particularly productive when general problems are dealt with: she herself often grasps themes essential to community life and proposes them relentlessly. Fragile and insecure in the personal encounter (in which the invasion of her space, already difficult and hardly defended, would more easily be consumed), she has chosen the social plane as the privileged place of her position: and in it she uses all her resources, from bourgeois family values of courtesy or personal care, to intellectual (even aggressive) criticism.**

**Thus these examples, which show how everyone can take possession of themselves in a different way within the hospital today, do nothing but confirm the entry of external society, with all its contradictions, into the hospital field: and the reduction of it to a small model of well-integrated contradictions.**

**However, the C sufferers who have the door last**

**open, they are the first to have to face a reality that no longer contains a "beyond", a further closed space in which to reject (project) uncomfortable negations. So all that remains is to deal with the real situation, in which the limits that the external society does not want violated emerge dramatically: they are still paid by the people.**

**Paola: It is difficult to describe in a few words a person who was able to survive his own destruction and has discounted and still pays his story on himself. In her harshness and cynicism we recognize a constant reminder of our will of bad faith: she rejects her destruction and survival in the face of everyone, she knows she has been excluded and trampled on in many ways, but she doesn't want to accept it as her destiny. .**

**The woman cannot accept to lose her identity forever. He cannot experience total self-denial. Perhaps, it can be placed at a distance that is becoming aware of its own exclusion, of its belonging to the largest category of the excluded; awareness of the violence of the system and of the need to act (against it) like the others excluded, in the tension that brings the denied body from immobility to history.**

**It cannot be a privilege of the hospital field to deny the roles, which everyone would find themselves wearing again when returning to external society: it has become indispensable *to be in the same way,* inside and out, no longer bringing in the "values" from the outside, but carrying outside anti-institutionalism, anti-hierarchization**

**of roles, the anti-division of work to which the ambiguity of our being inside forces us.**

**The opening of the doors is a forced passage point: but there are no rules on how it should happen. However, many problems arise, from time to time, in front of each department "in the process of opening". In October '67, in front of C women, the last closed ward, these issues were discussed for a long time, in various locations and with a variety of views. The particular interest of the debate that we report here (in which a part of the treatment team participates, unfortunately incomplete and accidentally lacking some members directly involved in the institutional work of the two departments concerned), lies, in our opinion, in the fact that the issues are carried out in the perspective of a completely open hospital: and the anticipation of a new reality is inextricably linked to the analysis of the current reality.**

**JERVIS It seems to me that two problems arose. On the one hand, the problem of opening times and methods in relation to the evolution of the hospital and the different concrete situations that arise in the various departments: it is a problem that must be compared with the needs that gradually arise in the hospital as well. as it is now. While five or six years ago the opening could have been implemented abruptly, as an action to break with the asylum situation, today instead the opening is placed within a reality**

**tendentially communitarian and no longer as a simple subversive act against the asylum situation. The other problem seemed to me to be a more fundamental problem, that of the meaning of the open ward. At a certain point it was said: what does "open ward" mean? And ultimately what are the reasons for opening a department? It is a problem that has been raised both, evidently, because there may be different degrees of openness of a department, and because even the apparently more complete opening can be a precautionary opening in various ways, "mitigated" and ultimately mystified so that one must ask whether this category is a category that is valid in itself, or whether it has meaning only in the context of the particular modalities in which it is realized.**

**BASAGLIA This is precisely the problem. It seems to me that both the opening implemented within a fully mental asylum situation, and the opening of a ward at a time when the rest of the hospital is already "open" in the highest sense of the word, are always moments of negation; that is, a closed ward is always an asylum ward even if it is in an open hospital. The opening of a department is always a breaking action being always a moment of the dialectic of negation. I can't think of openness as a conceptual elaboration**

**of the people who live within the closed system that needs to be opened; I think that opening is a "revolutionary" act and a "revolutionary act."**

* **it is not an elaborate act, it is not a "mature" act in itself, rather it is an immature act. Let me explain: a certain action is elaborated and can lead with its effects to a maturation of the overall situation in a certain direction, however the opening itself is an act of rupture that compared to the norm is considered an act of immaturity, but only because the "revolutionary" act does not recognize the norm, it is out of the norm. Therefore the "revolutionary" act does not take into account the sanction which is connected with the norm; not recognizing the norm, the breaking action apparently leads to that situation of "chaos, disorder, anarchy" we were talking about.**

**SLAVICH It seems to me, however, that in this way one describes rather an "anarchic" way of proceeding, rather than a progressive, if we want "revolutionary" practice of subversion of a norm, such as the one we are discussing which wants that in a hospital psychiatric wards there are closed wards.**

**JERVIS I don't think so; I think that the "revolutionary" touch represented by the opening of the ward can be conceived in two ways: or as a maturation**

**necessary, as the culmination of a process of maturation for which, when the objective conditions exist, then it opens up - but first there must be a whole preparation for which there are certain contradictions that come to be resolved, there is all the personal maturation that arrives to awareness, and then finally there is the overturning of the norm, etc. - This is the traditional conception, so to speak, of the "revolutionary" act. Or there is a slightly different and new, quite current conception to which I think Basaglia was referring, that is, of the revolutionary act as a stance, as a decision that in a certain sense is ahead of the times, which is pronounced in a moment. in which the objective conditions are not yet mature, which does not wait for the objective conditions to mature but precedes and forces them. If the objective conditions are truly mature then there is no revolutionary act, but only an automatic reversal.**

**BASAGLIA Let's assume that certain groups of nurses in still closed wards come to spontaneously decide to open: it would be like waiting for a "quiet" system without internal tensions and without stimuli, to decide, with a democratistic mystification, out of the blue to change its own ideology in a radical way.**

**SLAVICH But the "revolutionary" act in the closed ward does not seem to me to be that of only opening the door. It is the people, the conscience of the people who live in the ward that create the system, the specific situation of the ward; and in my opinion it is first of all not so much acting to force the door to open, but rather carrying out a series of acts, subversive with respect to the norm of the system, to act on the conscience of the people who are in the ward, therefore to have a more profound effect on the situation in the sense of openness.**

**BASAGLIA We are faced with the usual problem of the avant-garde. There is little to say: if we had thought of "educating" the hospital on the opening, on the vision of the new institutional psychiatry, I believe we would still be here talking; in reality we have forced the situation. There was perhaps an "immature" action, but only apparently immature, in my opinion; because I don't think that there are really moments of objectivity on which the maturity of an action is measured; we cannot be objective, we must side with a certain choice, otherwise we would not be able to do what we do.**

**SLAVICH** **Of course, we take sides, we act in a subjective way, sometimes even biased, if we like;**

**but in each of these actions of ours, to reach the goal it has always been necessary to have a specific time, different from zero; and also in this particular case, I think that a series of acts is necessary, among which the opening in and of itself is in a median position, and is not the initial act; the opening of the ward is discolored of its magical meaning, and becomes a simple intermediate act of a process for achieving the purpose of a real opening of the ward. The simple physical opening of the ward must be preceded by a series of preparatory acts, carried out in a fixed and not delayed time, according to a strategic line that we must consciously choose.**

**BASAGLIA Why did the nurses get anxious at the prospect of the door opening? Because this is out of the ordinary, and consequently they are still subject to the fear of sanction.**

**BIG HOUSE** **But when you, Slavich, say: a series of well-foreseen, conscious acts, etc. is necessary, do you assume that all the opening of the wards must be done in a certain, objective way?**

**SLAVICH No, and why? It is necessary to study well the situation of each department and act accordingly; this takes time in my opinion**

**determinable, which absolutely must not be able to constitute an alibi for those who do not want to open the department, but cannot be reduced to practically zero, running out at the moment in which "we must open" is stated.**

**JERVIS However, these times do not take place as a maturation process that has certain stages; it seems to me that you understand them in this way, but in my opinion the opening does not lie within a process of maturation, but is an act that intervenes from the outside to force the maturation process.**

**CASAGRANDE In my opinion, openness only intervenes when the "revolutionary" act of opening itself takes place, regardless of the objective conditions. This act to be performed is an eminently subjective and unconditional act; I would give more value to the subjective component while it seems to me that you place a lot of emphasis on the objective component.**

**SLAVICH But it is evident that it is an "objectivity" filtered through the subjectivity of the doctor and the group of people who are rethinking the situation in a subjective way; I fully agree that the result of an objective analysis should not be expected to be really such, but an analysis must always be carried out; and I also agree that without an intervention we can say so spontaneous**

**here you could do nothing or almost nothing. CASAGRANDE If, however, the doctors, as you say, do not**

**they perform the opening acts suddenly and wait respecting a certain succession of events, even if they think about it and rethink it when at some point they decide to do so, this decision seems to me to be very subjective, and not something that arises from events.**

**BASAGLIA** **If we leave the decision to open the department to the community situation, as we understand it, it would be necessary for everyone, truly everyone, to be convinced of the opportunity to do so.**

**SLAVICH Actually I think that since a department**

* **consisting exclusively of people; the way to open the department is to act on people.**

**BASAGLIA I would like to say to Slavich, when we started this new institutional action it was the two of us, now we are at least a hundred here; and this action was immature, reversed, it was a kind of action that was absolutely objective to no one. It was a series of acts done by a certain avant-garde who decided to do certain things which then led to certain results.**

**SLAVICH So then "they carried then", they were certainly subjective actions, but not instantaneous.**

**BASAGLIA Instantaneity concerns, for example, the moment in which it opens. Today it was said in the assembly: "It is true that the doctors put the key in the lock, but those who turned the key were the sick." Today it is said and it can be said because the sick have perhaps, like us, matured a certain awareness of the situation; but when we said: let's open the door, by opening the door we placed ourselves outside the norm, and we were all afraid of what could happen.**

**JERVIS The problem, however, is also to consider why yes**

* **taken this initiative; it is an unfortunate, though probably not accidental, coincidence that the vanguard who takes the initiative to open a department is represented by the institution's top hierarchy, that is, by the director, by the doctors. And this creates a somewhat ambiguous situation, because this avant-garde identifies itself in practice with a maximum of institutional power.**

**BASAGLIA** **And it is okay, let's say so, that the avant-garde in this case could only identify with the maximum of institutional power; because perhaps it would have been very difficult for "the island of the excluded" to develop such an awareness, to become so aware of exclusion as to be able to say "let's open the doors" and**

**above all he could find the complete means to do it. JERVIS It seems to me that Slavich refers to the need for this avant-garde no longer to be, after a certain number of years in which the hospital has experienced a tendentially communal situation, represented only by the top hierarchy, that is, that it no longer necessarily identifies itself with the top of power, but that it is an avant-garde involving one**

**minority of people.**

**This minority must involve middle managers: and this seems to me to be fair enough; in a certain sense it is a pity that after a certain number of years in the therapeutic community one still finds oneself in a situation that even at the beginning was fully justified, that is, that the initiative for the opening of a department always starts from the top; at the present moment this vanguard should spontaneously recreate itself within the community at the intermediate levels, among nurses for example, or, in the most optimistic hypothesis, among the sick.**

**BASAGLIA** **This discourse is equivalent to saying, paradoxically: if a revolution has taken place in one state, how come after a few decades by the force of example another state does not make its revolution? Our hospital is made up of eight departments of which five, then six, then seven departments have opened, it is a process that seems continuous but yes**

**arrives at the last ward that is struggling to open; because? In my opinion because in this last island the norm is represented; and this rule must be broken, there is nothing to be done.**

**JERVIS I think we all agree on this. SLAVICH Of course, I don't think we're discussing if it is**

**whether or not it is appropriate to break this rule; rather we are discussing, at least on my own, how to break it; in my opinion it is necessary that a real power group be constituted within the department, even in open contradiction with other groups, which clearly tends to open the department; and that the request for opening is not represented only by the doctor.**

**BASAGLIA In any case, this group of power would be such because we participate in it; no, I don't think we can wait for the department to mature to open it.**

**JERVIS On the other hand we have to make ourselves** **I realize, and perhaps even be quite satisfied with it, of the fact that at this moment in the hospital there is a pressure towards the opening of the C women's ward that no longer starts with us, it comes from many nurses from other wards, from the sick to what you hear in the assemblies and, I think, also from some nurses in the C women's ward.**

**BASAGLIA If there is no break in opening**

**the department, this may perhaps open up, but in a potentially reformist way, because time has already been given for the reconstitution of a norm which, in my opinion, risks nullifying the very meaning of the opening; on the other hand, it seems to me that even the C men department at a certain moment was opened with a forcing, because not all the nurses agreed.**

**SLAVICH Not all of them, but some of them were: and this "consent" had taken quite a long time; and it seems to me that it was not so much a question of convincing the nurses of the "goodness" of openness, of which they were already convinced, as above all of acting to ensure that the proponents of openness organized themselves as a group of power. Secondly, it was a question of reassuring them that, when the closure of the ward was "broken", the automatic connection of the sanction with the norm was also broken.**

**JERVIS I would like to ask you one thing, on which I seem to disagree: let's assume that within the closed department all the staff were against the opening, that is, that an objectively unripe condition existed, and that at the same time there was from the nurses and sick people from around the rest of the hospital great pressure to open this**

**last department. In this case, I believe that the department should be opened with a breaking action, while perhaps you think that you need to give the time at the forefront to organize the opening from the inside. In my opinion the trouble is that in a certain sense at this moment the opening of the C women's ward is still proposed too much by the management team and too little by the sick and the rest of the hospital, without forgetting that there are requests in this sense. I am. In my opinion, the C women's department must still be open from the outside, in the current state of things; if ever we must try to avoid that it is opened only by the director, by the team of doctors: in a certain sense it should be opened by a mass of nurses and patients from the rest of the hospital who force the ward to open up and adapt to the new situation.**

**SLAVICH We keep in mind that out of seven departments that have opened so far, this has never happened; the first four wards clearly opened for the direct intervention of doctors, the last three mainly for an internal maturation process, even if this was ultimately to be linked to a series of actions and pressures on the part of the medical team . It is a fact, however, that in this case we are faced with a situation entirely**

**particular because this is truly the last closed ward which, as Basaglia said before, truly represents and symbolizes the persistence of the asylum norm.**

**BASAGLIA The fact is that from this particular case the discourse can only become typically and exclusively political.**

**JERVIS It must be the nurses of the other wards who say: enough with all these second thoughts and hesitations, we must open and help to open the C women's ward, then the people inside it will have to adapt,**

**SLAVICH However, it is also necessary to worry about the effect on the cohesion of the team of the staff of the ward, for the purposes of the possibility of its therapeutic approach towards the patient after opening. We must ask ourselves what effect this siege would have on the part of the other wards, that is, this imposition of a superiority deriving from what would be felt as a new norm, that is, the "moral superiority" of the open ward over the closed ward.**

**BASAGLIA Now there is nothing in ward C and certainly there is not even a sense of group among the nurses, as long as the ward is closed. When you open it, anxiety enters, and in this case anxiety is certainly the most important element of the therapeutic dynamics of the ward.**

**SLAVICH This anxiety enters the ward long before that**

**open the door.**

**BASAGLIA There is also now, fortunately there is a situation of uncertainty due to the fear that the department will open.**

**JERVIS But look, Slavich, why is there this situation of uncertainty within the ward? Because inside the ward they know that they won't be the ones to decide: if the ward staff knew that it will only open when they want it, there would probably be no anxiety and no uncertainty and the ward would not open. If something is moving now, it is because in a sense the opening has already taken place.**

**SLAVICH Yes, that's right; in a certain sense, the opening has already taken place at the moment in which the intention of the ward has begun, to summarize it in the dynamics of the hospital, to act within it even before the doors are opened; in this sense the maturation process, as I intended it a little while ago, I think is already underway; certainly our action must tend to speed up the times, but it cannot ignore this necessary time of maturation.**

**JERVIS The fact is that this maturation began when the threat of opening the C ward began.**

**BASAGLIA It is a speech that we have always done, since**

**from the beginning with Slavich: I am always for the short times, he for the short times but a little longer due to his need to see clearly what he was doing; I, on the other hand, have always been of the opinion that if you leave time to organize themselves to those who do not want to move, they can not really move.**

**SLAVICH The fact is that all the risks, such as those of openings, for example, that we have taken in recent years, have been run, at least up to a certain point, with good reason; in the sense at least that, before opening any department, we evaluated and studied the particular situation of that department, carrying out a certain number of operations, on some particular resistances, with some reassurances ...**

**BASAGLIA It was basically a very relative study; because always when problems were identified, in practice it was revealed that the real problems were not those but others. So perhaps with those operations we reassured ourselves, around something that basically did not admit reassurance; after all we knew very well that everything that was being done was valid only at that moment, because the problems would then be other. We must not give time to those who tend to delay, to organize themselves.**

**JERVIS Yes, but among the staff there are not only representatives of the "reaction"; there is a great danger, in my opinion: since there is this vanguard that opens the departments so to speak with the "flags in the wind", which operates this process of rupture, since this vanguard identifies itself with the apex of institutional power, there is it is a danger that some of the nurses with greater initiative will be mortified, and that they will be deprived of the possibility of being part of this vanguard.**

**BASAGLIA At the beginning of a job in a traditional hospital one can only think of being alone and act accordingly by constituting himself as an avant-garde; in a situation like the present one with a single closed ward in which the reaction of the traditional hospital is concentrated, what needs to be done? Or you change the staff of that department, and this is also a possibility; or the department opens with a breaking action; otherwise what can we do?**

**SLAVICH In my opinion we must be careful not to use the wording "all the bad apples are in here". Perhaps it is more appropriate to think of this last ward as having a representative sample of all the positions expressed by nurses on openness, and that even in the closed ward it is possible to search for people who can**

**be the vanguard of that particular situation. We should rightly not leave time for those who tend to programmatically delay organizing themselves; however, if in a general plan we can actually neglect and deny this tendency to delay, in particular concrete situations we must take these resistances into account, in order to overcome them, one by one.**

**BASAGLIA I think that in the work we do there must always be a share of ambition, there is no doubt about this; if we analyze too much the consequences of everything we are doing, we do absolutely nothing, because we would be afraid of our acts.**

**JERVIS But the problem is to know whose this ambition must be.**

**BASAGLIA Possibly of all.**

**JERVIS Here, that's the point. Why isn't it everyone's?**

**What are the consequences?**

**BASAGLIA Of all; but when we want to do a certain thing and we cannot do it because we are not all there yet, then we must start it with this avant-garde, even if we can only be us. That's pretty serious, although I don't really know how we could do otherwise. There is a risk in all of this, the risk of the situation**

**contradictory in which we live. We are determined by the system, of which we are a part in spite of everything, to carry out actions against this system that are certainly deviant. At first here in the hospital everyone said: Eh, eh, they - the doctors - know what they plan to do! And we really knew absolutely nothing of what we were going to do tomorrow; the situation was dealt with here and there, with no plans, and everything was fine. They still said: you are wrong, because you do not instruct us! If she instructed us we could help her while we do not know what she is going to do and she knows it, she explains it to us then at the right moment, when it is already done; but the important thing was that this need arose to do something together.**

**SLAVICH On this I disagree, whatever was thought in terms of the short term, but there were still operational times, preparation times, during which if nothing else we would formulate ideas, perhaps for deny them immediately afterwards; proceeding gropingly, in fact, one tested the resistances, and even if the "plans" were then changed, the fact of having overcome those resistances did not remain without a trace; and all this took some time.**

**BASAGLIA Now the speech you make is possible, but at the beginning it was not possible. Now to open the**

**department C should be a bit 'everyone, and not only the director should arrive, with the golden key placed on a plate and say: I open the department. Now it would be absurd and in fact we continually try to involve everyone as much as possible, and within certain limits the nature of the avant-garde has almost also changed, and a large part of the hospital is an avant-garde.**

**SLAVICH I would say that even now it is not possible or necessary to wait for the consent of all the people who are and work in the closed ward, whether they are nurses or sick; in my opinion we should put an end, demonstrate with a series of acts that the process towards opening is irreversibly underway, respecting the times, making it clear that opening must also be done against the resistance of someone, explaining and discussing all levels because it is considered necessary to open the department; it seems to me that it is above all so that the opening can come to have a deeper meaning, and that it is not only symbolic, and that it can really affect the internal situation of the ward which is still typically asylum.**

**BASAGLIA If, for example, we also open against the will of the staff, what happens? There will probably be a fairly violent reaction, overt or covert, against us; on the other hand I think we have to take this risk that it is**

**inherent in this denial process. The denial is like that, a bit unrealistic in itself. To truly change the situation in the ward, we have to go through denial. It is a negation by its dialectical nature. It is not a simple "no", nothing is built on "no", but a certain dialectic can move from "no" that can build a new reality, in our case, a new department. When it opens it is really "crazy" to open, because in practice we don't really know what will happen; on the other hand it is a type of "madness" which is always at the origin of every practical reversal.**

**SLAVICH However, I would not say that the only reversal act is**

* **crazy "is that of the opening. For example, the fact that some patients in the closed ward, "ugly" and in any case stigmatized, go to stay in a nice open ward, and that this ward welcomes and manages its relationship with this patient in a therapeutic way against the prevailing opinion in the ward closed at a certain point this too is a reversing event, it is a negation that leverage in the sense of opening on the closed ward.**

**BASAGLIA It is in fact in order to be able to transfer these patients we had to carry out an act of denial.**

**JERVIS So here we come back to the problem: what does the opening of a department mean? This is one**

**necessary and sufficient condition to change everything, or not? I have the impression that for. mechanisms still partly obscure, at least to me, there is an organic relationship between the fact that the doors are locked and the fact that inside the ward the patient experiences a whole series of oppressions, even if not necessarily physical. It seems strange to me that such a simple fact as a closed door is so closely linked with a well-defined microsociological dynamic within the ward; and this makes me think that as long as the ward is closed the members of this ward, both the sick and the nurses, cannot realize, due to the very dynamics of the closed ward, what living and working in an open ward can mean ; and that therefore in a certain sense the opening always takes place from the outside.**

**BASAGLIA It is a characteristic of all total institutions; when the situation opens, all relationships change.**

**SLAVICH Then there is also the contradiction of our contemporary belonging to the wider system that is not the microsociological one of a ward or hospital; the problem of the contradictions that derive from the social mandate and the consequences of this on our attitudes ...**

**BASAGLIA Since we open the department,**

**we deny the social mandate and if we consider ourselves within the norm, we believe we have made the revolution and instead we have made reformism. The only ones who came from outside were us and it could only be us who opened the department. Later, this vanguard increased, we were two, ten, twenty, thirty who opened the department.**

**SLAVICH Sure, but now it will always ultimately be you and Jervis and whoever else works in it who will open the C women's ward. The pressure of the hospital as a whole towards the C women's ward, if it is expressed only as advice and says: why don't you open, you could open like we did, it is an uncommitted pressure, it is not an act of breaking.**

**BASAGLIA** **The big problem of the hospital will be when all the wards are open because there will be new problems and it will no longer be the time for denial. Until the last department is open we are always in a phase of denial. When the whole hospital is open we will have the problem of building on denial and then it will be the biggest problem.**

**SLAVICH** **We will really talk about the projection outside.**

**BASAGLIA Reality will truly be on the outside, unless we make a return, out of fear or anxiety**

**back and that we make the whole hospital a large closed ward. Then we become a reformist action, we make the hospital a large liberalized hospital, in which there is a certain norm, certain sanctions and then we believe we have solved the question. We are now still in a typical moment of denial. After all, being a denier is like being in the mountains with an enemy in front of you. And at the end of the revolution to be integrated by America, isn't it? This is more difficult, not**

* **being in the mountains. Our biggest problem will therefore be when we have also opened the C women. There will then be two possibilities: either to truly make a hospital open in the total sense or to make a large closed ward apparently open with a particular mediation towards the outside. But this also depends on how we will open the C women.**

**JERVIS There is indeed a contrast of opinions between Slavich and Basaglia. On Basaglia's part there is a reference to the inevitability of the act of rupture, as an act that precipitates a situation that otherwise never matures: this act is in a certain sense against the norm. On the part of Slavich, on the other hand, there is the need for a department opening which is conceived as a maturation stage towards a new equilibrium. According to Slavich, openness is seen as a necessity that ad**

**a certain point takes place in its successive stages, at a certain point a particular stage becomes necessary.**

**SLAVICH Active action is needed to mature the situation; this is not waiting, in the hope that the situation will mature by itself, but it is a subjective commitment to make the situation mature.**

**JERVIS But in order to make the situation mature we end up resorting to the very thing that you would like to exclude, the threat of openness.**

**SLAVICH It is not a question of threatening to open the ward, it is a question of not opening suddenly, of not putting the nurses in front of a fait accompli.**

**JERVIS Yes, but how can you threaten to open the ward if you are not willing to open it? That is, you tell me: I threaten the nurses to open the ward, so they mobilize in the meantime, but in the meantime I don't want to open it and I wait for them to decide. If you threaten to open the ward and threaten the nurses to open it yourself, you need to be ready to actually open it at this point.**

**SLAVICH It should be said to the nurses: in my opinion we could open the ward in two months if we do this, this and this and in these two months we really do it.**

**BASAGLIA And then there will be other problems and then**

**of the other problems and then of the other problems. SLAVICH New problems are not taken into consideration. It is not important to solve all the problems that pose them, it is important that they mature in this time and in this time they see the date on which it opens approaching. As in the end, that's what happened to the men's C department. In ward C men it was enough that among the nurses there was someone in favor, to be able to do so; but from a certain point on there was a consciousness of inevitability**

**opening.**

**BASAGLIA Of course, to carry out an action of this kind you have to start in a few, unfortunately you start in a few.**

**JERVIS I would say that there are always a few, because if there are many, it means that things go too slowly. But the danger is that these few who make up the vanguard in the first place are always the same, and then they fight against enemies who are objectified as enemies instead of being considered recoverable people. The danger of a minority vanguard of the barricadier type is that of shooting possible fellow travelers. So whoever does not run at our pace, not only stays behind, but is an enemy: instead this is very dangerous, because whoever goes a little slower can actually belong to the brigade, and the executions are paid.**

**SLAVICH And actually look, at the beginning we lost a lot of them.**

**JERVIS But it is quite odd that the majority of nurses are now on our side. Am I just out of opportunism? I do not think so.**

**BASAGLIA Perhaps they see no other way of working than this, that is, they think that it is no longer possible to return to traditional work.**

**SLAVICH I think there are very few who think of a good old time. Maybe there is still someone in ward C.**

**BASAGLIA In reality, the open hospital now works with very few nurses. I would say it works with some of the nurses who are in the hospital because the others come in the morning and don't even know what to do but clean the floor. In other words, in the concreteness of anxiety, their anxiety takes concrete form in cleaning the floor.**

**PIRELLA** **I would say that this is one of the big reasons against the opening: they lose the sense of their presence in the department. A head nurse in one of the first days of the opening of the C men said that it was much better before because he was in his clinic and directed the whole ward. Being in the clinic while all the doors are open no longer makes sense, patients can open the door and**

**Leave.**

**BASAGLIA At this very important moment for the reversal of the institutional and traditional situation, anxiety is the condition for working. For example, those three medical assistants who came here to do internships, after a first month did not have the courage to go get the month's money because they felt guilty. They had been anxious for a month and didn't realize that their anxiety had to be paid for. In our community work we never find our role, we resort to the ghost of the role, because we look for the norm, and the norm that we always reject; but being anxious is bad. That is, the moment of denial that we keep chasing is perhaps the determining element of our community work, but I know that most of you disagree on this.**

**JERVIS Yes, on this formulation yes.**

**SLAVICH I don't think negation is so negative, negative to the point that it would seem that it leaves no room for a dialectic.**

**BASAGLIA We are looking for a dynamic and insomniac role, which however we absolutely do not know what it is.**

**JERVIS Yes, we may know what it is, but we continually wonder if it really shouldn't be any different.**

**BASAGLIA I have a degree in medicine for twenty-five years and I understood what I had to do when I came here to do my job. But**

* **a job as a doctor? I do not know at all what a "doctor" or "psychiatrist" job is in an institution.**

**PIRELLA The role of negation, on the other hand, emerges very well. I remember the first few times I was here, one of my worries was that no accidents would happen. One of my main commitments in a department that was opening or was open was that "inconveniences" did not happen; therefore it was an essentially limiting concern. Then I realized that the traditional ward had to be denied.**

**BASAGLIA I wanted to say something else, another of our cases: you shouldn't have an electroshock, you shouldn't be given medicines. Well we give the medicines in a certain way, we do the electroshock, but in a minimal way, we try to deny everything: we will have to go further and understand what they mean and also deny these things.**

**PIRELLA Today a nurse said something that seemed to me very valid on a practical level: "Of course, it seems to me that now is the time to discuss whether to refuse drugs."**

**JERVIS But in short, what does a closed ward mean, what**

**does it mean open ward?**

**BASAGLIA It seems to me that you mentioned this before, what it means.**

**JERVIS So let's ask ourselves: why do you want to open a department? I mean, why does all the efforts go there at some point? In many respects there is an anxiety of perfectionism to be able to say that the whole hospital is open, to be able to say: I have opened that ward, to have the satisfaction of creating chaos and then being inside with nurses, sick in the new anxiety situation, etc. But from the institutional point of view, from the point of view of the destruction of the hospital, what does this mean?**

**BASAGLIA I would say that from an institutional point of view, it is a personal need that is inscribed in the general meaning of one's political position. It is not that our job is to open departments, but to the extent that we are psychiatrists who act in a given institutional reality, our commitment is to break the institutionality of the reality on which we act.**

**JERVIS From the institutional point of view, the opening of the ward can perhaps be justified as the violent breaking of a balance scheme in search of another balance scheme. With the doors closed, the department has its own balance, its own dynamics, opening the doors is forced to look for a new one**

**dynamics and a new balance.**

**BASAGLIA I would say** **that a new balance occurs only when all departments are open, in my opinion. There is still now an unopened department that allows us to continue denying: afterwards we will have to go in search of another denial to deny practically everything.**

**JERVIS Yes, in short, opening all departments brings us back to reality; as long as there is still a department to open, there is basically this false problem of opening the department. In a sense it is a problem that absorbs all other problems into itself. These, on the other hand, will be clearly re-proposed only when the last department is open.**

**PIRELLA The meeting we held on drugs demonstrates that the first denial of the asylum reality is the creation of a hospital reality. We are already living the next step: it is the denial of medical reality.**

**JERVIS Then I agree. When I said before that the opening of the ward is not the real problem, I did not mean that the opening of the ward should not be done because it is secondary; I just wanted to say that I have the impression that as long as all the departments are not open one remains in prehistory, that is, one remains in a mental asylum in which there is always a timeless corner.**

**When all departments are open, it goes down in history. BASAGLIA Our problem is to be a community**

**therapeutic on denial and not a therapeutic community that starts from an already reformed base. Let's admit that we enter with all our staff in a situation like it is now, in an open hospital, what would we do? Certainly our attitude would be very different from what it was at the beginning. If we leave here, we suppose, and another distinctly different staff comes, they certainly do a different job from ours; it would no longer be a work based on denial.**

**JERVIS In a certain sense, it is now very easy to do anti-psychiatry.**

**BASAGLIA No, we do non-psychiatry. JERVIS After all departments are open, you have to**

**to be able to establish more clearly what our enemies are in order not to weaken the denial of psychiatry.**

**BASAGLIA It seems to me that if the revolution needs violence, our violence is. the opening of a department.**

**JERVIS For something to be done after the opening, the anti-psychiatric tension must be maintained, otherwise we end up in reformism, in perfectionism.**

**BASAGLIA, We would be in the impasse of all situations**

**underdeveloped.**

**JERVIS Yes, but at this moment we are still hospital breakers; I truly believe that in order to pass from the breakdown of the hospital to the breakdown of psychiatry, we need to make a qualitative leap.**

**BASAGLIA We do it at the same time: the rupture of the wards, and the rupture of psychiatry.**

**SLAVICH By opening all the departments we are just at the point where debts are abolished and land is given to the peasants. However, at this moment, when all the departments are open, the problem of the psychiatric nature of our work arises more urgently.**

**JERVIS Yes, only that Basaglia rightly says that there is a way, which is not just any way, in which the opening of the departments is done. This is already a premise for a further denial, for a challenge to psychiatry that goes far beyond the simple denial of the traditional asylum reality: we therefore do much more than claim that wards must be opened. So there is already preparation for future work when the departments are open.**

**SLAVICH When all the departments are open it will be possible to begin to attack certain mechanisms of power within: for example, the fact that certain patients are forced to save by certain people. This**

**of course it will be a pretty big problem. JERVIS In a certain sense I would say that we can be**

**quite optimistic that the opening of the department is a problem and not an end.**

**BASAGLIA It seems to me that then there is the fact that after the institutional denial the psychiatric problem arises.**

**PIRELLA At this point it seems to me that the psychiatric problem should be clarified.**

**BASAGLIA The fact is that we don't really know what modern psychiatry is, because most likely modern psychiatry is nothing more than a perfectionism of the old psychiatry. It is nothing but the perfected hospital.**

**PIRELLA Modern psychiatry is nothing more than an attempt to make exclusion less obvious and more muffled.**

**It may be interesting to report, as an example of practical verification of the previous discussion, what were the opening times and methods of the last two closed wards, the C men and the C women. Although the degree of involvement of the entire department was different in the two cases, in both cases the constant pressure of what is called the "vanguard" in the discussion, formed by some doctors, by the**

**psychologist, the social worker, and some nurses, to reach a decision that, however you want to consider it, is always an act of qualitative break with the past. The attitude of the patients oscillated between the continuation of institutional dependence and an ambivalence regarding the problem linked to the opinions of the staff. However, a clear favorable opinion was expressed by some.**

**The doors of the men's C department were opened on July 14, 1967. Over the last year, this was preceded by a series of liberalizing decisions. The most significant of these concerned the growing number of patients who had gained the right to leave the ward when they wanted to without being accompanied. In the days preceding the opening, it was decided to check, during the ward meetings (nurses and patients, particularly the first ones), of the concrete possibility of opening the doors. The medical team and a certain number of nurses expressed, with greater or lesser vehemence, the need to open the ward without doubt, while some hesitation and opposition came from some of the staff. The stages of the decision were these. During the meetings it was initially decided that the opening would take place near the annual festival that would be held in**

**first week of August. Subsequently, also due to pressure from impatient people (the anxiety of waiting perhaps seemed intolerable or absurd, as it was not linked to any specific "preparation") the opportunity to open the department immediately, much sooner. The date was set for July 17, a Monday. This decision was the result of a meeting which took place on 13 July.**

**The next day the ward was opened with a significant demonstration. There was even a toast with orange juice, wanted by a patient, leader of another ward, who had witnessed the opening, and who wanted to be photographed while throwing away a bunch of keys. In other words, the decision was anticipated with a choice of the ward, favored by the presence on shift of a head nurse who warmly supported the opening, with other nurses in solidarity.**

* **it should be noted that the final involvement of that part of the staff that had always opposed the opening went through an interesting contradictory element. In other words, it was highlighted that only with the opening could the department definitively lose that negative connotation that had made it the place of the last excluded. This was made manifest in a sensational way with the repeated request by a patient of the ward, hard-working and "useful" for the cleaning work, to change ward. The obvious impossibility of opposing this request,**

**which relied on the transition from the closed ward to an open one, made it clear that stiffening in a position of refusal would keep the ward in a condition of degradation and "confinement". The "best" of the inpatients would slowly leave and the rest of the hospital would be tempted to transfer the**

* **worst ". The opening of the department thus responded not only to a decision of the "avant-garde" but to objective requirements that cannot be contested. Paradoxically, the closed ward in an open hospital is forced to deny itself.**

**In the last few months before the opening of the C men, the existence of a similar problem for the female half of the hospital had been largely overshadowed. This fact persisted even after the opening of the last closed ward for men, as if the success achieved in having completely opened one half of the hospital made it impossible to think of anything else.**

**When attention turned to C women, the general assembly constituted the natural place for a re-proposal of the problem: the last closed ward became the fault of everyone, but in particular of its nurses, who felt implicitly accused of not carrying out the step that everyone now expected from them. The problem at this point was taken further by setting up a weekly meeting for nurses**

**of all the female wards: here, the nurses of the C were further blamed by their colleagues, to the point of touching a feeling of inevitability and paralysis. Not entirely wrongly, they felt there that they were being forced into a role of "scapegoat" for the hospital. Within their group, a small minority that adhered to the need for avant-garde began to mature in this period: however, it did not manage to structure itself and find a leader, who would oppose the people who dumbly continued to boycott the liberalization of the department.**

**The result was an almost fatalistic adherence to the opening project, and finally an attitude of passivity towards the director and the management team, who "in any case would have opened the department".**

**This de-accountability de facto delegated to the team the task of setting the date for the opening. First it was envisaged as imminent, "before Christmas", in a generic time that allowed to postpone any "preparations" for the opening (in particular, the transfer of some patients to other wards already open - "the problems" - decided by patients and nurses of the sending ward, discussed and accepted in the destination ward). The deadline was then made more pressing, "within a month" for "preparations" to be accelerated. But it was noticed that all the preparations**

**they could be considered insufficient to guarantee the possibility of opening, and that the length of time up to the deadline was filled with ambiguous justifications.**

**So on the evening of November 21, in the weekly meeting of all the nurses, the director asked: why not tomorrow? and nobody wanted to oppose.**

**The internal dynamics of the nursing team as a whole had undergone an evident change, and the nurses assumed the responsibility of managing the ward after it opened, of dealing with the new situation, while refusing to make it their own as free protagonists of the overthrow.**

**Domenico Casagrande**

**An institutional contradiction:**

**the alcoholics department**

**BEN. I am against alcoholics living among themselves and if someone told me to come to the *community***

***social* 29 I would immediately ask why. I prefer to live together with others because I find that the problem of alcoholics is the same as that of others, of other patients suffering from other diseases, let's call them mental as well. I personally am against it because living with other alcoholics in other institutions, I heard them say at a certain point: but we are not crazy, we are alcoholics and that's it. Instead I think that the problems of us alcoholics and those of other sick people are the same.**

**CASAGRANDE In addition to the reasons just mentioned and which seem to me to concern the general problem of the relationship of alcoholics with other patients, are there, in your opinion, other reasons more closely linked to the structure of this hospital or not?**

**BEN.Yes, it bothers me to see an alcoholics ward alone, for example to see the nurses who, unlike their colleagues in the other wards, do not wear uniforms, to see alcoholics together, to often make their own food and so on, it seems to me something that is unfair in short. I would prefer to see alcoholics together with other sick people, not only because they have the same problems, but also because then we should put the schizo with the schizo, the depressed with the**

**depressed and so on, while here we tend to live all together.**

**CASAGRANDE If I understand correctly, in your opinion, a structure has been created that contrasts with the rest of the hospital?**

**BEN. Yes, yes, just that; in fact I talked to other alcoholics who unfortunately are not here now, inviting them to come with me to participate in this meeting and they replied: "No, there in the alcoholics department we have nothing to do with the others".**

**This dialogue was extracted from the recording of one of the daily meetings of the hospital's only ward that was formed using a nosography parameter). In fact, seventeen alcoholics live in this ward, called the social community. However, the patient who intervenes here is not part of this nucleus, but has asked to take part for some time in the meetings of alcoholics as an observer. After a period of about ten days, during which he apparently participated passively, when one of the patients raised the question of how those living in this ward are viewed by the other members of the community, he intervened, as demonstrated the documentation, questioning the validity or otherwise of the existence of this relationship structure**

**to the institution as a whole.**

**As is clear from the dialogue on the one hand and as indirectly confirmed by the problem posed by the inpatient of the alcoholics ward on the other, Ben poses himself as a lucid and aware spokesperson of a contradiction present in most of those who live and act in the hospital community. they patients, doctors or nurses.**

**Ben's complaint is reflected in various intolerances that have gradually manifested themselves over time, up to their conclusion in acts of rupture.**

**The hospital is now experiencing a situation of free movement and free communication, in which contradictions are exposed and present themselves at all levels. Now we are in a crisis that requires a reconsideration of the meaning of the alcoholics ward, a crisis that is highlighted, after the dialogue reported, even in a meeting of the treating team, where we find ourselves analyzing the reason for the existence of a ward that until then it had seemed the most advanced solution and in conformity with the general organization.**

**The alcoholics ward was born a year and a half ago, that is in April 1966. This is a difficult period in the history of the hospital. Two wards are still completely closed, community general assemblies have started from**

**about six months, not all departments still have their meetings. It is at a time when the institutional overthrow still in progress, the denial of an old concentration organization, which results in the debasement of man, and the stripping of his dignity, are starting to create a new organization whose evolution is unknown and cannot be predicted over time. In such situations, anything that takes place which denies the traditional institution has value and takes on meaning; in other words, anything is well done. This is the moment when the therapeutic community takes shape and begins its expansion within the hospital. However, it would be wrong to think that this department arises only to be *à la page* ; on the other hand, its constitution corresponds to a need as has happened for all the achievements that preceded it and for those that will follow it. In fact, in the modernization of the men's acceptance department we find the roots of his training.**

**After the restoration, the patients, who during the work had been divided into groups and located in different buildings, find themselves reunited. However, they carry with them elements of diversification that had gradually formed and consolidated in the previous subdivision. Thus we find on the one hand the "dispensaries" (ie those hospitalized with mutual aid obligations) that have the**

**ability to more or less refuse hospitalization, enjoy greater freedom of movement, live in separate rooms from others and have better food. Next to them are the psychotics, considered as those who need assistance most, because they are weaker, as they find it more difficult to blend with others and who until then had participated in a psychotherapy group set up precisely for the purpose of strengthening their weak, and in order to facilitate their insertion with the other patients. Then again we have alcoholics and they too had participated in psychotherapeutic sessions until then, tending to exploit the fact that these patients spent the various hours of the day together, forming a homogeneous nucleus, which reduced contact with the other patients to a minimum. Finally, a last group comprising the neurotics, the depressed, the organic, the old. There is therefore a problem of homogenization of these four categories, which certainly do not correspond to nosographic needs, but rather indicate four different social connotations resulting from a particular situation. How can we fail to recognize first-class privileges in dispensaries? And are not psychotics the "incomprehensible", those who are considered the only and true "madmen", from whom one must continually differentiate oneself and who would be better off admitted to the closed ward? Alcoholics are not the same**

**vicious, guilty of not having willpower, more in need of severity and a hard pulse? And finally who are the others if not people who are hospitalized to rest or to escape their work commitments, or old moaning senseless, or people who cry without any purpose, ultimately "pain in the ass"?**

**It is certainly not easy to homogenize the privileged and the oppressed, between the guilty and the pariah. It certainly does not seem a solution to extend psychotherapeutic groups also to others, both for theoretical reasons and, even more so, for practical reasons. In fact, there is no time to continue even those who had already started and moreover it becomes extremely difficult for the doctor to play at the same time the double role of psychotherapist and community sociotherapist. However, the problem must be solved and the most suitable way, given that a wing of a long-term ward has also become free, seems to be the removal of alcoholics. But why them, one wonders, and not any of the other categories?**

**There are many considerations that have led to favor this group: first of all it is the strongest and most numerous, it is the one with the greatest number of relapses: we find ourselves acting in a province included in one of the regions with the highest incidence of alcoholics. Furthermore, their separation suggests a greater possibility of**

**cohesion among the remaining classes. We are heading towards a new experience whose evolution we do not know how to predict and which we hope will lead to elucidations in the field of alcoholism.**

**Thus begins the life of the new department which starts with a first group of patients including all those who had been part of the psychotherapeutic group. As places become available following resignation, more alcoholics are introduced, mostly from the acceptance department. The choice criterion is the high number of relapses and the difficulty of solving social problems. Therefore in this new ward are always welcomed inpatients with not recent alcoholic addiction, many of them with various previous experiences of hospitalization in traditional environments, with various episodes of different types of acute intoxication and with signs of mental deterioration behind them. Furthermore, for the most part these are people who have already been "established", that is, who, according to the 1904 law on psychiatric assistance, have passed the observation period, are therefore associated with the hospital and socially stigmatized.**

**The ward is totally open, includes a maximum of seventeen patients and to date it has registered the presence of sixty-two people. It is governed by the community according to the canons of self-government. Meetings are held in the evening**

**daily in which patients, doctor and nurses participate, in which all kinds of decisions are taken together. These meetings represent a moment of mutual verification and contestation, with all the limitations and contradictions that this approach entails (see for example the essay on self-government in this same volume). Different phases can be recognized in the evolution of the department.**

**At first there is a refusal of collaboration. Absences from meetings are numerous, everyone tends to be on their own and tries to create their own space outside the ward. But precisely the difficulties they encounter in the relationship with others, due to that sort of formation of dynamics of bad faith and mutual incomprehension that are established between alcoholic and non-alcoholic, determine the return to the group. Participation becomes more active, by now the "community culture" is becoming a common patrimony, the common therapeutic goal that unites doctor, nurse and patient is gradually recognized. The example of the first ward straight to the therapeutic community becomes a model to follow. Union is found in moments of discussion ranging from elementary facts such as food to more complex ones that also involve a greater sense of empowerment. The patient thus gradually becomes aware of his decision-making possibilities**

**as part of the management of the department and the formation of the rules that must govern it. He begins to feel it as his own thing, which belongs to him and no longer as something that is arbitrarily imposed on him from above. At the beginning, in fact, he was considered as a person who is estranged from others, who is not allowed to stay in the acceptance department and wants to bring him closer to long-term patients, which is why he does not intend to accept his new accommodation, he tries to to move away from it, to sabotage it, but when he experiences his own difficulties in relating to others, he returns to them, discovers new possibilities, feels reassured and prepares to defend him. In fact, it is from this first period that those who escaped the department sought to integrate themselves at the level of the general community, so that some who direct their attempt to insert themselves in the general assembly experience their difficulties right here, are continually stigmatized by the others, whose grievances on the other hand they cannot bear, which are sometimes raised against them. Then when they manage to reach some position of a certain responsibility (such as the presidency of the assembly), they are unable to complete their task. Their attempts at exploitation are almost always demystified from the beginning, remaining in front of others without any defense, without any**

**screen behind which to hide. At the bar, where everyone can have a daily beer, they often feel refused even this. That is, they realize that they are *hospital alcoholics* , for whom there is no understanding. If one screams, argues, becomes boring, after all the community bears it, if one drinks a few more beers at the bar and then disturbs, after all he is understood and supported, but if one of the alcoholics department does it, here is the margin of endurance no longer exists, suddenly it is annulled and he becomes the scapegoat for all tensions. The ward meetings of this period are often resolved in long silences and the few interventions by the patients tend to underline a climate of oppression or develop vaguely persecutory themes that are the index of their rejection by the hospital community. Here arises the need to create one's own space as an alternative to the exclusion of others.**

**A second phase then begins which we would like to define as settling. More and more initiatives are taken and tasks are distributed. In this period, some stand out for their abilities, gathering the consent of others. In this way the first leaders are formed, who are those who propose initiatives, which they bring to completion while also making others responsible. They act as spokespersons for the department in general community assemblies and make up a point of**

**alternative reference to the doctor and nurse. When the alcoholic tries a sortie, still looking for a relationship with patients from other wards, he experiences a further defeat which results in a further conviction of his marginalization. This leads him on the one hand to consolidate his trust in the group, in which he feels reassured, and on the other to become aware of having found a different way to deal with others, other than his own alcoholic addiction. In fact, in the group he realizes that he no longer finds himself in front of a blind and objectifying authority, which he cannot oppose, which constantly blames him, which forces him to his own dependence as the only possibility of a relationship, albeit reified and objectifying. That is, he does not experience a situation that oppresses him, but a conflictual situation in which continuous alternatives are proposed to him. It is no longer the other who chooses for him but it is he who continually finds himself in the possibility of being himself. However, he experiences this only in the ward where he gradually discovers his own ability to stand up to the other and discovers that he can live with the other without disguising himself or lying. That is, he feels "understood and accepted", while when he is outside his group he continually feels a brand that haunts him and forces him to a role he does not accept. Therefore he seeks in his group a continuous maturation of relationships**

**reciprocal, an ever greater search for clarity and awareness, a better homogenization. In this phase the department acquires greater strength, it sets itself as an example to the other departments by virtue of its initiatives (trips to the city, dinners, outings, organization of parties). It also initiates relations with the outside of the hospital, both by virtue of the initiatives mentioned, and by making more and more family members participate in the meetings. It is precisely in this period that there is a tendency to reject the denomination of alcoholics ward and the name of "social community" is expressed by patients and nurses as a symbolic attempt to reject exclusion, reversing it into the community underlining of the current experience. At the same time, however, relations with the rest of the hospital community are becoming increasingly rare.**

**The participation of alcoholics in general assembly meetings is increasingly sporadic, the rare times that they intervene they do so in groups for the sole purpose of exploiting it for some project they have in the pipeline: they are the only ones who do not take part in group trips. Individually they try to monetize themselves as much as possible in order not to expose themselves, on the other hand placing all of themselves in bringing the department to a cutting edge position. This is their way of reacting to the exclusion of the community to which they responded by setting up a leadership department which in turn tends to**

**to exclude. Now they feel that they have something constructive to oppose to others, with satisfaction they see that other departments are also following in their footsteps. It reaches its climax when the whole assembly decides that for the New Year's trips each department will have to take an interest in its own. The alcoholics department thus deceives itself that it has won its battle. The whole hospital is now open, free movement has become possible for everyone. Communications between the various departments and the various patients are also more liberalized. There is a greater possibility of exchanging views, there is a greater need for discussion even outside the institutional settings represented by the various meetings. Alcoholics thus realize that their kfro space is too small; they feel the need to expand it, they have now become aware that ultimately the mechanism that led them to hospitalization is the same as that which led to the other patients; that is, they become aware of their exclusion from society. It therefore seems logical for them to attempt homogenization with the rest of the hospital. A party is then organized offered by the "social community in favor of the hospital community"; for this realization they are praised and thanked by all. This is therefore considered the right time to launch. In this counter-offensive, however, some significant facts are not kept in mind.**

**In fact, it had already happened for some time that some patients from other departments, advised by the doctor and accepted after presentation and discussion in the alcoholics ward, then manifested regressive behaviors. Take for example the case of Giovanni, who was offered the possibility or not to transfer to the alcoholics ward, where he could better face his difficulties. He actually experienced this invitation as an order. In the following days he made continuous gestures of breaking. Asked for an explanation, he claimed to have been forced to move, as he had realized that, with a refusal, he would not prevent the doctor from finally obtaining, with persuasive attitudes of pressure, what he intended to do. If on the one hand this was a behavior that tended to undermine the role of the doctor, seen as an oppressive authority, on the other hand it emphasized the rejection of a condition that was perceived as negative. This was also corroborated by two other cases of former patients in the alcoholics ward, who, hospitalized for a relapse in the acceptance ward, refused the transfer, although on the other hand they actively and spontaneously participated in the meetings. Often then it happened that during the meetings of the various departments or the general assembly, when some cases were questioned of people who had abused alcohol during leave or temporary expulsion, disturbing**

**then all of them on their return often felt the threat of being sent to the alcoholics ward, which was therefore no longer experienced as a privileged place, but as a place of punishment.**

**When the alcoholic carries out his own intention of homogenization with the rest of the community, he finds a different reality from what he had imagined. The hospital's free communication brings him back to the contradictions he had scotomized when he lived in the narrow world of his ward. So when he participates in general assemblies he suddenly becomes aware that his unit, which he had so jealously defended up to then and which he believed to be the best, is considered by others as a place of punishment. He feels that the phrase that had been circulating for so many years and that he too had used: "If you are not good we will send you to ward C" (the closed ward), has been replaced by the other: "If you drink and disturb us, we will send you alla frasca " 30 He therefore realizes that he is even more stigmatized than before. The complete opening of the hospital in fact brought as another consequence the discovery by the community that the inmates, those who were held either because *they did not understand* , or because they *were bad* , or because they *ran away* , and therefore *irresponsible* , were basically like everyone else. Only achance had meant that they were the last to be "released". After all, they demonstrate that they take over in a way**

**responsible for the new space that is granted to them and on the other hand underline, in a more conspicuous way, the alcoholic's difficulty in taking possession of his own space which is either dilated or restricted always beyond measure. So now**

* **the alcoholic who becomes the irresponsible, the one who breaks the rule.**

**Here then is suddenly clear to him the difficulty of transferring, here again he experiences the department not as a place that the institution has created to help and defend him, but to defend himself from the self-destructive mechanisms that he sometimes puts in place. Coming into contact with the other departments, in fact, he realizes that the tolerance margin that others have towards the alcoholic co-adjutant is high and that only when a certain limit is exceeded does an exclusion mechanism trigger and this, coincidentally, directs him towards the alcoholics department. At this point he is offered a choice, either to fight his own exclusion and join the others, recognizing them as himself or to be defeated again.**

**In fact, the alcoholic who arrives at the hospital is already excluded, in a society that does not understand him and does not accept the weak, so he pushes away from himself what, although his own, he does not want to recognize, objectifying it and making it other than himself in order not to be forced to question yourself.**

**The alcoholic is then entrusted to the institution, to be removed from sight, to be preserved there or at most returned as society wants. "Give him a few tablets that will stop him drinking", "Make him taste better", "When he doesn't drink he's so good, he listens to me, he does everything I tell him, it's when he's drunk that he always has to complain": often these are the words that accompany him at the entrance. However, he finds himself in the same situation as all the other inpatients and disputes in the only way he knows: that is, by taking advantage of the freedom he enjoys by drinking and carrying out breaking gestures. Here, however, little by little he experiences a new possibility of relationship, he becomes more closely linked to the group, in which he finds himself, in which he no longer feels rejected, and uses it as a gym. In the group then he strengthens himself and with the group he enters into**

**competition with the rest of the community. At the same time he becomes aware of his own exclusion, which is also that of the other patients in the community, in which he finally succeeds in recognizing himself. However, when he tries to establish an equal relationship with the other patients, he finds himself thrown back into the starting situation. In fact, he is not**

**Luigi or Mario, but he is Palcolista, he is the culprit, he is the different. It is only the case that even in a situation where all the labels are placed in parentheses, one feels the**

**its like Punic. He is thus objectified again, compressed into his space from which he has desperately tried to escape, he falls back into an even more tragic situation than the one he had tried to leave behind, as he becomes aware of being excluded in a community of excluded. His task at this point becomes extremely difficult. There are too many fronts on which he must now commit himself, he is assailed by an anxiety that he is no longer able to dialectize, therefore he tries to challenge the institution that locked him up in the ghetto. He tries to put it in crisis by adopting the weapons it has given him, but no longer in a constructive way, but destructive. The only thing left for him to do is destroy this department which proves to be only a contradiction in the new situation that has been gradually evolving.**

* **against this background that the department is in crisis. The crisis therefore has a sense, it has a meaning, it has a purpose. The institution can no longer ignore this situation, it must make it its own and clarify it.**

**Here are some of the most salient passages from a recording of the meeting of the care *team* :**

**BREGANT In my opinion, what has come to change in the department is the system. In other words, I am saying that the dynamics of the system crystallized with the almost total absorption of all the initiatives. That is,**

**I would like to say that somehow there has been an involution. We now ask ourselves: what should we do? Looking for new initiatives, greater flexibility in the awareness of each individual? I don't know, but I feel that somehow the system needs to be overhauled and revised.**

**CASAGRANDE It seems to me that before being able to seek solutions, we must ask ourselves why this situation has come about. At the moment of the beginning of the experience one of the inconveniences that we tried to avoid was that the maturation process of the group took place without giving rise to breaking actions that had involved it, now instead we find ourselves right in front of this reality and in my opinion this fact has its origin in the problem of the integration of the social community with the hospital community.**

**TRONCAR The fact is that the social community, whenever it has confronted the general community, has adopted the technique of trying to exploit without putting itself in crisis.**

**BASAGLIA** **If we think about the personality of the alcoholic, it is undoubtedly difficult to think that, in a community situation like ours, he is able to question himself in order to enter a crisis. It will hardly take these risks. I think like**

**group has too much strength to suffer such an attack from the hospital. Instead, it seems to me that what Casagrande said should be discussed. What are these spontaneous alcoholics who are aware of their addiction? These are people who drink excessively, many of whom enter forcibly, against their will and are then sent to that ward because the general community or the doctor so wishes. Eventually there is a pedagogical attitude of the community that leads them to a certain situation. What's more, this is a particular alcoholic ward compared to other similar wards, because it is a community that lives in the midst of another community of sick people.**

**CASAGRANDE But in fact I have asked myself several times why alcoholics here who even recognize their addiction refuse to be called alcoholics, which happens to anonymous alcoholics, for example.**

**BASAGLIA Of course, because in our case it is a community within another community that considers alcoholics in a particular way.**

**TRONCAR Here every time someone claims to be an alcoholic is immediately blamed.**

**DI CECCO Yes, but we hear every day saying: I'm here**

**because I am very addicted to alcohol and I can't help but drink.**

**BREGANT I would like to give an example of these days, Giuseppe B. who at first denied that he was a drinker, in the end he recognized his addiction, but did not want to call himself an alcoholic.**

**BIG HOUSE** **In fact, it is evident that they reject the appellation of alcoholics, as for them it becomes a brand that connotes them negatively, that is, they are placed in a disadvantageous situation compared to the others, with no or scarce possibility of defense.**

**PIRELLA I wanted to remind you that some alcoholics in the admission department admit very easily that they have this problem and I propose that this happens, because these people are not in a situation of social ostracism and therefore do not need to defend themselves from a 'slanderous and degrading accusation.**

**DI CECCO There is a possibility that a patient, having to choose between being an alcoholic or mentally ill, will probably prefer to be an alcoholic.**

**BASAGLIA However, I would say that the central point is what Pirella has touched, that is, the relationship between alcoholics and non-alcoholics in the hospital.**

**PIRELLA** **In fact there is a social characterization of the alcoholic with respect to the non-alcoholic and vice versa, there is**

**that is, a misunderstanding that exists, as between the good and the bad. In fact, the person who is bad is never understood by the good and vice versa: they are two poles of an antinomy. That is, there are two categories, that of the excluded and that of the non-excluded. And I would say that alcoholics with regard to the rest of the hospital is really a situation of exclusion.**

**BASAGLIA But this dynamic of exclusion begins in the other departments. In fact, the other patients are never told: that is a schizophrenic, that is a neurotic and so on, while the only one who is still indicated is the alcoholic, and even if the others are stigmatized, they are not labeled anyway. In the first case the person is questioned, in the second not.**

**From the discussion it emerges that by now everyone has become aware of the crisis and the first impulse that arises is to do something, to intervene in any way ("looking for new initiatives ... the system must be reviewed and revised", he says at the beginning a nurse). In the remainder of the meeting, solutions are always proposed:**

**BREGANT ... the individual who comes out of the hospital is put in a mess, so we have to**

**give him outside help.**

**DI CECCO The hospital must also move outside ...**

**PIRELLA** **The ward could be transformed, no more alcoholics, for example a small ward for the recovery of those more institutionalized patients.**

**CASAGRANDE It could be a good idea.**

**But all these claims, all these searches for a positive solution are nothing more than an attempt to disguise the failure of the company. The experience was born out of a practical choice determined by the evolution of the hospital and supported by a methodological need that found its fulcrum in the denial of exclusion. But precisely these two aspects of the same reality, the practical therapeutic choice and the refusal of exclusion, contradict each other. The institutional reality which, too, has been modified by this experience, originally born of a necessity, now reveals its contradiction in its need to reject it.**

**John Jervis**

**Crisis of psychiatry**

**and institutional contradictions**

**The main purpose of this paper is to examine some problems that arise in the management team of a psychiatric hospital. These are problems that can be examined from various kinds of considerations. In the first place, those that arise directly from the concrete experience of a determined team, which in our case is represented by the "staff" of the Provincial Psychiatric Hospital of Gorizia. Secondly, those that refer to a general examination of the position of those who work in any psychiatric institution, inserted in a specific social reality. Finally, those even more general considerations that derive from the awareness of the choice of one's own theoretical tools of analysis, in an institutional context.**

**The problems that we propose to ourselves derive directly from a particular practice, that of a psychiatric hospital, and cannot be generalized immediately: their origin and their field of empirical verification remain sectorial, limited to the field of action of a daily work that is takes place within an institution. On the other hand, the same criticism that examines and modifies an institution from within it inevitably expands into awareness and positions that aspire to have a meaning even outside its borders.**

**Beyond the "criticism of the asylum" and indeed fin**

**from within it, ideas for analysis appear, but also for active experimentation, which go beyond the themes of "humanization" and "modernization" of psychiatric care. Inevitably, new problems that are not strictly institutional arise. These problems depend on the one hand on a more accurate investigation of the asylum condition, which demonstrates its connection with the societal instances, while on the other hand they refer to a series of theoretical investigations that involve all psychiatry, and the crisis of its aims. . Finally, the crisis of psychiatric institutionalism does not refer only to a general criticism of institutions in the strict sense, but tends to question, with psychiatry, the validity of "technical separateness" as a particular form of division of labor and as a repressive institutionalization of power.**

* **our belief that the analysis of mental institutions and their crisis provides a particularly fruitful point of view and a series of operational criteria to reveal, in a series of in-depth studies and checks, some of the "cultural" deceptions that seem increasingly necessary, today, to maintain the corporate status quo.**
* **it is good to realize, from this point on, the presence of a double and symmetrical danger: that**

**empiricism and that of generalizing and unverified abstractions.**

**The danger of empiricism arises from the inability to apply appropriate tools of theoretical analysis to what is the starting point of all mental asylum criticism: indignation at the inhumanity of the traditional asylum. This indignation risks proposing reforms that are prisoners of the same structures that generated it. The proposal to empirically reform the psychiatric hospital leads to an ideology of the therapeutic community, and only postpones the underlying problem. On the other hand, reformism is the first response to the typical de-responsibility attitude of psychiatrists who run asylums: sometimes in good faith, they believe that they cannot do anything to truly change their institution, and they hide behind the sins of politicians and administrators, who do not provide laws, regulations and funding. In reality the asylum images (oppressive, old, crowded rooms, misery of people and things, technical neglect and delay, hidden and explicit violence, brutalization in inaction) fully justify the temptation of empirical reformism: it is necessary to do something, immediately, to even slightly change a very serious situation. This need must be respected, and encouraged with all the greater force, the more it is true, and verifiable, than the structures**

**asylum organization can be changed by the doctors directly responsible, only if they so wish. The indignation referred to must lead to the identification of a guilt, and indeed of precisely identifiable guilt 31**

**Therefore, if on the one hand the idea of responsibility and direct fault of mental hospital doctors demonstrates the possibility and the need to "do something anyway", even on the level of simple empirical reformism, on the other hand it is quite true that this reformism constitutes the ground for verifying the real intentions of its promoters. At this point, either reformism is passed off as a solution to the asylum problem, or it in turn becomes a limit, a contradiction, a necessary object of criticism, and a starting point for more radical and coherent proposals.**

**The opposite danger to empiricism is that of an abstract type of denunciation; of a global, extremist and imprecise denunciation. It may also have its value, and the writer believes it has it despite appearances, since the risk of an "angry" bias may be the best way to counteract the old "scientific", "objective" and "balanced" criticisms to the social system. Only, it is not certain that a complaint of this type must necessarily start from the asylum terrain.**

**1 The Gorizia experiment demonstrates, if nothing else, that a more traditional asylum can be radically changed in its structure without any legislative, administrative or financial facilitation and without the social and psycho-environmental conditions significantly differing from those of the most of the Italian provinces. (It can be added incidentally that, in this regard, the main difference between the Gorizia situation and that of the rest of Italy probably consists only in the particularly high percentage of alcoholism problems: an aspect that certainly does not facilitate the work. smallness of the province, there is no doubt that they are largely offset by other particular disadvantages, among which in the first place the serious lack of financial resources).**

**Alluding to some group socializing techniques used in psychiatric hospitals as "modern tools."**

* **in a substantially unchanged institutional structure, there was talk in Gorizia of "sociotherapy as an institutional alibi". In reality, the discourse can be carried further and if today we are happy to talk about therapeutic communities instead of asylums, it can well be replied by arriving at a critique of "therapeutic communities as an institutional alibi" and finally, logically, a crisis of "institutions as an alibi ". The danger of these**

**subsequent disputes do not lie in their extremist aspect, but in their suggestive acceptability: they are easily received in an abstract way, and also appreciated as generally unconventional and "revolutionary". For the same reason, a very superficial discourse on the "myth of mental illness" has been enthusiastically accepted by too many without the difficulties and contradictions faced by an albeit necessary destruction of the traditional image (both "vulgar" than "scientific") of madness.**

**If, therefore, it is necessary to arrive at a radical critique of many clichés and ever new alibis, this can only happen in relation to a praxis. It is not necessary that this is an institutional practice: only, it will be a question of whether an institutional practice allows sufficient verification of positions which, considered in isolation, can rightly be accused of abstract extremism. In this context, it must also be added that if on the one hand the need for new forms of dispute always precedes by one step the implementation of their verification, on the other hand it is also true that one cannot speak of dispute, if not starting each time from a previously verified dispute. Thus, every accomplished experience tends to be validated by its own success, and therefore to constitute**

**his own ideology immediately: but it is from the rejection of this ideology, that is, from a self-criticism, that a further contestation tends to arise.**

**At this point the problem of the specificity of the psychiatric organization arises. The traditional defense of the psychiatric institution always starts from the reference to a technical specificity: the mentally ill must be treated because it cannot be denied that they need it; they must be treated in a particular way, because there are difficulties and technical limitations (which can only be assessed by competent people) which prevent faster, more effective and less unpleasant therapies. In this perspective, on whose falsity it will be necessary to dwell later, there are no direct relationships between the forms of psychiatric assistance and the organization of society. The latter, evolving on the path of progress, will be able to provide better medicines, a greater number of beds, more qualified personnel and more welcoming and better organized premises, but the forms of assistance will always be decided by psychiatrists on the basis of their knowledge.**

**Before returning to this point, it should be noted that there is also the opposite danger: that of believing that the psychiatric organization of a given country is perfectly consistent with the dominant social structure. By giving in to this temptation, it may seem easy enough to centrifuge the problem of mental disorders**

**resolving them in social contradictions, and believing that therapeutic-welfare organizations obey directly the logic of power. The dangers in this regard are to think that power (to get down to a more concrete level: capitalist power) constitutes a homogeneous system, free of contradictions, identifiable in the first person in the "capital" or in the rational plans of an elite of neo-capitalists; and to believe, at the same time, that psychiatric organizations are being modified and structured without contradictions according to the dominant political schemes. In reality, it is necessary to consider the hypothesis that psychiatric organizations are "lagging behind" or "different" in relation to the institutional needs at the level of society in general, that is, despite everything, to some extent they have their own history and specificity. Only at this point will it be possible to examine the "anachronistic" character of institutional structures and to trace, in history as well as in the analysis of the present, the relationships between psychiatric hospitals on the one hand, and psychiatric theorizations, dominant ideologies and the most immediate needs for the conservation of the social order.**

**We will for a moment put the problem of mental illness, that is of "specificity" (in**

**meaning alluded to) of the forms of therapy that according to some make psychiatric institutions as such necessary. In this perspective, it is possible to examine the structures of psychiatric care as forms of control of deviance. We go back to the historical origin of psychiatric hospitals and to what is the current justification of their existence, according to common opinion, the state laws and their internal regulations: the constitutive function of such institutions is not primarily therapeutic, but repressive. Asylums are concerned with defending citizens from some subjects with deviant behavior, once the doctors have established that this deviance is due to illness: subjects "dangerous to themselves and others or of public scandal" are segregated. Starting from these premises, the problem can be placed in a broader context and described according to various formulations**

**32**

* **The institutional framework is made up of social norms. They can be violated, and are sanctioned by violence. The reasons that lead to trample on social noririe derive from anticipated satisfactions of drives. We have always interpreted the world with the eyes of our needs, and these interpretations are preserved in the semantic contents of everyday language. It is therefore easy to see that the institutional framework of a company fulfills two different tasks.**

**On the one hand it consists in the organization of violence which can force to repress the satisfaction of the drives, on the other hand it consists in a system of cultural traditions which articulate the mass of our needs and anticipate claims to the satisfaction of the drives. These cultural values also include interpretations of needs, which are not integrated into the system of self-preservation - mythical, religious, utopian contents, that is, collective consolations as well as the sources of philosophy and criticism. A part of these contents is reoriented and used for the legitimation of the domain system " 33**

**This system of domination undoubtedly includes psychiatric hospitals. As for the "contents" mentioned, they also concern the ideology of the mentally ill and custodial ideology. The legitimacy of all the "organizations of violence" that deal with subjects whose deviance is attributed to mental disorder is based on these ideologies. However, the role of these ideologies does not stop at a simple apology or a posteriori cover of the infamy asylums, just as the infamy asylums are not the only way in which the organized repression of that "anticipated satisfaction of drives" of which it speaks is expressed. Habermas. The culturalized image of madness and its repression is not**

**contains only the global justification of psychiatry as a specialized theorization erected to protect the healthy, but it also serves to reorient the needs of freedom, defining the latter as the freedom of what is "lawfully healthy", as opposed to madness, the image of a freedom not tolerated.**

* **It is very difficult to trace the psychological components of the dominant cultural stereotype of madness, because this stereotype presents itself to us as already institutionalized in attitudes encouraged and sanctioned by social power (civil authorities), and by medical power. On the other hand, we must not be afraid to recognize that here there is a terrain in which very particular psychological dynamics come into play.**

**The importance of these psychological dynamics can only be hinted at, even considering that it would be very difficult to verify them accurately with an investigation. The meaning of prisons can be considered in the first place: the very exclusion of offenders in prisons is an indirect confirmation of the honesty of the citizens who are outside, and is therefore an instrument of social cohesion ("belonging"). The excluded in prisons are necessary to place a safe and non-passable barrier (in both directions) between order and disorder; it is also quite clear what are the acts leading to the**

**prison segregation. As for the institutional sanctions of madness and therefore psychiatric hospitals, it is easy to observe how no one knows precisely how to avoid them. Not only that: each of us feels obscurely that all the learning of a "healthy" behavior is a tiring and always fragile conquest of psychic disorder. The latter is very close, but hidden: always repressed, but behind the door. Here the asylum is identified with the very need to make the category of abnormal behaviors clear and distinguishable. The fact that the "mad" are discriminated against and end up in hospitals defines the boundaries of normality and rewards the images of "acceptable" behavior. The learning of normality here is not the simple search for a balance, but the mutual reassurance of belonging to a world where everything must be controllable and sensible. Those who pay the price due to maintain their mental health know, obscurely, that their sacrifice is too high not to immediately become a privilege.**

**If mechanisms of violence present in the social context are introduced into this exclusion of madness, this means that the attitude of exclusion towards the mad is already permeated with an institutionally approved violence. On the other hand, the violence of society itself comes**

**controlled and sanctioned: only the psychiatrist is substantially free to operate, in his asylum, outside of any social control, indeed invested with a power that society is happy to offer him once and for all. The system continues to protect its victims (even in prisons) only to the extent that the sanction for deviations determines behaviors in subordinates that are still included in the ethics of violence and productivity. The mentally ill, the irrational dross of social rationality, is crushed because he is the only one who totally leaves the rules of the game. Institutional psychiatry is free to address all the violence of society to the insane precisely because the societal norm expels from itself, identifying it in the mentally ill, the "incomprehensible" and "dangerous" image of the possibility of overturning into something totally "disordered" it's different. The healthy person defends himself from the temptation to reject a coherence which is also complicity by projecting in this defenseless individual an aggression which he is not allowed to direct elsewhere and which continually risks destroying him; for the sane, the laborious acceptance of a socially determined "reality principle" requires the temptation to yield to be objectified outside oneself. His "normal" being is thus confirmed by the inhuman mask that he applies to the madman: in refusing to recognize himself in the latter, he**

**gladly accepts the inhumanity of his subordination. The exclusion of the insane is sanctioned and justified by the**

**psychiatry. If there is a general "culture" of mental health and illness, there is no doubt that the psychiatrist is involved. On the other hand, this psychiatrist does not live from an abstract institution himself, but performs a function which is situated in the roles and general ideology of medical power. It has been discussed elsewhere, in relation to a well-known page by Talcott Parsons, of how the ideology of medical technicism is itself largely a mystification. The doctor is an individual endowed with a certain power, and in order to exercise it he needs to accept the myth of the omnipotence that the patient lends him: the psychiatrist, however, unlike the internal doctor or the surgeon, is invested with a much greater power, and it does not make use of its own technical omnipotence to act sectorially on a part of the body that belongs to the patient, but acts globally on the patient, who belongs to him.**

**From this moment it is legitimate to express the suspicion that psychiatry is unable to clearly define the particularities that make deviant behavior its competence. However, there is a preliminary problem: it concerns the danger that the eventual scientific demonstration of the presence of a disease underlying an anomalous behavior will serve to**

**justify an abusive extension in the technical definition of deviance, and thus favor technocratic proposals of discrimination, repression and re-education of deviant behavior. It could be immediately observed that these psychiatrists, who as specialists tend to sequester problems of social competence in their psychobiological universe, are dangerous reactionaries. It may be that they are, and it can easily be seen that they are in fact: servants of power who, hiding behind their incomprehensible technique, work to hide and transmit, together with scientific acquisitions (or without them), very specific ideological reasons linked to the defense of historically defined values and interests. In reality, the reactionary character of psychiatrists' use of the concept of deviance does not imply a political and ideological choice at all: the very idea that a particular deviant behavior can receive a technical definition in medical-psychiatric terms implies the possibility that deviance in general it is defined according to criteria that no longer have anything to do with sociological relativism, and which therefore escape the possibility of political criticism. At the same time, a definition of some forms of psychiatric deviance inevitably refers to general models of normality. The danger is therefore not so much in one**

**"abusive" extension of the technical-psychiatric definition of deviance, as in the very fact that this definition, even if it is applied to a few cases, immediately tends to assume a universal character.**

**Traditional psychiatry had an apparently solid line of defense on this point until a few years ago. According to positivist psychiatry, behavior is abnormal (at least in theory) not because of its phenomenal characteristics, but because it is nothing other than the direct external manifestation of a disease of the higher functions of the nervous system. If it is indisputable that a liver affected by cirrhosis is abnormal, it must be equally clear what the morbid character of insanity and of all mental disorders consists of: a disorder has some intrinsic characteristics that define it as such, it is loss of functions, disintegration, death is not a departure from a conventional norm. In reality, the very concept of disease in general was not at all easy to define, and the assimilation of mental disorders to organic diseases, however, ended up taking place on an empirical and approximate level. Referring to the naturalistic medicine of classical antiquity, and bypassing the same enlightenment and "moral" premises typical of the birth of modern psychiatry in the late eighteenth century**

**and the beginning of the nineteenth century, positivist psychiatry conquered its positions at the end of the last century, consolidating them with the discovery of the syphilitic etiology of progressive paralysis. The existence of treponemes in the brains of paralytics provided the basis for forming the "model psychosis" from which all other psychiatric interpretations of disease were derived, and seemed to promise reconciliation between psychiatry and general medicine.**

**It is generally believed that this "organicist" view of mental illnesses has been superseded by the "dynamic" conceptions introduced by Freud and his successors, and that the old model of mental illness as a disease of the brain has been superseded by the observation that neuroses, and probably even the main psychoses do not develop on any demonstrable lesional substrate.**

**This "modern" conception is still partial and questionable for a number of reasons. In the first place, it is not so evident that Freud constructed an interpretative model of mental disorders substantially different from the mechanistic one: while acknowledging Freud the merit of having made the first and most decisive break with the old schemes, the theory that he has introduced a new type of mechanism, equally deterministic and ahistorical. Secondly,**

**Like, the thesis that in many behaviors labeled as "mental disorders" there is an actual "disorder" (whatever that term means) of higher nervous functions is not at all to be dismissed too casually, and in any case it refers to problems of extreme complexity. Thirdly, it is even questionable whether positivist psychiatry was really founded, in practice, on the model of disease borrowed from general medicine. Throughout the nineteenth century and until today, psychiatry has continued to define its field of action by marking the external boundaries of a taxonomic system based on the grouping of "typical" behavioral disturbances into nosographic systems and subsystems. In other words, the classificatory effort, in the impossibility of making psychiatry a science, continued, in practice, to found an empirical system based on the phenomenal description of behaviors, rather than on the reconstruction of objective dysfunctions that could not be revealed.**

**The crisis of positivist psychiatry actually occurred for a whole other series of reasons, which can perhaps be summed up in one only: the impossibility of including behavioral disorders among phenomena that can be objectively described in naturalistic terms. In part, there is no doubt that it was an empirical failure, a general bankruptcy: psychiatry, whether it is**

**considered in the medical disciplines than in the human sciences, it has kept very few of its promises. Little or nothing is known about the cause of the vast majority of mental disorders; as a therapy the situation is not much better, and if it is known that drugs have little more than a symptomatic effect, on the other hand there is still doubt about the meaning of psychotherapy. On the theoretical level, the failure of "medical" psychiatry has led to a series of other attempts at synthesis: it is the whole history of contemporary psychiatry, from Freud to the present day. To understand how much the situation has changed, it is enough to read the old writings of Kraepelin, or Babinski, and compare them to the "moderns": to Sullivan, to Binswanger, to Laing. What is striking in the clinicians of the late nineteenth century is the extraordinary respect for the *facts* . Mental illness is there, present in the mannered gestures of the schizophrenic as in the cortex of the demented: for the scientist who observes them, these are sensory stimuli all the same, objects to be collected and processed as data of a system. Indeed, the mentally ill is already a system to be discovered, totally enclosed in itself, with its own laws still partly unknown, separated from the observer who does not participate in any way in his universe. The very concept of behavior seems to continually vanish from the interpretative categories of the psychiatrist: the mentally ill is an isolated entity *that***

***it just works* (and it works badly), *it doesn't behave.* But for this to happen the psychiatrist must deny his own categories and any relationship between subject and object, and demonstrate that the patient, pure objectivity, is not such because he objectifies him, but because he belongs per se to the world of facts of which he is concerned. deals with science. It is not possible to apply any interpretative category to this object world for the good reason that the facts reconstruct themselves according to *their own* categories, as long as the scientist collects them in sufficient numbers and with perfect neutrality.**

**We know today that modern science moves in all other perspectives. The facts no longer speak for themselves, the observer is present in the research and is not outside it, with his own practical interventions, his own interpretative categories, his own ideology. Empiricist naturalism and the immanent metaphysics of positivism have been overcome and definitively destroyed. For psychiatry this destruction was on the one hand particularly radical, on the other partial and ineffective.**

**On the theoretical level, all the necessary premises have undoubtedly been laid for the overthrow of medical empiricism, and of objectifying positivism. This occurred mainly in two stages: first with Freud's demystification of the traditional separation between "healthy" and "sick"**

**field of psychopathology; later with the discovery of the "human" character (with all the ambiguities that this term may entail) of the psychological dynamics traditionally considered "sick", made by existentialist psychiatrists. The destruction of the asylum justifications of madness which this volume deals with has not only verified the impossibility of considering the mentally ill according to special criteria, other than those used for the healthy, but has also shown that the "scientific problem" Of the "disturbance" does not exist except to the extent that the behavior of some people is artificially traced back to a functional alteration of the nervous system. The mistake, however, is not to suppose the possibility of such a functional failure, but to identify it with the "altered" behavior: the latter, on the contrary, can be correctly understood only if inserted into the dynamics of the interpersonal and social relationships that have given a face. Even in cases where it is possible to relate the 'disturbance' of behavior to a brain injury ('disease'), this injury is only an intermediate point in a series of previous events, which have contributed to causing it, and in a chain of successive events that determined the individual's way of reacting to his inferiority. What can no longer be sustained is the**

**the "natural" character of the disease, and the possibility of a *direct* cause-and-effect relationship between the more or less hypothetical brain dysfunction and the way in which the "patient" manages (or fails) to live with others. In most cases, however, the hypothesis of a brain injury appears unfounded, artificial or irrelevant, because the interpersonal disorder acquires meaning only in the context of that social dynamic that has gradually given it shape, creating its patient, and gradually rejecting him out of the possibility of having social relations. In this perspective, even the psychiatrist's examination of the patient tends to lose its traditional character, that is, it now takes place in the context of an interpersonal relationship that is no longer the dichotomous "psychiatrist-patient" one, but becomes a confrontation of mutual difficulties. in the awareness of a social context that creates differently defined roles. These roles define psychiatry. The main difference between the psychiatrist and the patient facing him lies not in the imbalance between health and disease, but in an imbalance of power. One of the two people has a greater power, sometimes an absolute power for which he can define the role of the other according to his own language. We will return to this point later.**

**On the practical level, on the contrary, psychiatry has remained mostly anchored to medical empiricism, and has continued**

**to borrow its values. Even today the majority of university professors, with the same gestures as their nineteenth-century predecessors, lead the mentally ill into the amphitheater of the lesson and "demonstrate" it to the students, just as they exhibit a cirrhotic liver on the anatomical table: the movements, the words of the patient continue to be "facts", not actions located in a context. Thus the practical objectification of insanity accurately reflects the *management* of the mentally ill by psychiatric institutions.**

**There has been talk of contradictions between modern anti-positivist psychiatry and psychiatric practice as a medical discipline and as an institutional practice. In reality there are relationships between these two apparently opposite poles, and it is worth examining them.**

**After Sullivan, all the more active and aware modern psychiatry has become aware of the fact that mental disorder no longer arises as an individual problem, within the objectified body of the patient, but can only be experienced correctly in its inter-individual aspect. However, the criteria for examining these inter-individual problems have remained fundamentally those deriving from psychology and psychoanalysis: instead of studying how social and political problems affect group dynamics and**

**determine in their historical concreteness, it was preferred to expand the psychological and psychiatric examination up to the social sphere, removing it from political criticism.**

**In this way, the premise was set for realizing the old Enlightenment dream of bringing all deviant behaviors back to rational control, as they are always due to psychological disturbances, to passionate derailments. Psychiatrists received a larger contract from power and mental illness was reinterpreted as a psychological dysfunction of *all* social relationships. Psychiatry has therefore handed itself over, tied hand and foot, to the custodians of the corporate order, responsible for defining norms, deviations and sanctions according to their criteria.**

**A part of modern psychiatry has become aware of the existence of this problem, and has realized that it operates and theorises according to *societal values which* cannot be defined in psychiatric terms, but which, on the contrary, define the nature of psychiatry. A sector in which this awareness took shape in a less crude way was that of the imbalance of power, and of the difference of roles and values, which determine the concreteness of the doctor-patient encounter. Social psychiatry and interpersonal psychiatry have examined both the socio-cultural context in which the patient is defined as such, and the "therapeutic" relationship as a system of**

**psychological interreations: psychiatry itself, as a psychiatric practice, has become the object of psychiatry. Here too, however, the psychiatrist has only raised his own level of investigation: by considering himself, in his relationship with the patient, as the object of his own discipline, he has confirmed the substantial validity of the latter. The psychiatrist continued to accept the social mandate while acknowledging its conventional character: he accepted, for example, that the young delinquent or asocial can be considered sick or not according to social norms, that neurosis is a collective problem, that the mother of a schizophrenic may be, in a certain sense, sicker than the child, that individual therapy has no more meaning (and perhaps less) than family or work group therapy has, has agreed to be accountable to his opponents of the fact that psychiatry tends to integrate the individual according to the needs of power, has even accepted *the idea* that it needs to be *treated* no less than its patient. What he could not accept was to undermine his nature as a power contractor, and his subordination to the definition of the norm established by power. He remains the master of the situation.**

**Even if, as mentioned above, the psychiatrist-patient relationship is experienced as a "crisis", the patient**

**continues to be examined in that report through the use of a new theory which, if it has renounced to appeal to traditional psychiatry, has not been able to deny itself, its own claim to scientificity, its own appeal to norms and values.**

**Psychiatry has therefore set all the conditions for its own destruction, but has not been able to draw the consequences. The psychiatric hospitals remain to testify of this failure: the theoretical foundations of psychiatry have dissolved, and psychiatry continues to exist as pure power. It should be pointed out at this point that in all probability the coercive power of psychiatry does not tend to diminish at all over the years, nor does it dissolve in the "free" relationship of the comfortable patient who deludes himself into choosing his own therapy by choosing his own therapist or one's own clinic: industrial psychiatry on the one hand (in its aspect of re-education to productivity and consumption) and institutional psychiatry on the other, are probably destined to increase their field of action together. Just as the psychiatric specialist serves, together with the psychologist, the psychoanalyst and the sociologist, to re-educate the citizen to consumption or to adhere to power regardless of the presence or absence in him of what we continue to call "mental disorder", also the coercive psychiatric institutions have changed since**

**internally (the process is already underway) to safely manage those excluded who cannot be immediately reintegrated, asocial or antisocial, which industrial megalopolises today tend to produce and evade from the game of productivist competitiveness, to a greater extent every year. The increase in hospitalizations of "maladjusted" or "vagabonds" indicates the obligatory direction of a more extensive psychiatric repression in the years to come; modern psychiatry has already forged the theoretical tools necessary for its new tasks.**

**Institutional reform can only be partially derived from the crisis of modern psychiatry. The examples of "open" asylums in the nineteenth century not only demonstrate that it is possible to liberalize a psychiatric hospital without the help of the sedatives in use today, but also that there is always an empirical ground on which it is not so difficult to start breaking the circle vicious asylum. If institutional violence disappears, the violence of the mentally ill also disappears, and the latter changes face, loses its psychotic characteristics described in the old treatises, disappears as "catatonic", "agitated", "lacerating", "dangerous" for reappear in its true light: in its appearance, that is, of a person who has been psychologically raped before and after his entry into the asylum. The mentally ill**

**it loses its "incomprehensible" characteristics to the extent that it manages to insert its discomfort in a context that respects its existence and reasons.**

**Problems arise at this point, however, and it is the patient who asks them to the doctor. The crisis of modern psychiatry offers us today the tools to truly understand what is happening in a liberalized institutional context, and allows us to carry the destruction of the institution much further forward. Once the doors are opened, the process continues and tends to become irreversible, but new contradictions appear.**

**The internal contradictions of the institution are summed up in the difficulty of abolishing the subordination of the patient, overcoming the danger of paternalism. The external contradictions concern the fact that the asylum space is not destroyed, because society sends its excluded back there, binding them to precise provisions of the law. The former inpatient does not find work, or is confronted with the same dynamics of family and social violence that led to hospitalization; the inpatient discovers that he can be free as long as he is inside the institution, but that he cannot leave it when he wishes, without specific repressive mechanisms being triggered.**

**The progressive internal destruction of the asylum system tends to create a living space in which to use**

**of instruments of self-government seem to promise the solution of all the problems of coexistence: but it is the external society that imposes impassable limits, and indeed intervenes continuously to prevent the renovated hospital from becoming an island outside the world. To the extent that internal problems are not "solved" with organizational measures of a "democratic", "community" or "progressive" type, but above all discussed and always re-proposed, they inevitably end up confronting themselves directly with those more real problems. , which do not concern the marginal dysfunctions of a life based on self-satisfied communitarianism, but the impersonal and bureaucratic aspect of corporate violence. In a Provincial Psychiatric Hospital the typical risks of private therapeutic communities are not run, where the very preselection of patients in relation to the census and the morbid forms constitutes the basis for a golden protection against the impact of external society: here, on the contrary, the provisions of the asylum laws, the misunderstandings of politicians and administrators, the bureaucratic impositions and above all the *poverty* , the lack of resources, the impotence of the patients are a real fact, which prevents any mystification.**

**If we mentioned this aspect of the psychiatric hospital in the process of transformation, it was to clarify**

**better the characteristics of that ambiguous character, who, in front of the patient, places himself at the same time as part of the internal reality, and as the agent of the external society; it is the carer, doctor or nurse.**

**Nurses are not of interest to us here, even if they would constitute the occasion for a speech of great importance, but a note on their location can be useful to better define the particular ambiguity in which the doctor finds himself. Even in the most traditional psychiatric hospitals it is easy for the nurse, beyond the "arbitrary" nature of his power over the patient, to establish a direct relationship with him that the doctor cannot have. Both the reasons of cultural affinity and the same closeness for many hours a day favor this contact, which never ceases to be such, that is, a personal relationship, even when it is articulated, as often happens in old asylums, according to openly sadistic mechanisms. The character that distinguishes this type of relationship is the lack of rational mediations, of ideologies expressed in an objective form, of scientific diaphragms.**

**On the contrary, there is almost always a mediation between the doctor and the resident. We are not referring here to the classic asylum situation, where we cannot even speak of**

* **doctor-patient relationship "because this relationship does not exist, but to the changing institutional situation,**

**where the doctor's attempt to renounce his own institutional power clashes with the indispensable character of a cognitive superiority, which is a cultural and class privilege. The doctor's *reflection* on his relationship with the patient, of which this book is an example, is the latest expression of a privilege that always tends to be reflected in the intellectual image that the doctor makes privately of himself and of the patient, through the help of knowledge and theoretical tools which the patient is not provided with. All the more concrete difficulties that make the psychiatric role ambiguous are articulated on this basic imbalance.**

**In the psychiatric hospital in transformation, the management team perceives its unease as a division between adherence to traditional roles and values, and an anti-institutional tension devoid of new roles and clearly defined values.**

**The team is always responsible for the "good performance" of the hospital vis-à-vis public opinion and the legal authorities, and knows that its possibilities of action are limited by social tolerance, by the good disposition of a public prosecutor, by the the very fact of embodying in front of the outside world a technical power and an image of social prestige that partially protects it from the violence of those who prescribe that**

**the hospital is closed, and the sick are safe. Yet, the team tends to refuse the institutional mandate, and this is not a minor refusal. The social mandate does not require the institution to be shattered, but to maintain it; not to renounce that psychiatric technicality that validates repression, but to use it; not to criticize the oppressive or integral role of psychiatry, but to validate the "seriousness" of this discipline in such a way as to justify oppression and integration; not to favor the power of contestation of the excluded and oppressed, but to defend the privileges of those who exclude and oppress; not to create a horizontal structure in the hospital, but to reflect, making it absolute, the hierarchy of external society; not to subject the techniques of manipulation of conscience to constant criticism, but to provide society with structures of assistance**

* **modern "that are functional to it, and do not go beyond the limits imposed by laws and cultural conventions.**

**The denunciation to the asylum today has a scientific guise, or at least is articulated according to a clearly theorized criticism. On the other hand, this theorization, if it indicates what should not be done, does not prescribe anything specific: if modern psychiatry has come to deny itself, it does not tell the psychiatrist how he must act to renounce his mandate. The only indication concerns the need for the doctor and patient to compare and seek new roles,**

**forgetting to be one doctor and the other inpatient: but the imbalance of roles actually exists, and the inpatient is imprisoned in the institution just as the doctor continues to live according to the values of freedom, of rational intelligence, of his own social responsibility .**

**In other words, the "liberalized" institutional reality once again proposes psychiatry as a problem.**

**The difficulties arise at the level of the patient, as he is unable to regain possession of his own separateness, contesting it; and at the level of the doctor, since the attempt to renounce his own superiority and privileges puts him in conflict with himself. The greatest contradiction, however, concerns the doctor, who, unlike the patient, does not have to conquer his own freedom to survive and recur to the world, but is called to renounce a cultural and class universe in which he enjoys privileges. Indeed, the doctor remains tenaciously anchored to this social position, to the way of thinking of his class, to the presumptions of his scientific training, to the ideology of productivism, of property (including intellectual property), of individual oppression. Getting rid of all this is not easy for him, not even as a first step: nor are a voluntaristic choice, a benevolent and neurotically restorative busyness, or a more or less naive community training sufficient.**

**The whole antimanicomial dynamic is complicated by the fact that it does not take place on the ground of a claim for power (in a political sense) by the patient, but in the still closed world of an institution that has no other purpose than to preserve its existence. The resident lives in a world of separateness. As excluded, it is the scapegoat of the coercive organization of exploitation in external society, but it is not directly the exploited. He is the dross and the extreme victim of social violence, but as he is expelled from productive violence and entrusted to institutional violence, he is unable to oppose the political world of productivity, because the latter has marginalized him from the universe of possible interlocutors. The relationship that always exists between exploitation and exclusion is obscured, and the patient who tends to reclaim his own exclusion as separateness, and to oppose it, does not have at his disposal the tools suitable to contest the exploitation that caused it. The inpatient in a psychiatric hospital cannot compare himself to the producer of goods or services, still inserted in a system that demands from him the "free" alienation of his workforce: he is alienated as a person in the institution, and is useless to the system in the to the extent to which, after the coarctation of hospitalization, his institutional presence now contributes**

**only indirectly to corporate stabilization.**

**The second reason that hinders the antimanicomial dynamic is the persistent presence of medical intelligence. The most typical example is that the psychiatrist advises the patient (of course, for his own good) to take some medicines that will help him sleep if he is tired, to control himself better if he is angry, to detoxify if he has been drinking. The patient is (also, and not always) *treated* . In some cases he can heal himself, take a sleeping pill if he does not sleep, and in any case he is treated by the other patients: but the destruction of the institutional role of the doctor finds here one of its most difficult limits. Even if the doctor takes off his white coat, agrees to discuss with the patient, or is put into crisis, he continues in fact to use his superiority: the authority that the patient attributes to him, even before he demands it with violence allows him to impose his own therapies.**

**On the other hand, the renunciation of medical power, even when it occurs, risks reaffirming the subordination of the patient in another form. In practice, the proposal to destroy the asylum institution from the inside never arises from the patients, but from the treating staff and from the managers of the organization. The latter use the power that derives from the social mandate to create conditions that allow the patient to challenge the**

**institutional power: but they still remain the representatives of power and as such they remain the agents of liberation for the sick for a long time, before the patient can make it his own independently. The anti-institutional role of the doctor resembles that of an "active" pedagogue, who educates to *freedom* with the hope that his pupils will come to contest his own pedagogical role.**

**In the field of the institution, however, freedom does not exist in fact, nor can it be mystified as interior freedom in the absence of objective freedom. If to this observation it can be answered that freedom does not even exist in the external world, and that the institutional sphere has at least the advantage of making a general illibery clear, it is also necessary to reply that the external world offers the opportunity to link his own rebellion against a world of productivity, and against a revolutionary political practice. These possibilities within the psychiatric hospital appear remote and veiled. Thus, the awareness of exclusion is often still experienced by the patient as an accidental injustice, as an imperfect delimitation of the boundaries of the norm, and hardly comes to criticize the concept of norm. The psychiatrist, for his part, has already lost the illusion of his own objectivity, and knows he cannot distance the patient from himself by obicting him in the investigation; but if it easily tends to ennoble the**

**the concept of deviance, by subtracting the automatic corollary of the sanction from the latter, is unable, however, except with great difficulty, to propose a practical universe in which the very traditional concept of deviance is put into crisis.**

**For all this to happen, a revolutionary practice is necessary: on the other hand, from what we have said, it is quite clear that the psychiatric hospital, however uninstitutional it may be, does not specifically privilege this type of action. The destruction of the psychiatric hospital is a political work, because traditional psychiatry, by dissolving, has left psychiatrists and patients directly confronted with the problems of corporate violence: however, it does not have the typical characteristics of a revolutionary work.**

**This explains some of the limitations of inpatient awareness. For the latter, it is understandable that healing values continue to be considered more easily according to the conformist definitions of the external society, that is, as a function of an attempt at integration, rather than according to values that are much more difficult to elaborate (and more difficult to sustain even on the level of psychological effort) of a challenge to the corporate structure.**

**Even for the care team, to the extent that it is unable to forge a new type of consciousness**

**antipsychiatric, the risk of continuing to act exclusively in the context of the contradictions of its old mandate is evident.**

**The discourse would seem to end with an observation of impotence. However, when the practical limits of an anti-institutional action *starting from psychiatric hospitals have been clearly stated* , it is also necessary to propose a newreversal, and recognizing that it is possible to deny once again the specificity of psychiatry.**

**For the patient, this reversal is embryonic to the extent that the anti-institutional practice already contains in itself the rejection of the principle of authority; for the treating team, the experiment makes sense when you no longer register just the incongruity of psychiatry, but the formulation of a protest with a more general meaning and scope.**

**Others may take up this protest, but it already exists in its choices of origin. The fact that some psychiatrists from various parts of the country have come together to experiment with anti-institutional work in Gorizia is not due to chance, nor to the inevitable coagulation around a "school" of the existing imbalances in Italian psychiatry, but to a series of preliminary analysis and policy choices. In this sense, the denunciation of traditional asylum psychiatry as a system of**

**power essentially aspires to two ends: on the one hand, to provide a series of critical tools suitable for destroying, together with others, those "self-evident truths" on which the ideology of our daily life is based; on the other hand to draw attention to a world, the institutional one, where the violence of the exploitation of man by man is reabsorbed in the need to crush the marginalized, to manage and render the excluded harmless. Psychiatric hospitals can teach us many things about a society where the oppressed is increasingly removed from the perception of the causes and mechanisms of oppression. At the moment in which political criticism begins to leverage the subversive potential of all those who have been declared "out of the game", the *ambition* of antipsychiatry aims to indicate, in a decidedly anticipatory experiment and theorization, some of the ways possible for a totally different society.**

**Franca Basaglia Ongaro**

**Institutional overthrow and common purpose**

***A total institution as* defined**  **by**

**Goffman 34 can be considered as the ltiogo in which a group of people is determined by others, without being left with a single alternative to the imposed type of life. Belonging to a total institution means being at the mercy of the control, judgment and projects of others, without anyone who is subject to it being able to intervene to modify its trend and meaning.**

**In the case of a total institution such as the Psychiatric Hospital, the custodial purpose of the treating staff determines - at all levels - the group of inmates, who are forced to consider the protection measures taken against them, as the only meaning of the their existence. The only possible identification within this type of total institution is, for the hospitalized, the need for defense of the healthy towards them. This means that the patient's recognition of his own identity passes through the stereotype, well defined in the physical and psychological structures of the institution, of the inmate as *the one from whom the healthy person defends himself* . In addition to this charactercoercive, on a defensive basis, the total psychiatric institution presents the absolute non-problematic nature of one of the poles that constitute its reality (cause and at the same time effect of every forced institution). The sick person - once associated with the hospital - is defined as *sick* and**

**his every action, participation, reaction is interpreted and explained in terms of illness: institutional life is based, therefore, on the absence of value, a priori defined, of the inmate, who is presumed to be irreversibly objectified by the illness, thus justifying, on the practical-institutional level, the object relationship that is established with him. In this sense, the overthrow of a total psychiatric institution should essentially consist in the breaking of the coercive system and in the problematization, at all levels, of the general situation.**

* **here it is clear that this is not a simple reversal that would remain in an equally aproblematic terrain such as the classic institutional one. But the reversal should act within the relationship that unites the opposite terms of the relationship, to deny their clear opposition. This means that contradictory terms such as slavery and freedom, dependence and autonomy, *cannot be understood as the opposite of the other.***

**If these abstract categories are brought back into the practical field of a psychiatric hospital, the opposite of coercive authority should be the absolute permissiveness that would force the treating staff into a forced condition; that the opposite of slavery, symbolized by the closed hospital, should be the freedom of the patient who has become the sole arbiter of the situation;**

**that the defeat of the authority and absolute power of doctors should automatically correspond to the complete autonomy of the sick; that addiction problems should be solved by reversing the poles of the relationship.**

**But the reversal of a situation implies only the inversion of the terms of the problem, without actually anything being changed in the type of relationship that binds them.**

**On a practical level, by examining one of these *coercion -freedom binomials, it* is evident that the only possible meaning of the concept of freedom should correspond to the condition of a patient who - previously closed, forced, determined, cosified by the institution - is free to choose from a number of possible alternatives. The subjective limit implicit in the need for an objective condition to freedom is what will still keep the discourse equivocal.**

**To *overturn* a closed asylum condition, two concomitant elements are needed which are, however, more closely correlated and interdependent than we usually think: 1) the objective condition of the patient that allows the passage from one type of reality to another; 2) the subjective condition of whoever provokes the overthrow, who finds himself carrying within himself the social values of "norm", which will define the limits beyond which freedom will *appear to him unsustainable.***

* **It is clear that the passage from one condition to the other (coercion-freedom) is more dependent on the ability of the person who determines the overthrow to cope with the situation that is being created, more than it depends on the real objective conditions. In other words, the freedom of the patient and the degree of permissiveness that exists in a psychiatric institution are inversely proportional to the need that the doctor and the treating staff have to defend themselves in the face of those entrusted to them. In this case, the clear division between *positive* and *negative experiences* exists until one has the awareness of being able to cope with the negative: once this awareness has been reached, there are only situations to face, since the positive is nothing more than a negative. it is known and not feared.**

**An example of this is a very brief excerpt from the report of a community assembly, with a subsequent discussion report by the treating team - in the comment in italics what is mentioned here is evident:**

***April 14 '67.***

**... The assembly is disturbed by the presence of a somewhat noisy cerebropath. Apparently it does not seem to give weight to the disturbance it causes. However, there is a**

**removal from Elda's assembly, due to the boy approaching her chair ...**

**In the discussion of the team, the opportunity to allow disturbing elements, such as oligophrenics or cerebropathy, to participate in the assembly is analyzed. A doctor argues that their presence produces a general regression (also for the recognition of the sick at the worst level, for projecting oneself into them). However, preventing access would be - for a second doctor - an arbitrary act, in the sense that the possibility of establishing the limit of "participation or personal experience" necessary to justify the presence of a patient would always remain in the hands of the treating staff. of this type, in the assembly. It is evident that if the institutional reality is also that given by the presence of these patients, if doctors take a discriminating attitude towards them "by misleading the person, or by making sure that they are not accompanied if they need to be", it would sound like medical endorsement of an act of general exclusion. *However, the fact that Elda felt frustrated by this threatening presence does not only have a negative meaning, or at least it can offer the possibility of different movements and reactions. If Elda is faced with a danger that she is unable to face, the institution cannot resolve her discomfort.***

***eliminating the existence of what produces it. Elda should have been helped in another way to cope with the situation, through the general involvement of the assembly on the problem she was experiencing. If this had happened, Elda would not have felt alone at that moment, and having passed such an anxious experience, would have placed her at a higher level of endurance. Otherwise (as it actually happened) regression is fueled more than rehabilitation is stimulated. Eliminating these opportunities for encounters between different levels of patients means maintaining the barrier between positive and negative experiences, revealing the limit within which it is considered possible to manage the situation. This would highlight the institution's need to "stop" before provoking a situation that it does not feel safe to face. In this sense it would seem more realistic to recognize that the need for a certain level of exclusion corresponds to the awareness of one's own limits (in this case the limits of the institution), beyond which one presumes not to know, or not to be able to dialectize the situation.* It could not therefore be argued that - beyond a certain limit of personal experience - the element participating in the assembly is negative, but that beyond a certain disturbance limit, the institution is not yet able to handle the**

**situation.**

**The overthrow of an institution should therefore imply a simultaneous overthrow in both poles of the situation in which it acts, through the negation of the reference values that support its condition at both levels. Only in this case would freedom lose the character (typical of permissiveness) of concession controlled from above, and, at the same time, that of overturning a forced situation into the simple supremacy of the former subject; to become the overthrow of a defensive system, implicit in the relationship between dominated and dominator.**

**The definition of a total institution as a place where a large number of inmates find themselves at the mercy of a small controlling group, already makes clear the nature of the relationship that exists between the poles of the institution: on the one hand, a care team that carries out its social mandate of a custodial-dialistic nature, determining - according to the values of the society of which he is a representative - the level of regression of the patient that can best guarantee the good performance of the institution; on the other hand the patient who, in order to defend himself from the anxiety and the problematic nature of living objectified and at the mercy of others, tends to increase the level of regression produced by the disease and by the definition that was originally made of it.**

**If this is the real situation of a total institution, it is**

**It is clear that if the problem of its overturning is not posed within the relationship which, on the one hand, binds the poles of the relationship and, on the other, the opposite terms of the overturning (coercion-freedom), there is a risk of simply inverting the terms of the situation, without modifying the elements that determined and maintained the condition.**

**A similar problem arises in the overturning of the principle of authority at the staff level. In the institutional reality, the leader of the treating group plays a role of power over the group, since he is the only one who has in hand - due to his social mandate - the tools that the "authority" usually uses to defend itself. and create distances from what it wants to dominate. But in the case of an action of overthrowing the principle of authority, the overthrowing of the values on which our hierarchical society is based, must take place both in the leader and in the group, through a process of negation of one's own reference values.**

**In the leader this denial can pass through the dilution of his power into autonomous and complementary roles, which tend to destroy the image of the leader as arbitrary authority, pruning it of the spurious elements given by pure power, or by the power of the role. His negation would therefore come to be implemented in reality, through the negation of one of the real faces of his**

**role, represented precisely by the social mandate implicit in it (hence the constant displacement between the denial of one's power through the dilution into autonomous roles, and the social responsibility preserved intact in his figure of "manager"). But this denial would be valid and real only when the situation - originally born from the voluntarism of a leader who assumes the rupture of the authoritarian-hierarchical system as a personal choice - turns out to be so mature as to make a position born as voluntaristic irreversible: when, that is, the leader can no longer "go back" with an authoritarian act to re-establish a different balance of power. Only then would the denial of authority be implemented on reality, through the establishment, on a practical level, of a dimension that prevents the artificial division of a power that can be given and taken away at will.**

**On the other hand, the overthrow of the principle of authority by the group should pass through the negation of the reference values implicit in it: that is, through the negation of the competitive and antagonistic mechanisms typical of our bourgeois reality, which would lead to the negation of the authority implemented by the leader, as the acquisition of personal power and authority. The autonomy of roles coincides - even in perfect correspondence with the so-called dominant values - with**

**purchasing power. It could therefore result as a reversal of the principle of authority, even what, in reality, would only correspond to its consolidation at a different level. The *obviousness* with which the acquired, automatic autonomy could be experienced by the group, might not make the link between autonomy and responsibility as automatic. What unites the action of the leader and that of the group, in the institutional overthrow, is the responsibility towards a *common purpose* that should be able to prevent any personalistic slippage. Autonomy without responsibility is the first step of an action in which decisions can be made without paying the consequences; responsibility in autonomy becomes a highly gratifying personal achievement; but the common purpose within a responsible autonomy requires constant reciprocal checks, which often undermine the autonomy of both the group and the leader.**

**In a working group, if the transition from autonomy to responsibility within a common purpose is not implemented, there could be - on the one hand, mutual unconscious resistances on a practical and ideological level, from which it would be difficult to separate the psychological reasons from the real objections; on the other hand, the recognition of the leader as *a classical authority,* with the consequent behaviors**

**of total adhesion, servility and reciprocal exploitation, typical of the servant-lord relationship.**

**What is evident is the need for the overthrow (if it wants to be defined as such) to take place in all the layers of which the institution is constituted, each through the denial of its own level of integration to the system of values on which the institution is founded. and therefore the society of which it is an emanation. Otherwise we would remain within a system of communicating vessels, where we would limit ourselves to transferring, from time to time, the same mechanisms that have conditioned and condition the situation we want to overturn.**

**The difficulty would lie entirely in the concept of a *common purpose* which should be one at the same timeprerequisite, an indispensable condition for the *reversal action* ; and, at the same time, something constantlyverifiable in reality, therefore something that cannot be given once and for all. In fact, the confirmation of the existence of such a common purpose will be verifiable only through actions whose results are not predictable, given that there are no reference models capable of ensuring the outcome of a reversal, once the premises.**

**However, having recognized the various possible contradictions within an institution in the process of overthrowing, it would perhaps be useful to identify which one**

**it could be the purpose, common to all the elements that compose it.**

**Going to the origins, one could begin to say that the purpose of the mental institution (therefore of all the roles of power implicit in it) was exactly the opposite of what could have been the purpose of the inmates. The asylum institution lived to aproblematize the problem of the patient, for whom the only possible identification remained the hospital structure, created to destroy him. In this way the inmate was forced to participate in that one purpose, collaborating himself in its total dehumanization.**

**In an action of *institutional overthrow* , the refusal of the institution could be the first common step at all levels, inmates and care teams. But, insofar as the institutional overthrow coincides with the general problematization of the situation (therefore with the conquest of a freedom, at all levels, which, to be such, passes through responsibility), it also coincides with a crisis general and individual at the same time, where everyone finds himself in a position to seek his own defenses, to survive the anxiety of a relationship that does not allow masks or shelters.**

**That the institutional overthrow goes through different degrees of empowerment (which means degrees**

**of the negation of one's own reference values) is evident from the problems that emerged from a series of assemblies, of which some elements of discussion are reported here:**

***From 20 to 28 April J67.***

**... The beer problem is discussed. Too much is drunk (beyond the agreed limit of one beer per day): therefore, its abolition or total liberalization (coercion-freedom) is proposed.**

**Some new entrants, not directly interested, propose its total suppression; he is told that when the sale of beer was not allowed in the hospital, many "contraband" spirits entered. Prohibition serves as a stimulus. Vittorio (alcoholic) intervenes by saying that the problem is to take responsibility in front of others, that is, towards the community. F. intervenes by saying that it is also a question of making oneself responsible: wine hurts me, so I don't drink. Pirella points out the possibility that someone, although aware of the fact that wine is bad, wants to drink precisely for this, that is, with a self-destructive purpose (some comments of assent, as if we were talking about something known). Basaglia intervenes saying that if the patient does not take responsibility, even the doctor cannot**

**be responsible for his relationship with the patient: if the patient is irresponsible, how can the doctor be responsible for something that is not there?**

***Overall, alcoholics seem both attracted and repelled by this possibility of empowerment. The hospital is, for them, the refuge where they turn to when they give in to alcohol and no longer know how to cope with their addiction. If even the hospital assumes in their eyes the problematic face of their daily life (that is, if in the hospital there is the same possibility, left in their hands, to drink) it loses its function of refuge, to become the ground in which they must continue. to try, measure and take responsibility. On the other hand, the prohibition serves only for the period of hospitalization; not as an education in self-control. If the institution limits itself to prohibiting alcohol, its action remains within the limits of a "suspension" of the problem (which authorizes the alcoholic to resort to other means of drinking) in the sense that, for a period, it would protect the alcoholics by themselves. Their failure would also take on the value of demonstrating their degree of dependence in the eyes of the institution. That's all. The alcoholic himself - on the other hand***

* ***seems to prefer this condition, which does not call him into question as one of the subjects of the situation: if the institution abolishes beer and does not appeal directly to him, he will be free to drink "contraband***

***To "take revenge" on the institutional prohibition.***

**Various proposals are made that continue to oscillate between prohibition and total liberalization:**

1. **completely liberalize beer with a margin of control given by everyone;**
2. **move the sale to the departments instead of the bar, so that the responsibility of the bartender is diluted and divided into the different departments;**
3. **liberalize, but with time restrictions;**
4. **create a separate kiosk for the sale of beer only, which would allow for greater control;**
5. **gradually increase the cost of beer after the first bottle.**

**Some proposals retain the coercive-punitive-restrictive character (the price increase, the time restriction), others tend to a greater responsibility of the community. The reactions of the Assembly are of a different type:**

1. **In alcoholics such as A. it is clear the need for the issue to be resolved with authority by doctors, hoping for the complete abolition of beer. *Evidently he does not feel strong enough to be able to decide for himself whether to drink or not, and he wants to have an authority in front of him that forces him and that, for this reason, he will feel authorized to attack in***

***somehow (drinking).* The state of anxiety that comes from being free and responsible is such that it is unbearable. At the end of each session he concludes, aggressively proposing to delegate responsibility for the decision to be taken to the doctors.**

1. **Some non-alcoholics propose the liberalization of beer, moved by a total skepticism towards alcoholics: if one wants to drink, let him drink. He will learn the hard way and understand for himself. Once the law is made, the deception is made. With the prohibition, they will continue to find subterfuges and ways to drink. Man is what he is, nothing can be done!**

**3) Renato (non-alcoholic, but subject to sudden acting-out) openly oscillates between the proposal of free beer (why not also cognac, and grappa?) And total abolition, with the threat of locking the offenders in a "cell" . *He still and always moves between concession and prohibition, according to his need for authority or total permissiveness, without ever putting himself personally into question.***

1. **Furio points out that the beer was not "granted" by the doctors, but that the community had decided to agree to undertake to drink only one bottle a day, which is very different. If doctors allowed the liberalization of the hospital, the situation would not be unlike that of a traditional hospital,**

**where the doctor is the only authority. The doctor's authority has not disappeared, but is reduced by the presence of groups of patients and nurses who divide and contest it. To speak again at this point of liberalization or total abolition means openly declaring a failure as regards the commitment that each one had made towards the common decision. *(Here the dangerous game of blame could come into play, with the results that usually accompany it).***

**5) The patient manager of the bar intervenes by explaining how *the beer problem arose* : he could no longer maintain a certain control that he could before. ( *The general crisis is therefore also linked to an act of defense against the problem, which is linked to permissiveness as closely linked to both the objective condition and the subjective capacity to cope with the situation)* .**

**The terms of the discourse - of which only the fundamental elements have been summarized here - continue to oscillate between the need for an authority (which eliminates or diminishes the anxiety produced by the dimension in which the whole institution tends to move: empowerment) , and the need to conquer a freedom that passes through the conquest of one's own responsibility. This is for the inmates. The same mechanism is, however, present**

**in the treating staff (doctors and nurses) who may be attracted by the need to defend themselves either with their own authority or with the authority of others, depending on the level of anxiety (with consequent need for shelter and regression) that an action of overturning entails.**

**In this sense, if the overthrow takes place in each role of the institution, through the negation of one's own institutional face (so for the sick, as well as for nurses and doctors), the negation of the institution and of the institutionality would result in a common purpose. to everyone. To the extent that each component of the institution**

* **objectified in its own institutional role (linked, oppressed, direct, determined, albeit to different degrees), institutional denial as *a symbol of the struggle against any system of oppression and abuse of power* , becomes aa qualitatively common movement, which goes beyond the community, a priori implicit in the classical concept of therapeutic community. Here the breaking of the traditional link between the institution and its components remains within the institution itself, without affecting the system of values that underlies it.**

**If therefore, anti-institutionality turns out to be a real common purpose, in the practical terrain of the institution, the *challenge* of the patient as the only modality consideredvalid as a moment of negation of the institution that oppresses it at all levels, it could be overcome through the**

**denial of one's own institutionality (which corresponds in the patient to the regressive role to which he abandons himself to defend himself, as well as in the doctor and nurse to the regressive role of power) in a subsequent act, which could lead to a community of actions at the same level and same goal, which went beyond the division of roles. In this way it would be possible to identify a dialectical movement within the contest itself, which could push the situation towards a further step, using contradiction as a way towards a subsequent reversal of reality. This is done without presuming to resolve conflicts, but to address them on another level.**

**However, if the qualitative leap in identifying a common purpose has not yet taken place, the reality of *an institution that denies itself* can easily find itself entangled in regressive-antagonistic moments, which would highlight the failure to negate the institutional side of each term of the relationship. . The misunderstanding could then remain on a search for a "democratization of relationship" which would risk being an end in itself, causing the situation to be reversed, on the level of the bourgeois concept of interdisciplinarity (each seeks confirmation of himself in the other, keeping intact your area of expertise). The democratization of relations within *an institution that denies* itself is justified**

**as a *problem* only in the moment of denial of an action which, inasmuch as it is the proposal of an overturned reality, poses itself as anti-authoritarian and anti-hierarchical. But it should not exist as a problem in itself at a later stage, where it would have the sole function of slowing down and confusing the meaning of the action.**

**The discourse here would remain open on the meaning of an institutional overthrow, on the limits of overturning and on the origin of these limits: that is, if they come from the level of negation in which it operates ( *"we are never completely contemporaries of our present"* R.Debray), or if they could not be the expression of a more hidden concern whose nature would not be clearly understood: the concern for the democratization of relations, as the ultimate institutional mystification that would prove to be less "overturned" than it thinks it is.**

**Gian Antonio Gilli**

**An interview: sociological denial**

**The following interview concerns the "career" of a sociologist who found himself in contact with the work of a psychiatric hospital. In practice, it concerns an experience conducted at the OP of Gorizia, in which the writer participated as a consultant sociologist of the medical staff of that hospital. The direct relationship with the asylum institution, the fact that it constitutes the immanent background to the professional events described here, is the first justification for including this interview in this book. However, there is perhaps also another justification, based on an argument that would need to be developed at length but whose terms, schematically, are these. Sociological research, or, more generally, the social sciences, have been increasingly constituting themselves as a system in recent decades. This system, which has also developed its own culture, shows some decidedly *institutional characteristics* , including, *first* , the need to affirm its own "model" in the presence of certain resistances, and *second* , the need for an absolute integration of the members who make up. This means that every researcher, every member of the social sciences community, is such only to the extent that he has fully internalized certain prescriptions, which result above all in the continuous re-proposition and defense of a certain type of approach to reality (the approach sociological), and of interpretation e**

**explanation of this (the Sociological Reason). If we agree on the identification of these institutional characteristics of the social sciences, we understand the reason for the insertion of an expression of refusal of sociology (as this paper proposes to be) in a work of negation of the Institution. Except that the target is no longer the hospital institution. Indeed, for the researcher in the PO.P. which becomes aware of certain contradictions, and wants to draw all the consequences, the hospital appears to be the mythical liberating institution from which Research, its techniques, its ideology, are first recognized as an Institution, and subsequently denied.**

***The sociological literature on the psychiatric hospital has experienced a kind of boom since the early 1950s. What is the significance of this phenomenon? What is the position of the sociologist in the OP?***

**To answer this point, I would first like to recall two cases of research that have particularly impressed me. In 1951 an anthropologist obtained permission to enter a psychiatric hospital, pretending to be mentally ill. In this capacity he collected material on the interaction processes within the department to which he was assigned; after which, of course, he went out and published the**

**material thus collected. The second case is similar to the first. A few years ago, some graduates, posing as alcoholics, attended a series of meetings at the local office of an anti-alcoholic organization, the Alcoholics Anonymous; they wore modest clothes and were "carefully instructed... to sit, throughout the meeting, appearing tense and uncomfortable." This experience was also illustrated in an essay. Both researches were criticized, mostly on "technical" grounds, more recently, on "moral" grounds 35 To tell the truth, these are borderline cases. In general, the role in which the researcher enters the OP is less distant from his real role: he enters it as a "doctor", as a "nurse", and sometimes, openly, even as a sociologist.**

**However, if we examine more deeply the role of the sociologist in the PO.P., We can come to the conclusion that, among all these possible ways of "entry", there is no substantial difference: the researcher in the PO.P. He "plays a part" that he did not write, and his decision is limited to the costume to wear: of a sick person, of a doctor, of a sociologist. To try to clarify this statement it is necessary to develop the two points posed in the question.**

**The first point is the following: why this sudden boom of research on a social system - the OP - for so long neglected by sociology? The answer is the following: sociology «is**

**aware "of the OP because, in advanced capitalist society, the OP, as it is, represents a problem, a contradiction within that society. This still tells us nothing about the relationship between society (this society) and sociology (this sociology). But let's see in the meantime why the OP is a problem today. In very general terms, it can be recognized that two basic types of organization of collective action operate in Western societies: organizations and institutions. These two types differ in many respects, but the fundamental difference concerns the yardstick against which they are judged by the more general system of which they are a part. The judgment of the organizations takes place in terms of *efficiency* , which means reaching the goal with a maximum containment of "costs". Institutions, on the other hand, are not required to operate with maximum efficiency; on the contrary, they do not even care that they reach the goal, - which is often purely verbal and ideological. What the system expects of the institutions is that they perform certain functions which completely disregard the stated purpose, which often go in the opposite direction, and which no official representative of the system would ever be willing to admit (in sociological terms, "latent" functions) . Since the very way in which each institution is structured ensures the performance of these functions, what**

**the general system asks the institution, in our case, the OP, is the *maintenance of the* original model, the exact conservation of the borders, of the internal relationships between sub-subsystems, of the immutable distribution of resources (mainly, of power) .**

**However, many facts indicate that, in the advanced capitalist system, which places a high premium on efficiency, institutions, at least in their traditional form, are viewed with disfavour. The most conspicuous example, in Italy, is perhaps given by the series of attempts at bureaucratic reform, aimed at setting the institutions of the public administration according to criteria of efficiency. In the case of the OP, however, this push for "modernization" is even stronger. In fact, if the material on which the bureaucracy works (its "resource") is information, the resource of the OP are individuals, *human capital* , and, in the present conditions of production, more thanany other resource (raw materials, energy) human capital requires large initial investments, and a high maintenance cost. In this perspective, the way in which a part of this capital is "treated" in the PO is undoubtedly a "waste" 36 One may wonder why this was not felt from the beginning (and indeed, the massive confinement of the sick in asylums roughly corresponds to the leap in industrialization of the first decades of the nineteenth century).**

**We can perhaps hypothesize that the profound change in production structures that took place in the last hundred years, and the changes that have occurred in the availability of different resources, have led to a redefinition of the concept of workforce: compared to the fabulous "Manchesterian" entrepreneur for whom those many men, women, children who needed, in practice, to satisfy a specific production need, the modern entrepreneur counts as workforce all those who live, now and in the future, in a specific area, and must therefore be more selective, more concerned with the good preservation of human capital. The concept of workforce, that is, from a *concrete concept* (almost an ostentatious definition: *these* specific individuals, taken, according to criteria of geographical proximity, robustness, docility, etc., from an almost inexhaustible mass, as they are - were - inexhaustible air and water), has become *an abstract, analytical concept* (almost a normative definition: all those who live within a given socio-geographical space are workforce). Being part of the workforce has thus become, from status achieved, status ascribed: there is like presumption; that everyone is part of it.**

**However, this presumption, and the all-encompassing definition of workforce that underlies it, crashes against the walls of the OP in its present form, - of a**

**a system, that is, which either does not return the resources that are passed to it at all, or returns them with excessive delay, and in any case without ever giving sufficient guarantees on the possibility of complete reintegration of such individuals. The pressure of the general system towards the OP is therefore aimed at obtaining greater efficiency: more discharges, shorter hospital stays, safer results.**

**More specifically, this requirement of the general system turns in two directions: on the one hand, as mentioned, the PO is required to operate based on efficiency criteria; on the other hand, at the level of the single individual, the integration of the inpatient into the new hospital system is required, which will allow him to be reintegrated among his peers in professional conditions. These considerations fully explain the reasons for the need for an intervention (in the form of research) of sociology, and the way in which this intervention takes place. Sociology operates as the main branch of social engineering, and must indicate how to overcome certain frictions and frictions towards a well-formed society with the lowest cost (greater efficiency). This social engineering work, aimed at the OP also obviously requires a large investment in material plants and technical resources: but the role of the sociologist, in particular, is oriented towards a more complex task: that of redefining the social fabric of 'hospital, of**

**reformulate the schemes of human relations that best adapt, are functional to the new hospital oriented in terms of efficiency. This experience of rationalization of the old structures is sometimes lived by the sociologist, ideologically,**

**as an experience of "humanization"; correspondingly, the sociologist believes that the initiative of this process rests in his hands, and that it should be exercised almost "against" the system, overcoming its resistances. Instead, it is necessary to keep firmly in mind that: i) the sociologist or, in general, anyone who operates purely and simply in the sense of greater liberalization, etc. of the OP does not at all place itself in a revolutionary and subversive position, but collaborates in eliminating an element of contradiction from the more general system (the OP in its old structure); that: 2) independently of the collaboration of the sociologist, and of any initiative of his, the overcoming of this contradiction is a necessity, first of all theoretical, of the system, and it will be the system itself to resolve it.**

* ***perhaps it is appropriate to better specify the meaning of this collaboration, and to see to what extent, within his role, the sociologist can maintain a critical attitude towards the exploitation, by the general system, of the reform in the sense***

***humanitarian of the Psychiatric Hospital.***

**An important point must be clarified immediately, which may seem obvious, but which must nevertheless be made explicit and taken to the most distant consequences. That is, to do a research, to enter the hospital, to interview, to observe, *to put himself in short as a sociologist* , the sociologist needs power: This power is conferred on him by the general system: regardless of what he believes, by the he image he has of himself (for example, as a "mediator" between the general social system and the world of the excluded), from the sympathy he feels towards the object of research, he exists only to the extent that he exercises that power. If power failed him, he would no longer exist as a sociologist. If this power were exercised in a way that did not conform to the prescriptions of the system, or even turned against the system, all this would still be resolved to the advantage of the system, which founds this power.**

**But we intend to return to this point later, which seems fundamental to us. Let us now follow the sociologist who enters the OP. He knows he is entering a world of the excluded; knows, on the basis of statistical research, that the population of psychiatric hospitals is strongly selected according to social class; he knows, from having read it or observed it in practice, that they are exercised towards the mentally ill**

**stereotypes that tend to institutionalize the patient in a deviant role, to "reward" him precisely when the patient's behavior meets the expectations of the people, who want him to be "different" 37 etc. The sociologist, however, feels calm, above all methodologically, first of all because he "knows" these things, and therefore can beware of them; secondly, because the little or much of cultural relativism which inspires him suggests that he recognize a legitimacy, a legality, even in the deviant system. On this basis, the actual "observation phase" begins. The researcher comes into contact with doctors, nurses, and above all the sick; the "normality" of these patients strengthens his methodological good intentions (this feeling is all the more alive since, in fact, he expected them to be "different"), and the sociologist soon discovers a logic of his own in that world. It is therefore easy that at certain moments he feels as distant from the external world as from the internal world. But this "equidistance" is precisely the ideal position for what the general system demands of him.**

**During this first period of observation, however, this process of reassuring one's methodological super-ego is latent; The immediate purpose of this phase, rather, is the clarification of the subject of the research, and of the basic hypotheses. Examination of the literature on OP shows us that any research**

**it falls into one of these two groups: research on aspects of the hospital structure and organization; research on aspects of the patient's position and participation in the hospital. If one reads these researches while remaining within the current sociological ideology, one can perhaps observe a certain variety of arguments, and a different degree of "imagination" in the various authors; from an external perspective, however, all these searches have the same face and identical characteristics. This is due to the fact that the implicit basic assumptions underlying all these researches are actually strictly conditioned by some fundamental constraints imposed by the system. Let's see this point a little better for the two types of research.**

**Researches of the first type, ie those on structural and organizational aspects of the institution, are the most numerous. It examines the interaction of patients, leadership patterns, differentiation and stratification, how patients react to different types of authority. But, just to stop on the latter case, both as regards the "reaction" of patients and the use of authority, the range of behaviors of patients considered significant, and the range of possible use of authority are , implicitly, truncated at one end: the one that can question the profound structure of the OP**

**reaction of the patients, the scale that the sociologist builds to "measure" it easily includes the maximum of positive reaction (the "good sick one"), but excludes the maximum of negative reaction, that inpatient god who does not react, does not care about the questions that they are addressed to him. But we would like to return to this point by talking about research techniques. As for the use of authority, the scale of possible modalities ranges from an authoritarian to a "democratic" use of authority, meaning by democratic the fact that patients can speak in meetings, they can decide, by majority, whether to see the first or second television channel, who will participate in a group trip, and so on. One thing is not spoken of: real power, which always remains in the same hands, which is never redistributed. Yet it is precisely this power that, at a certain moment, decided to allow patients to decide on matters of such importance. Of course, the weak point of this "democracy" (so close to external democracy) is not the fact that the patients discuss ridiculous issues, but the fact that this possibility is the result not of an autonomous realization, but of an external concession, concession determined on the basis of needs that do not affect them, if not in a negative sense: first of all, the need to ensure greater "consent" of the patients by extending the rules to them**

**of the game.**

**This mystifying aspect of the basic hypotheses is even more evident in the other type of research, those focused more specifically on the behavior of the individual in the hospital. Research on therapeutic groups belongs to this category. Here a premium is placed on the fact that the individual behaves as a good member of the group, that he participates profitably in discussions, that he diminishes group tensions, that he contributes to bridging the gap between the group of doctors and that of patients. The reasoning behind it is roughly the following: the patient had to be removed from society because in his relations with others he was out of the ordinary; it is therefore necessary to teach him to interact correctly with others, to know how to practice human relationships. In practice, in short, reintegration into small units, neighborhood units, neighborhood units, is taught to individuals who have been excluded due to the operation of mechanisms that go well beyond those of the neighborhood unit, individuals for whom the difficulties of behavior with neighbors, with workmates, with family, are often only the symptom of a conflict on a larger scale. It is thus evident that the diversity of approach and topic of the various researches is mere appearance, since they all have to deal with certain constraints (the basic hypotheses, in fact) imposed by the system. The sociologist willing to**

**subjecting one's role to analysis cannot fail to recognize, at this point, that his encounter with the experience to be studied is not at all free and original, but rather, is severely limited and, in a certain sense, predisposed. The researcher in the OP who rethinks his own experience thus realizes that the formulation of the research topic was nothing more than the first expression of that power that the system gave him, and that this power was used to cut and orient the social situation of the patient (before and after hospitalization) in a way that is perfectly functional to the hospital system and to the general system.**

***Does this characteristic of the initial phase of research, that is, of constituting the exercise of a power, also extend to other phases and tools of research?***

**The question posed in this question is legitimate. In fact, it is not difficult to see a particular research criticized "from the left" precisely on the basis of these considerations, that is, that the fundamental presuppositions of the research itself have their roots in the system towards which, perhaps, they claim to be critical, or "neutral" ". However, it is necessary to go further, and try to show that the iron control exercised by the general system over sociological research extends well beyond the**

**initial formulation of the hypotheses and definition of the research object. Let's focus on two aspects, or phases of the research, the formation of the sample and the interview. It is clear that, if our sociologist does not want to limit himself to a statistical analysis, or to mefa observation, he will have to carry out a series of *interviews* with a *sample* , however defined, of this hospital population. As is known, a sample, taken from a population, can be more or less representative of that population. The sociologist normally aspires to the maximum representativeness of his sample, and usually comes very close to it: which means, in practice, that the same percentages of males and females who are found in the general population will appear in the sample, that the composition for age, hospital seniority, etc. it will be roughly similar for the universe and the sample, that all departments will be equally represented, and so on. But what is this sample representative of? it cannot be said to represent the population of inmates - but only the group of inmates *willing to collaborate* with the researcher, to listen to his questions and to answer him. The mystification that the notion of representativeness (apparently "neutral") entails then becomes evident: the fact that it is a partial representativeness is hidden and masked by the apparent representativeness by sex, age, department, type of diagnosis, etc., of the whole 'hospital.**

**However, this basic mystification is not the source of any conflict for the researcher trained in the myth of self-worth; it does not undermine research, because it occurs *upstream* of research itself, as it is conceived in bourgeois sociology. The sample, and therefore the research, does not include those who reject the research, who do not respond to the interviewer; instead, there are all those who accept the rules of the question-answer game.**

**This last group presents, for the discourse we are making, a singular theoretical interest, above all because it deals with a general figure, and the discourse can therefore easily extend to the other social sciences. It is possible, for example, to draw a parallel between these inmates who "collaborate" and the so-called informants of anthropologists, those informants on whose statements, behaviors, attitudes, beliefs, so much anthropology is based 38 From the theoretical point of view, the analogy between these two figures is clear: they are individuals willing to participate in the expression of a power. But what does "participate" mean in this case? it does not already mean autonomy, independent activity; instead it means accepting to place oneself as an object, as the focal point of the expression of a technical power by the researcher (sociologist, ethnologist, etc.). Both the member of primitive societies, who lends himself to collaborating with the anthropologist, and the "good."**

**patient "who agrees to be part of the sample," voluntarily "face and undergo this reduction to an object by the researcher. This "acceptance" can go a long way: in this way, the "good sick man" often becomes the skilled and willing guide of the visitors to the OP, the one who illustrates the new achievements (TV, game of bowls, flower beds), and however large the effort of the visitor, of the "white man", to understand this excluded world, however great his sympathy may be, and his desire for the emancipation of others, the "good sick man" largely outweighs it, in the sense that he is able to accept , to justify the values of the outside world (on the basis of which it was excluded) rather than those of one's own. It is on him as an object that sociological research operates 39**

**But now let us ask ourselves how the patient can refuse to be reduced to an object, what alternatives does he have to lend himself to collaborate, to share (undergoing) this expression of power. The other alternative, in very simple terms, is this: if he does not lend himself to collaborate, if he does not participate, the researcher (the holder of power) leaves him alone, he does not consider him. This means that for the researcher, for research, for power considered as a process, this patient does not exist (in "scientific" terms: he is not part of the sample). The objective choice that lies before the inmate is therefore the following: either to accept**

**be objectivized, or accept to be denied, and further excluded. This alternative has enormous significance and significance, and its significance goes far beyond the position of the recluse and the "black" in general: as should already be clear at this point, it invests the same position as the "white" (sociologist, ethnologist), and confronts him with the same crudeness. But, as we shall see, the Sociologist can overturn this alternative, while it is not at all clear how this overthrowing of alternative can be possible for the inmate, who must instead undergo it entirely.**

**However, at this moment of his research, the sociologist still does not think of any reversal (at most he feels a slight discomfort). On the basis of the sample thus formed, it is time to start with the "interview campaign". Of course, with such a selected sample, the interviews "are fine". All the better if, as the questionnaire technique advises, you have been warned to jot down some idiom of hospital jargon, and you know how to slip it into a question at the right time. Finally, the knowledge of the spoken language of the lower classes is excellent, in order to put the interviewee more at ease 40**

**Even with such a sample, however, problems can arise. The main problem arises when some interviewees break the rules. Main rule**

**of the interview (and, of course, of the social sciences): *neutrality* . An interviewee who in the middle of the interview asks for cigarettes, one hundred lire, who somehow establishes physical contact with the interviewer, violates the rules of neutrality. Suddenly, the interview "becomes infected": the sociologist forgets the expressions of hospital jargon, forgets the Italian of the working class, almost forgets the question he was asking. His embarrassment, discomfort, his "sincere disappointment" is so strong that at that moment, forgetting that neutrality and detachment have been arranged to guarantee him a better (more efficient) use of power, he uses his power to reassure himself of neutrality. It is fatal, at this point, that the tone of the interview becomes "more formal", and that until the end the sociologist does not lower his defenses.**

**But the worst violation of neutrality is when the patient turns out to be a "bad sick man": he does not respond, perhaps he spits, kicks. Faced with a patient like this, the sociologist, after a few "patient attempts", ends up concluding: "An interview is not possible! - and it is precisely an affirmation of this type which reveals to us, in reference to a leading technique such as the interview, that "research tools" are in fact instruments of power. In fact, what is the express meaning of the statement «The interview is not possible», and the position to which it refers? It is proof of the fact that the instruments of the**

**sociologist function as copies, as exact models of the mechanisms of overwhelming and exclusion at the general social level, in the sense that their usability depends on the level of social integration of the research objects. Let's consider this parallel. Social power determines the exclusion of a group of individuals: among these, some are "recovered" (reused) as long as they accept, to the point of internalizing it, the validity and legitimacy of the rules of the game on the basis of which they were excluded; others, among these excluded, who "cannot" make this acceptance, are further excluded and denied. The sociologist's procedure is identical: from this mass of excluded people, he recovers some, - all those, that is, to which the classical instruments of research are applicable; all the others, those for whom the application of such tools is not possible, the sociologist distances them from himself, does not consider them, denies them in the only way in which the power with which, as a sociologist, is endowed, it allows him to deny them: as impossible objects of research. Therefore, also with regard to the central phases of the research, the trust in the neutrality of the sociologist, of his tools (interview, tests, scales of attitudes, etc.), must fail in the face of the observation that the population discriminated by the use whether or not of these instruments coincides with the one discriminated (based on the criterion of reusability), for its purposes, by the**

**general socio-economic system.**

***What are the consequences of this "disruption" of traditional tools and techniques for the object of the research?***

**It was said before that, in practice, all research in the OP has as its object or certain aspects of the interaction of patients with each other (or with nurses, with doctors), or the way in which the patient adapts to hospital structure. Researches of the first type, we repeat, are aimed at identifying the most efficient ways of operating the hospital, without prejudice to the current, complete, asymmetry of power; in the second case, they are aimed at seeking new forms of integration of the inpatient in the hospital system, ensuring their substantial adhesion. If the sociologist, once this point has been made very clear, believes that he is collaborating with the general system in improving the kindergartens, making them more comfortable, more efficient, etc.**

* **crisis of the instruments "will come back immediately, because it has no reason to exist. In fact, the research techniques as formulated in contemporary sociology are perfectly suited to the achievement of those ends. What then this absolute subordination of sociology to the system is paid dearly, in terms of lack of**

**creativity, conceptual sterility, etc., is another matter.**

**If, on the other hand, the sociologist is not willing to put this crisis of instruments into place, but intends to seek a more satisfactory outlet for it (at this moment he is thus putting his subordination to material power in brackets), it is necessary for him to return to the problem of the object. research. The question to ask is the following: are there (and if so, what are) research objects that are not directly exploited by the general social system and by the hospital system for their own purposes? The answer, in our opinion, is this: there is only one type of research that responds, at least initially, to this requirement, and it is research that has as its object *the challenge of the hospital system and the general social system that takes place within the OP* This answer - let's say it right away - does not at all solve the problem of the role of the sociologist in this society; indeed it is still an incomplete answer, essentially ambiguous. However, we would like to talk about it, first of all because, in the course of a concrete research experience in which the writer participated, it constituted, at least for a certain period, a "solution", and it is probable that it presents the same appearance for other similar experiences, that is, generalizable; secondly, because it is not simply an interlocutory answer, but (when**

**arises from experience, from the praxis of dialectical research, as it contains in itself the premises for its overcoming.**

**What does it mean to do a research on the dispute in-TO.PP It means to collect and analyze each**

**manifestation (attitude, behavior), individual or collective, directed *against* the hospital social system and the general system of which the first constitutes the direct continuation. The fundamental assumption of a research of this type is that any manifestation within the aforementioned system can be evaluated with reference to two opposite poles, that of contestation, in fact, and the opposite pole of integration. If a patient breaks a window, smears the walls, refuses to answer, carries out aggressive acts, all these acts are taken as expressions of protest. The fact that an individual who has been subjected to oppression, who has been excluded from general society, stripped of his identity and reduced to an object, and who is now being signaled to attempts to persuade him to accept those rules under which**

* **been excluded, etc .; the fact that an individual in these conditions reacts, protests, possibly in a violent form, is the crucial phenomenon of the hospital experience. It is crucial because it is directly linked to the prospects of a possible intervention: like the sociologist**

**collaborator studies the forms of integration and adaptation to the OP, as it is to strengthen this institution, the sociologist in a critical position (for now we can not say more) looks for the forms of contestation to this system, in view of its killing. This contestation, in fact, is not an end in itself, it is not a mere outlet: it is the spring that, at any level of institutional regression, calls the whole system into question, a feeble attempt to deny it.**

**But now we are not so much interested in talking about the contestation itself, as much as about the meaning of a research on contestation for the critical sociologist. Although the decision to consider contestation as the only possible object of sociological research is, as we have already said, and as we will try to show later, a still intermediate position, to be overcome, it already represents a *reversal* of respect**

**to the traditional sociological approach, a total reversal, the same one that occurs from the negative to the positive of a photographic film. The collaborationist sociologist, in fact, cannot, literally, study the contestation in the aforementioned way, and *cannot* because he *cannot see* it as a sociologist: this is because, aswe tried to demonstrate first, if he wants to use the tools and techniques of his profession, any expression of dispute is excluded from the research**

**before this begins (all "bad sick people" are excluded from the sample), or is quickly marginalized if it becomes more evident during the research ("The interview cannot be continued!") The examples in the literature are innumerable: for example, in a text that comes to mind, the author illustrates a series of phases through which a therapeutic group passes, the second of which presents, from our point of view, an enormous interest, being very rich in disputes: just think that, apart from numerous serious infringements of the regulation and many cases of destruction of things, a block is even constituted in the communications by the group to the medical staff, and that this blocking is controlled by the group, which punishes the offenders. Well, for the author of the aforementioned paper, this phase must be interpreted as a phase of "social disorganization"! "All the doctors - he concludes sadly - noticed that in that period the therapy was largely ineffective" 41 Fortunately, in the following phases, things went better: communications with doctors resumed, the manifestations of act-ing-out decreased, and it is probable that the therapy has made great strides, rediscovering the indispensable "cooperation" on the part of the patient ...**

**Another way not to notice the fact of the dispute is to include it in the category of deviance: it is sufficient, for this purpose, to define the**

**deviant as one who behaves in ways different from, and unacceptable to, other patients; in short, the individual who disturbs, who focuses the resentful attention of others on himself, who obstructs ... is deviant ... 42 This dilution of the contestation into generic "deviance", closely associated with the fact that there is a very vast sociological literature on the "control of deviance", but very scarce, on the treatment of the contestation, has very specific theoretical reasons. In fact, deviance does not leave the system, so to speak: it possibly represents a departure from the ends recognized by the system, or from the means legitimately foreseen for their achievement, but with this, implicitly, it accepts and recognizes both means and ends; while, at the end of the contestation, however weak, clumsy and "regressive", there is the subversion of the system.**

* ***perhaps it is necessary to clarify, at this point, in what sense also for the sociologist, as well as for the recluse, the alternative "objectification-denial" arises, and, in general, the problem of the relationship between the role of the sociologist and power .***

**Before tackling the problem of power, it is necessary to justify a statement made just now, namely that**

**even a sociological research which has as its object the contestation must be overcome, because it represents an ambiguous and unsatisfactory position; and, above all, to see how it is possible to overcome it.**

**The essential reason for the ambiguity of a position of this type appears to us: clear if we consider that the general social system exploits sociological research in two different ways. The first, the most evident, refers to the well-known social engineering function of sociology: social research provides the system with useful information for restructuring, in the sense of greater efficiency, the OP (as well as the factory, the school, etc. .). The second modality of exploitation**

* **more subtle, but equally conspicuous: *for the simple fact of carrying out a sociological research* , the sociologistit exercises power on behalf and in the interest of the social system, to such an extent that there is a close correspondence between the techniques of sociological research and the techniques of general material power. It is clear, at this point, that a research on contestation is perhaps capable of eliminating the first type of exploitation, but leaves the second intact: the research itself, any research, is an expression of power.**

**This observation emerged very clearly in the course of the research experience to which this discourse refers, and that is: also a research aimed at highlighting**

**the contesting elements of the system is subordinate to the system, and instrumental to it, precisely because the researcher continues to operate on the basis of that power with which the general system had initially endowed him; precisely because the fact that this power is directed against the system *has less value* than the fact that this power is exercised in one way or another.**

* + **It is therefore clear that this position (research on contestation) turns out to be extremely equivocal, referring to the image of a desperately poised sociologist, who searches for every expression of contestation and who ends up contesting everything, except his own role. But it is interesting to see how the sociologist in this position justifies the non-inclusion of his own role among the objects of dispute. The main justification rests on the observation that the sociologist exercises a power, but a *technical power* , and therefore a neutral power ( *sic* ), or perhaps a "good power"**
* **which can be used against the system. Even this extreme defense of the role of the sociologist is revealed, however, from a first analysis to be essentially abstract and anti-historical: more precisely, it does not take into account the fact that, alongside the division of social labor, there has been a division of social power. Compared to the original undifferentiated social power, that is, technical power does not represent the outcome of a purification process, of**

**purification, but the result of a process of differentiation of this original power, a process that led to the distribution of technical and material power to different agents in the most suitable way for the system. Technicality of power means that there was first of all a division between holders of power and mere executors; secondly, within the latter, a division of tasks between technical executors and material executors. Technical power is therefore such to the extent that, alongside it, there is an executive power of disposition, of exploitation, of exclusion, and wherever there is technical power in the "pure" state, the use of this power is made possible by mechanisms of equally "pure" material power. (It is superfluous for the ethnologist to be armed, as long as the colonial police are).**

**The abandonment of this latter position as well, and the questioning of one's role, has a crucial significance for the sociologist. It constitutes as the last item of a general balance sheet of his intervention, a balance that could be, very simply, like this: "the participant observation does not work, the interview does not work, the sample does not return, the basic hypothesis also more advanced does not save anything ... But then the very possibility of research is called into question! "**

**All of this is correct. The research experience in the OP, perhaps more than in other systems characterized by asymmetry**

**of power (in the OP this asymmetry is total) consists precisely in the progressive crisis of the tools and techniques of research, to arrive at the crisis of research as a whole and, ultimately, the crisis of the very *idea* of research, and in the consequent *renunciation of research* . In this sense, precisely when he renounces research, and only at that moment, the sociologist fully understands that he has been the bearer of a power conferred on him by the general ); he understands that not only the search results, but his own tools, serve the system; finally he understands that the use of such tools corresponds to an act of objectification and denial which, as the representative of the system, the sociologist is carrying out at that moment.**

**In this final moment of his collaboration with the system, the sociologist also realizes that, of that power that had been entrusted to him, he was not the subject, but *the object* ; that is, in the exercise of this small power he suffered a much greater power, accepting to place himself as an object at a somewhat higher level, perhaps, than that of the sick or the "black", but always enormously far from the top. . In this more lucid moment of his awareness, the sociologist is therefore also aware of the fact that he arises**

**to him too the alternative that he posed, on behalf of the system, to the recluse: either to accept being reduced to an object (and to collaborate in this sense), or to be denied (which means, for the sociologist, that the his ration of technical power). More clearly than for the patient, however, it is possible for the sociologist to overturn this alternative ^ but he can do it in only one way: actively rejecting the very idea of research, thus configured, rejecting his own role as sociologist, in a word, committing suicide as a sociologist.**

**What remains beyond this violent act of self-denial as a sociologist is by no means clear. That something remains, that the discourse must go further, seems probable to us. This refusal of research should not be understood, in fact, in its simple cognitive-operative implication, but, essentially, as a refusal of power. This raises several problems, first of all: is it possible, does it make sense, starting from an absolute lack of power, to do research? To what extent, that is, the idea of research is linked with the disposition of a power? It is perhaps even superfluous to note that we are unable, at this time, to answer such questions. However, it is possible to indicate the two main conditions that must be satisfied before an answer can be attempted. The first condition is to know much more than is now commonly known about the role of the sociologist**

**understood, and on the division of labor and social differentiation to which it refers, in its current form. In particular: why does the role of the sociologist exist, in this form, in our society? Is it because our society is a complex society, or is it because it is a capitalist society?**

**The second condition is even more mandatory. To ascertain the links between research and power, to free, as we hope, research from power, *we need to do research* . The same is true for the previous phase: suicide of oneself as a sociologist makes no sense if done in the abstract, but only if it occurs on the ground of research. It is practice that must lead to this fundamental choice, and it is in practice that the theoretical correctness of a possible subsequent intervention as a non-sociologist must be painstakingly verified.**

***Appendix***

**It is considered appropriate to insert, in the appendix, two articles that reflect two particular aspects of the present moment: i) the problem of the *accident* and its meaning in an overturned reality, where a false step or an error can confirm - public opinion - the impossibility of an action that openly reveals its flaws and its uncertainties, while every other institutional reality takes care to hide them, each under its own ideology; 2) the problem of *managing* an institutional reality which, although denied, mustsurvive in order to continue to bear witness to the need and urgency of a denial of current reality, at all levels.**

**1.**

**The problem of the *accident***

**Any *accident* that occurs in the psychiatric institution is usually attributed to the disease, called into question as the sole responsible for the unpredictability of the inmate's behavior: science - in defining the patient as incomprehensible - has offered the psychiatrist the tool to take responsibility for of a patient who, by law, must monitor and care for. Thus, the psychiatrist has so far used this tool as the only one who could free him from the responsibility that his task entails. Responsible before the company that delegates him to control anomalous and deviant behaviors (where risks and failures are not admitted - as in other specialties), the psychiatrist has only transferred the responsibility for these behaviors into the illness, limiting himself to minimizing the possibility of subjective actions of the patient, through his total objectification, within an institutional system appointed to *foresee the unpredictable.* Only through the**

**freezing of the roles that make up this reality, the psychiatrist can guarantee control of the situation, by means of norms and rules that refer to the law (as regards the competences of the public prosecutor), to the internal regulations (as regards relations with the provincial administration on which the institute depends), and to science with its classifications and categories that define the characteristics, often irreversible, of the patient.**

**In this space where the abnormal is the norm, the turbulent patient, the agitated patient, the broken patient are accepted and justified according to the stereotypes of the disease; just as murder, suicide or assaults of any kind, up to those of a sexual nature that can occur in more liberalized (and therefore more promiscuous) institutions, are understood and justified if incorporated into the unknown and unpredictable mechanism of syndromes. The incomprehensibility of an act removes all responsibility from those who assist it or the environment in which it fits, given that when it is defined as *sick* , no one is taken into consideration, beyond the abnormal and uncontrollable impulse that is part of the nature of the disease.**

**But, once the sick person approaches, no longer as an isolated entity, closed in his incomprehensible and unpredictable world, detached from the social reality of which he belongs - although it is difficult to identify the place - detached**

**from the institutional reality 'in which only a passive role is assigned to him, the institution is also involved in each of its acts, as a party to its behavior, since every phenomenon is correlated to the situation in which the patient finds himself living .**

***The accident* can therefore be looked at from two opposite points of view, which correspond exactly to the two different ways in which the institution judges the patient entrusted to it.**

***In the first case* , we are talking about the classic closed institution of a custodial type, where the relationship with the patient is mainly of an object nature, given that efficiency is the primary purpose of the institution: the patient is an object, within a a system in whose norms and rules he must identify himself if he is to somehow manage to survive the oppression and destructive power that the institution exercises over him. But whether the patient opposes it with blatantly anomalous behavior, or adapts to it with openly servile and submissive behavior, the patient is in any case determined by the institution which - through the rigidity of its rules and the one-dimensionality of the reality it imposes - continues to fix it. in his passive role which does not allow him a single alternative, beyond objectification and his adaptation to it.**

**It is therefore the institution which, in its proposing a reality**

**devoid of alternatives and personal possibilities, which go beyond regimentation and serialization of institutional daily life, it gives the inpatient indications for the act that he is supposed to do. Indications that are implicit in the total absence of a purpose and of a future towards which it can be planned, and that reflect the psychiatrist's lack of alternatives, purposes and possibilities of becoming futuristic, as a delegate of a company that requires him to control abnormal behavior, with the minimum of risk.**

**In this forced situation, where everything is controlled and foreseen according to *what must not happen* , rather than as a function of a positive purpose towards the patient, freedom can only be experienced as *the forbidden-denied act* , impossible to take place, in a reality thathe only lives to prevent it. The crack of an open door, an unattended room, a ajar window, a forgotten knife, are the explicit invitation to a destructive action, to prevent which the institution exists. This is the result of identification with the institution to which the sick person is forced, who cannot but experience freedom as a self or heterodestructive moment, just as the institution has struggled to teach him. Where there are no alternatives, where there is no possibility to choose and take responsibility, *the only possible future is death,* as a refusal of a condition of life.**

**unlivable, as a protest to the degree of objectification to which one is reduced, as the only possible illusion of freedom, as the only possible project. And it is too easy to identify these reasons with the nature of the disease, as classical psychiatry has taught us.**

**In this context, any action that - in some way - breaks the iron circle of institutional rules is an illusion of freedom that is identified with death. The flight from an institution whose only possible future is explicitly "death" can only be an attempt to escape that future, in the illusion of being able to still be masters of one's life and responsible for one's acts; but it inevitably ends with the confirmation of one's own slavery or with death.**

**The only responsibility that the institution - paradoxically - grants to the inmate is that *of the accident* , which it hastens to transfer to the patient andillness, refusing any link and participation in it. The inpatient who, during the long hospital stay, found himself stripped and deprived of responsibility in all his movements, finds himself completely and automatically responsible for his only act of freedom, which almost always coincides with death, the closed institution, as a world. already dead in himself from the moment of objectification of the patient in his dehumanizing rules, therefore offers him, as the only explicit alternative, the death that**

**will present each time with the illusory face of freedom. In this sense *the accident* (of whatever nature it**

**sia) is nothing but the expression of *living the institutional rule to the end* , taking it to the extremeconsequences are the indications that the institution provides to the patient.**

**(At this point, the discourse can naturally be transferred from the hospitalized patient, to the person without alternatives, without a future, without a possibility, who lives in a reality in which it has no place. The exclusion of which it is the object, then serves to indication to the only possible act, which cannot but be an act of refusal and destruction).**

***In the case of an open institution* , the overall purpose of the institution is to maintain the subjectivity of the patient, even if this can be detrimental to the overall efficiency of the organization. This purpose is reflected in every institutional act: if it is necessary to go through the identification of the inpatient with the institution, it is an identification in which he can recognize and identify his personal purpose, a future possibility, given that the institution it presents itself as an open world, offering alternatives and indicating the patient's life as possible.**

**In this reality, freedom becomes the norm and the patient gets used to using it; which means it is a**

**exercise in empowerment, self-control, management of one's own person and understanding of one's illness beyond any scientific prejudice. But for this to happen, it is necessary that the whole institution (ie the different roles that make it up) be fully involved and present in every moment and in every act, as material and psychological support of the patient. This means the rupture of the rigidity of roles, the rupture of the object relationship with the patient whose aims are shared; the rupture of the authoritarian-hierarchical relationship in which the values of one pole of the relationship are taken for granted, as well as the non-values of the other; the possibility of more alternatives in which the patient is in a position to oppose the world of institutional rules, obtaining the perception of continuing to exist, within an institution that aims precisely to create the conditions for him to continue to exist. This means that the institution renounces any form of defense that does not consist in the participation of all the roles that make it up in the general trend of a community, in which the limits of one are set by the presence of the other and by the reciprocal possibility of dispute.**

**This is, of course, the utopian formulation of the open institutional reality: contradictions are present in this reality, just as they are in the external one. But what matters is that the institution is not in charge of covering them**

**and to hide them, but try to confront them with the sick and to highlight them where they appear more ambiguous.**

**In this context *, the accident* is no longer the tragic result of a lack of surveillance, but of a lack of support from the institution. The institutional action supported by the sick, nurses and doctors can sometimes fail, creating gaps in which *the accident is inserted* ; the failed acts, the omissions, theprevarications always have perfectly logical consequences and illness plays a very relative role here.**

***The open door* then becomes an indication for an awareness of the meaning of the *door* , of the separation, of the exclusion that the sick are subjected to in this society. It takes on a symbolic value beyond which the patient recognizes himself as « *not dangerous to himself and* *to others* "and this discovery cannot fail to lead him to ask himself why he is forced, then, to such an infamous condition and why it is *excluded* .**

**In this sense, the open hospital acts by stimulating the patient's awareness of being a real excluded person, being able to use an instrument that demonstrates - *as its only function is to demonstrate* - what has been made of him and the meaning. that the institution in which he was imprisoned had.**

**On the other hand, the open institution, as a contradiction in a social reality that founds its security and its own**

**balance on the clear separation into watertight compartments, categories, codifications that preserve the clear divisions of classes and roles, cannot fail to involve the psychiatrist and the treating staff in this awareness. They find themselves placed in a reality of which they are partly *accomplices* and partly *victims* , forced by our current social system to declare themselves guarantors of an order they want to destroy, excluding themselves and excluding at the same time. The open door therefore also acts on the psychiatrist as an awareness of his degree of slavery towards a social system that is supported by the *unsuspecting and silent perpetrators.***

**What is the meaning *of the escape* , *the accident* in this context? It is directly linked to the degree of openness to the outside and to the social nature of the reality towards which it opens: the possibilities that the institution offers can clash with the refusal on the part of external society to implement them. The future, the project of the institution, can only be *the outside.* But just as the traditional institution is involved in *accidents* , as part of their genesis, in the open institution - precisely inasmuch as it is open to the outside - this society, with its violent rules, discrimination and oppression, continues to represent the rejection, denial, exclusion of the mentally ill as one of the many disturbing elements, for which there is - precisely -**

**the institution and the appropriate space.**

**In this case, whose responsibilities are there? A sick person who can be discharged and who finds himself rejected by his family, his workplace, his friends, by a reality that violently rejects him as *a man too many* , what can he do but kill himself or anyone who has the face of violence of which it is the object? In this process, who can honestly speak only of disease?**

**FRANCO and FRANCA BASAGLIA**

**Gorizia, March 28, 1968.**

**2.**

***management* problem 43**

**When one analyzes a static and fixed institutional reality in its closed schemes, many elements - often the most essential ones - escape investigation under a labeling that rarely corresponds to reality. If we then propose to analyze - as we have tried to do - a psychiatric institution in movement, or rather in *permanent crisis* as we like to define the one in whichwe act, the company is even more difficult, thinking about the purpose that this action sets itself: the replacement of a schematic reference model with something that is not limited to being a *non-model* , but that wants to have the possibility of setting itself as an *anti-model* , capable of destroying the tendency to settle down in new frames of reference, opposed to the traditional ones. This means the destruction of the asylum institution, not only as a real overthrow of the coercive system on which it is based, but as an awareness of the *global level* on which the hierarchical-punitive system is based.inserts - which requires a *global discourse* that has a**

**precede the particular psychiatric one, or in which the specific psychiatric discourse can extend. A psychiatry, therefore, which does not just want to deny itself, but wants to assert itself as antiscience (if by science we mean an ideology that always confirms the values of the ruling class), through the necessary passage from a simply countertransference position, to a dialectic. Only in the crisis and in permanent internal criticism will it perhaps be possible to find the guarantee that it does not act as a decisive science.**

**The *first* phase of our anti-institutional action can be defined, as CT in general can be considered, *countertransference* , in the sense that direct contact with institutional reality has forced us to attempt a reversal - of an essentially emotional nature - of this reality, rejecting the violence with which it has always been handled. The encounter with the patient in the institution responsible for his custody and care involved us existentially as accomplices and architects of the inhuman condition to which he was reduced, requiring, on our part, an anti-institutional action which essentially tended to overturn the *negative .* of the asylum world, in the positive of a psychiatric institution in which the mentally ill is a man who has the *right* to be**

**cured. Hence the originally restorative meaning of our action.**

**However, the identification of the mentally ill as the *social excluded* who paid for the tranquility of our existence allowed us to take a next step, which consisted in identifying the common denominator for all the excluded, pushing us to search for the relationship between *the excluded* and that which excludes it. In this research it became clear that what happened in the psychiatric institution was common to all the other institutions on which our society bases its system: every institution is appointed to institutionalize those entrusted to it, whether they are institutions. psychiatric, or pedagogical, family, punitive, etc.**

**This *second* phase can be defined as that of the *rationalization* of the countertransference moment, whichit passes through the awareness of our position - therefore of the position of the institution in which we act - towards the social system in which it is inserted. In this sense, CT, as a scientific realization of the primitive countertransference response, can be the concrete expression of a new science - social psychiatry - which, by calling into question the social and environmental factors in the genesis of mental disorders, tries to run for cover. , establishing a psychiatric service**

**technically efficient and humanitarian. But the discovery of the "social virus" as responsible for the disease still keeps psychiatry in a countertransference - albeit rationalized - terrain since it limits itself to broadening its field of action, establishing internal and external psychiatric services that have the task, from on the one hand, to repair the disasters caused by its own institutions, and, on the other, to soften and soften social conflicts.**

**In other words, the analysis of the problem has passed from the countertransference terrain to the sociological one, without however losing the meaning of simple observation, typical of any investigation that limits itself to considering the object of the research as a *given* .**

**Proceeding along this line, it is evident that any institution created by the economic system in which we live is, by that very fact, functional to it; which means that all the institutions are responsible for managing the contradictions of the system itself. Through the creation of specific categories, the system guarantees the possibility of a general control that protects it against any surprise and imbalance. According to the various institutions, we will thus have different types of *excluded* or *codified* , whose specific exclusion is always functional to the society of which they are an expression. In them the contradictions are covered up by scientific ideology**

**(each institution will be guaranteed by its own specific ideology) which defines the limits of the category of competence.**

**Now, when it is realized that all the institutions are functional to our economic system, we arrive at a subsequent awareness that could be defined as the moment of *political rationalization* . In fact, insofar as they are functional to the system, the institutions reveal themselves to be directly linked to the values of the ruling class that creates and determines them, demonstrating how their function essentially consists in the maintenance of these values and in guaranteeing their effectiveness in the manipulation of a whole society. The action to be implemented in an institution functional to the system cannot therefore be limited to a simple humanitarian reversal of the specific situation, but should act within the functionality of the *institution towards the system itself.***

**However, once the process of institutional overthrow has been put in place, we realize the contradictory nature of the existence of an institution that denies its own institutionality within our social system, in whose dynamics we tend to absorb every movement that could alter the general balance. The existence of CT is accepted insofar as it is proposed as a new model of assistance**

**psychiatric, therefore as a proposal for a reformist healing of the most evident social contradictions. This reveals to us that we have fought against the system that determined an institution in the most functional way to it, to suggest a new internal solution, capable of making it overcome - through technically advanced methods - its own contradictions. In this sense, our action can take on a highly reformist and integrating meaning that does not correspond to the goals we had set for ourselves.**

**The problem now is what the next step could be, if one does not want, after the moment of political rationalization, to go back to the counter-transference situation, as the only possible action within a system that tends to overturn in affirmation of itself, what is its negation. As long as we remain within the system, our situation can only continue to be contradictory: *the institution is simultaneously denied and managed, the disease is simultaneously bracketed and treated, the therapeutic act is simultaneously rejected and acted upon* . This is the sign of the countertransference characterof our negation, or is it an expression of the limits within which our action is forced and beyond which there is no other alternative? The only possible overcoming, which goes beyond the institution and which does not turn into a confirmation of it**

**on a different level, it is the formulation of a science that - denied in the negation of the institution linked to it - is overturned in its essential meaning: a science that is not appointed to guarantee the values of the ruling class.**

**But, at the present moment, are we sure that we can begin to devote ourselves to the "disease"? What remained - in our psychiatric institution - after the series of successive reductions that freed the mental patient from the institutional and scientific encrustations with which he was covered, is to be considered the "disease"? Or the weight of the patients who - not having a *social solution on the outside* - we are forced to continue to manage, theredoes it still prevent us from being what we want, forcing us to create a *new* institution in order to survive? Is this the sign of our powerlessness, or of the inability to act within the system?**

**When our patients tell us: «Well, you convinced us not to be mad, in the sense in which they told us to be: we are excluded, rejected. However - crazy or excluded - we are always here, in a hospital that protects us and guarantees for us. What are we then? They formulate the problem exactly, as we ourselves are experiencing it. We could say that, as long as the institution is forced to manage a "sick person" who retains his status as a man cut off from civilian life as he is not**

**suitable for it, one cannot *yet* speak of "disease". There are other incrustations to remove and it is no longer the institution that can do it: it is society, the economic-political system that is challenged by these presences within a psychiatric institution, for which there is no reason nor justification.**

**In order to truly deal with the "disease", we should be able to meet it *outside* the institutions, meaning not only outside the psychiatric institution (which could suggest the "sector" or preventive systems), but *outside* any other institution whose function is to label, encode and fix those who belong to it in frozen roles. But is there really an outside on which and from which we can act before the institutions destroy us? Can it not be argued that the face we know of the "disease" is always, however, its institutional face? It is evident that any attempt to break the "norm" is absorbed as one of the poles of discourse within the same structure. If the "disease" can be understood as the condition of those who place themselves outside the norm, the institution is the sanction that has the function of bringing the abnormal back to normality: that is, it is the place - in the norm - for deviations from the norm .**

**The discourse could go on to make us argue that the one who is defined as "sick" (outside the**

**norm) is cured of his "illness" when he comes into contact with the sanction; and this not only through the proof of reality in the encounter with the harshness and violence of the institution, but also due to the fact that the contestative expressions that he wanted outside of it are recognized as in the "norm" and that, by this very fact, they lose their original meaning.**

**Here the patient finds himself ill with something else, that is, with a disease that could be defined as institutional, since it corresponds exactly to the imposition of a *role of abnormality* which has found its function and its meaning within the norm.**

**The destorification that the various institutions (family, scholastic, industrial, etc.) had tried to do against the "patient", through his de-responsibility, is reversed at the moment of his entry into the psychiatric institution where he - individually made aproblematic and adialectic from the one-dimensional nature of the institution - he finds himself living in function of it and of its history, thus reintroduced into the system as the object of an institution that is functional to it. The only moment of real historicity (however difficult to identify since there is no place that is *outside* the institutions) which consisted of his "being outside the norm", is denied him through the imposition of the institutional historicity to which he is forced**

**to join: destorified, de-responsible, aproblematic, adialeptic, the hospitalized in the psychiatric institution nevertheless fulfills its function of support to the system, precisely as it is categorized and defined within one of its institutions.**

**In this sense, the presence of the so-called "norm" within the psychiatric institution could be somewhat contesting, given that the explicit function of the institution is to contain what is outside the norm. This (as long as the system does not establish that the psychiatric institution is a new institution of the norm) could also 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 psychiatric institution, as place of the abnormal of the norm. This also means that the presence, within other institutions (family, school, factory) 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 the "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 reintegrated into society through the use of a reintegrating institution, but he can also fulfill a challenging function, in the sense that his mere presence**

**in the external world it would openly deny the world to a single dimension desired by the system and, at the same time, confirm the action of an institution that refuses to exist only as a place of contradictory discharge of contradictions.**

**This could be an outline for future indication. For the moment, the observation that can be made is that the mentally ill, entering his specific institution, begins his career, just as one begins any other professional career within another specific institution: in the eyes of the system there is no 'there is no difference, as long as everyone stays within their own category and sphere of competence. At most there could be an inversion of roles: the relationship towards the system does not change. There will always be scientific ideology - as the overcoming of internal contradictions - which will sanction and define everyone's place, so as not to upset the production and balance of the system.**

**At this point the problem shifts to the ground**

**of the scientific ideology that establishes, at the same time, the norm and the sanctions necessary to enforce it, in order to protect this balance. Norm, sanction and scientific ideology are always indispensable to each other, since they mutually support each other.**

**Now, if it is the scientific ideology that determines the norm and establishes the sanction best suited to the system, it is the scientific ideology that acts as the main institution that determines the disease as we know it. Indeed, the fact that bourgeois psychiatry is now willing to recognize that mental illness can be closely linked to the contradictions of our social reality, widening the field of investigation and treatment from the individual to the family, to the school, to the factory, means that in this management knows it can create new institutions (family psychotherapy, factory psychologists, social workers) that will dampen conflicts, without ever questioning the foundation on which the ideology is based: *the definition of the norm as a circle limit of the values of the ruling class and the division of roles as a subdivision within the norm of the different competences.***

**Now, our problem is, whether within an institution it is possible not only to break the institutional circle, but also to challenge the limit of the norm through the overthrow of a science that is not, explicitly, a class science. . If this discourse could have been, until recently, an intuition of the political significance of the danger our anti-institutional action could face, on the practical level it is now a real situation that presents itself with the**

**the same urgency with which the countertransference denial of institutional violence was presented. It is a question of both a theoretical and a practical impasse, which has nothing to do with the scientific dissertations we are used to: for us it is a question of understanding how an anti-institutional action can concretely affect structures; if it can, or if this attempt to affect the structure through the negation or overthrow of the institution, is only a new *utopia* (which turns into a new ideology), which allows us to endure the kind of life we are forced to to live.**

***The institutional career* is what closes - at all levels - each one 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 to live and act for the preservation of institutions and the system? Or does the political opening of the problem give us a chance to escape?**

***career* seems to show us a path that he has concretely concluded with his participation in the "African revolution". Frantz Fanon has followed, in his short life, all the institutional process that the system allowed him: from a brilliant psychiatrist in Lyon, to a psychiatrist working in the center of Saint-Albain, to**

**black psychiatrist with black patients in Algiers, during the war of liberation. It is here that, evidently, Fanon clarifies his position as a politicized psychiatrist, realizing that the relationship between doctor and patient (as well as the relationship between white and black, therefore between those who have power and those who do not) *was always an institutional relationship . where the roles were defined by the system* . The maximum that his action could bring was the reformism and technical perfectionism of an institution that offered - in exchange for the confirmation of the patient's dependence - "healing" and social reintegration in a reality that Fanon defined as "a systematized dehumanization" . The therapeutic act was an act of silent acceptance of the system and Fanon could only choose the revolution as the only place outside the institutions where he could act.**

**Your resignation letter 44 by médecin-chef of the Psychiatric Hospital of Blida-Joinville of 1956, says it explicitly:**

**... Bien que les conditions objectives de la pratique psychiatri- que en Algérie fussent déjà un défi au bon sens, il m'était apparu que des efforts devaient ètre entrepris pour rendre moins vicieux un système dont les bases doctrinales s'opposaient quotidiennement à une perspective humaine authentique.**

**Pendant près de trois ans je me suis mis totaiement au service de ce pays et des hommes qui the habitat. Je n'ai ménage ni mes ef- forts, ni mon enthousiasme. Pas un morceau de mon action qui n'ait exigé comme horizon l'émergence unanimement souhaitée d'un monde valable.**

**Mais que sont l'enthousiasme et le souci de l'homme si journel- lement la réalité est tissée de mensonges, de lachetés, du mépris de l'homme? ... homme de perdre sa liberté. Et je puis dire, que place à cette intersection j'ai me- suré avec effroi l'ampleur de l'aliénation des habitants de ce pays.**

**Yes, the psychiatrie est la technique medicale here if proposed de permre à l'homme de ne plus étre étraoger à son evironnement, je me dois d'affirmer que l'Arabe, aliene permanent dans son pays, vit dans un état de dépersonnalisation absolue.**

**The statut de l'Algerie? Une déshumanisation systématisée.**

***Or le pari absurde etait de vouloir coute que coute faire exister quelques valeurs alors que le non-droit, inégalité, le meurtre mul-ti-***

***quotidien de l'homme étaient érigés en principes législatifs* 45 *.***

**The social structure existant en Algérie s'opposait à toute tentive de remettre l'ividu à la place ...**

**... The fonction d'une social structure is de mettre en place des institutions traversées par le souci de l'homme. Une société qui accule ses membres à des solutions de desespoir est une société non viable, une société à remplacer.**

**Le devoir du citoyen est de le dire. Aucune morale professional, aucune solidari té de classe, aucun desir de laver le linge en fa- mille ne prévaut ici ...**

**Le travailleur dans la cité doit collaborer à la manifestation sociale. Mais il faut qu'il soit convaincu de l'excellence de cette société vécue. Il come un moment où le silence devient mensonge ...**

**Depuis de longs mois ma conscience est le siège de débats im-pardonnables. Et leur conclusion est la will de ne pas desespérer de l'homme, c'est-à-dire de moi-mème.**

**But décision est de ne pas assurer une responsabilité coute que coute, sous le fallacieux prétexte qu'il n'y a rien d'autre à faire.**

**Pour toutes ces raisons, j'ai l'honneur, Monsieur le Ministre, de vous demander de bien vouloir accepter ma démission et de mettre fin à ma mission en Algérie, with assurance de ma considération distinguée.**

**Fanon was able to choose the revolution. We, for obvious objective reasons, are prevented from doing so. Our**

**reality is still continuing to live the contradictions of the system that determines us, managing an institution that we deny, carrying out a therapeutic act that we reject, denying that our institution - which has become by our very action an institution of subtle and disguised violence - does not continue to be only functional to the system; trying to resist the lure of ever new scientific ideologies in which we tend to suffocate the contradictions that it is our task to make ever more explicit; aware of *engaging in an absurd bet in wanting to make values exist while the non-law, the inequality, the daily death of man are erected to legislative principles.***

**FRANCO BASAGLIA**

**Note**

1. **It was a "framework law" which, although incorporated into the health reform, was never accompanied by the health plan which should have defined funding, structures, personnel, etc.**
2. **In 1987 we presented to the Senate, with the Independent Left Group, the first bill implementing the reform that never came to be discussed. However, it stimulated and served as a basis for the drafting of the project for the protection of mental health, approved only in '94 and only partially implemented.**
3. **The recording took place in the summer of 1967 [Editor's note]**
4. **ERVING GOFFMANN, *Asylums* , Doubleday & Company, Garden City NY 1961**
5. **The sectoral care organization - mainly oriented and projected towards the outside - carries within itself the advantage of a more widespread prophylactic action and**

**timely. However, it remains to be said, in this regard, that if it is not accompanied by a simultaneous destruction of the psychiatric hospital as a closed, forced and institutionalizing space, its action would be undermined by the existence of the asylum, which would continue to act as a threatening force from to which the sick person only has to flee in order to save himself. The prophylactic action of an efficient mental health service would certainly be able to stop the entry into hospital of a large number of patients, avoiding the danger of hospitalization, with the risks that this entails in the current state of our psychiatric hospitals. But it cannot be denied that the principle of external psychiatric prophylaxis continues to move in the institutionalizing climate of the fear of hospitalization: hospitalization will be the extreme step that will be forced if the other means have not been able to solve the case previously. Nor the creation of structures such as the so-called 'open wards**

* **in psychiatric hospitals, it would solve the problem, in the sense that the privilege of the lucky ones hospitalized there with the mutual aid requirement would continue to exist, even in the hospital, as opposed to "closed wards." in which the "hospitalized by order" would continue to be placed and stamped.**
1. **The English example seems to us the representative pious to clarify the terms of the problem. Within the National Health, psychiatry does not occupy a secondary place, but the mentally ill, like any other patient, is considered "informal people" and is therefore integrated into the general medical system. But, if one can only agree with the general approach, it nevertheless represents a big question mark as integration to the system can hide the avoidance of the problem of mental illness and therefore the illusion of eliminating one of the big contradictions of our reality. To suffocate the problem of the sick contradiction in a sweet communitarian regression is the risk of some psychiatric organizations. Eg. Maxwell Jones's concept of "leaming leaving situation" or "sensitivity training" results, if not controlled by an authentic community check, an attempt at non-problematic integration: believing that that of "learning leaving situation" and "sensitivity training" can be a technique that resolves social conflicts, adaptable also to communities of non-sick workers, it can in fact represent the attempt of an ideological solution that does not take into account a contradictory reality (placing itself on the same level as the "resolving**

**social conflict "by Lewin). If the English approach is, therefore, to be considered on the one hand exciting because it gives the patient an active role in his sell making, it does not seem acceptable when this sell making highlights the tendency towards integration, hence the reformist meaning of the psychiatric system. Although the organization of the hospital in which we operate starts from assumptions similar to those in England, we are well aware of the danger that can easily be encountered: the sense of the patient's role and sell making are to be found in contestation and not in integration. (FRANCA and FRANCO BASAGLIA, GF MINGUZZI, Exclusion, programmation et intégration, «Recherches», n. "Paris, 1967**

1. **Reported by Jurij Davydov in *Work and freedom* , Einaudi, Turin 1966 (translated by V. Strada).**
2. **We are talking here above all of the therapeutic community experiments carried out in England and North America. Therapeutic community experiments are taking place all over the world. In *Italy* some private therapeutic communities (Napolitani) have been set up, others in some "open ward" of traditional psychiatric hospitals. The only psychiatric hospital in its entirety "a therapeutic community" (but the term is taking on meanings**

**less and less determined) is that of Gorizia**

1. **And not just psychiatric: the Borstal Institutions eg. they were attempts, carried out at the end of the nineteenth century, to humanize the youth prisoners. They have many points of contact with the therapeutic communities that have sprung up in some British and US prisons in recent years.**
2. **See R. HUNTER, One Hundred Years after fohn Conolly, «Proc. R. Soc. Med. ", 60: 8, (1967). See also A. PIRELLA and D. CASAGRANDE, fohn Conolly, from philanthropy to social psychiatry, in What is Psychiatry ?, Parma 1967.**
3. **See TF MAIN, The Hospital as a Therapeutic Institution, 'Bull. Menn. Clin. », 10:66 (1946).**
4. **I See in this regard:**

**A. STANTON and M. SCHWARTZ, *The Mental Hospital, Basic* Books, New York 1954**

**M. GREENBLAT, R. YORK and EL BROWN, *From Custodial to Tberapeutic Care in Mental Hospitals, Russe* ! Sage Foundation, New York 1955.**

**JAR BICKFORD, *Tbe Forgotten Patient,* Lancet, 5 November 1955.**

**D. V. MARTIN, *Institutionalisation* , Lancet, 3 December 1955.**

**I. BELKNAP, *Human Problems in a State Mental Hospital* , Mc Graw Hill, New York 1956.**

**M. GREENBLAT, DJ LEVINSON and LH WILLIAMS,**

**T *be Patient and tbe Mental Hospital,* The Free Press, Glencoe 1957.**

**WA CAUDILL, *Tbe Psycbiatric Hospital as a Small Society,* Harvard Universiry Press, Cambridge Mass.1958.**

**R. BARTON, *Institutional Neurosis* , Wright, Bristol 1959.**

**E. GOFFMAN, *Asylums* , Anchor Books, New York 196r. J. and E. CUMMING, *Ego and Milieu* , Tavistock, London**

**1962.**

**JK WING, *Institutionalism in Mental Hospitals,* «Brit.**

**J. Soc. Clin. Psycho !. », I: 38-51 (1962).**

1. **WESSEN, *Tbe Psycbiatric Hospital as a Social System* , Thomas, Springfield Il !. 1964.**
2. **See WORLD HEALTH ORGANIZATION - EXPERT COMMITTEE ON MENTAL HEALTH, 3rd. *Report* , Geneva 19.53**
3. **On the process of social learning ("social learning," as the most important tool of the community technique, Maxwell Jones has insisted somewhat in his most recent writings. According to this theory, mental illness is intimately linked to a process of deculturation, whereby certain attributes of mature adult personality, such as the ability to be with and interact with others, would be lost as a result of regression**

**morbid. The community therapeutic situation, cushioning in some way (see tolerance of delirium, interpretation instead of repression of acting.out, etc.) the shocks of the encounter between the sick individual and the others, would allow a process of re-learning, of re-acculturation whose ultimate goal**

* **rehabilitation and reintegration into 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, it seems to re-propose in a socio-psychiatric key the recovery of a fundamental bourgeois Manichaeism which finds precisely in the alienation that separates the sick from the healthy the justification for the rejection of the" mad "out of social commerce. Instead, it is exclusion from social commerce that 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 it has very little connection with mental illness.**
1. **It was therefore clear from Rapoport's study that the obstacle against which ideology struck**

**community in its attempts at concretization was constituted above all by the need to maintain the organization on a basis of functional efficiency; ultimately the communal ideology had to yield to organizational ideology.**

1. **See DH CLARK, Adminlstrative Psychiatry 1942-1962, «Brit. J. Psychiat ', 109: 178 (1963), for a detailed history of psychiatric institutional changes that have taken place in English-speaking countries in recent years.**
2. **One of the first therapeutic communities to arise in America is the Wilmer therapeutic community, in the Psychodiagnostic Center of the Oakland Navy in California, which has been so publicized (even a film has been made of it) that it is considered by many to be a kind of community model . It is hardly necessary to point out that it was a military repatto (in which the military hieratchy was respected) with very strict rules, inscribed in tables on the walls of all the rooms, moreover, it was a locked department.**
3. **Maxwell Jones himself, who in his first contributions had been very critical of medical power, then solved the problem of real power conflicts within the psychiatric hospital with the theory of "latent authority" ("When certain limits they come**

**once the latent authority (of the leader) has been reached, he must take action and take all the necessary steps to avoid undermining the confidence of the community in his own ability to control "1, and in hospital practice with a position of authoritarian leadership that coagulates the whole community activity around its leader.**

**19**  **A good example of applying the techniques of socio-psychological democratism to the therapeutic community is the one offered by Kole and Daniels: «Decisions [in the therapeutic community] are made through the process called 'reaching a consensus', you reach a consensus. The word "consensus" must be interpreted as meaning that no decision is final until it is backed up by a general sense of the group that a given action is necessary or acceptable. Achieving consensus avoids the suppression of minority opinion that could take place if decisions were made with a simple majority vote. Consensus often marks a change in the mood of the group. Usually someone who enjoys prestige makes a statement that brings together seemingly different opinions and clarifies the underlying moods; the tension then drops and people relax, often laughing and chatting ».**

1. **See KURT LEWIN, Resolving Social Conflicts, Harper & Bros, New York 1948. For an intelligent critique of Lewinian theories cf. HS KARIEL's article, Democracy unlimited: Kurt Lewin's FieldTheo'Y, “Am. ]. Partner !. ”, 62: 280 (r956).**
2. **See for example, regarding the application of group techniques to industry, M. s. VITELES, Motivation and Morale in Industry, WW Norton & Co., New York 19.13: "The use of group participation allows a softer" locomotion "towards the same" goal "without creating" tensions "that can lead to an industrial conflict. Participation in decision making in the industrial field is generally considered an experience in which favorable attitudes to a given change are also assumed by workers. The possibility of industrial conflict is removed as the modification of group perception resulting from participation in the group tends to bring the "goal" of production closer to the standard desired by the managers. Furthermore, "emotionality" is diminished because workers who play the "role" of planners tend to keep the discussion at a relatively depersonalized level ». See also M. Olmsted: “Maybe the business world can get the most**

**I benefit from a broader knowledge of the creative potentials related to group problem solving. “The plans and decisions that guide large companies are largely made by committees or other collective bodies. “Rightly or not, businessmen and others have come to see meetings as the best way to get management work done. "In short, billions of dollars are committed in the United States on the premise that group decisions are better, in one way or another, than individual decisions" (MIOIAEL s. OLMSTED, The Small Group, it. *The elementary social groups* , Il Mulino, Bologna 1963, pp. 82 83).**

1. **See H. MARCUSE, One-Dimensional Man. Studies on the Ideology of Advanced Industriai Society, trans. it. The One Dimensional Man, Einaudi, Turin 1967.**
2. **See s. D. ALINSKY. *The Poor and the Powerfu* l. "International Journal of Psychiatry", voI. 4, no. 4 (October 1967), p. 308.**
3. **See E. BLEULER, *Treatise on psychiatry* , trans. it. by C. Mainoldi, Feltrinelli, Milan 1967: "Even on many chronically ill patients, visits have the power to make it difficult to make a definitive adaptation to the new environment, which by now must constitute their new home ..." (p. 215).**
4. **It is significant that while there is a word to indicate who lives. the hospital (inpatients) there is no word that includes all those who interact in the hospital field, even if they are significant persons (inpatients, doctors, nurses).**
5. **In the hospital of Gorizia, the payers and the borrowers are hospitalized in the same ward where the "psychiatrists", subject to the legislation on the mentally ill, are hospitalized. The so-called neurological wards or wards opened in psychiatric hospitals are to be considered one of the latest mystifications of psychiatry in confirming the difference between the "registered" and "not registered".**
6. **F. ENGELS, *On Authority* , in MARX and ENGELS, Italian Writings, Ed. Avanti !, Milan 1995.**
7. **G. MINGUZZI, *The alternative to the «leader»* , «What to do», n. 2 (1967).**
8. **This is the name of the small alcoholic ward which is dealt with in this chapter.**
9. **Term used in Friuli-Venezia Giulia to indicate private taverns that are distinguished by a trasca. The term is often used in hospitals to refer to the alcoholics ward**
10. **The Gorizia experiment demonstrates, if nothing else, that a more traditional asylum can be radically changed in its structure without any**

**facilitation of a legislative, administrative or financial nature and without the social and psycho-environmental conditions differing significantly from those of most of the Italian provinces. (It can be added incidentally that, in this regard, the main difference between the Gorizia situation and that of the rest of Italy probably consists only in the particularly high percentage of alcoholism problems: an aspect that certainly does not facilitate the work. smallness of the province, there is no doubt that they are largely offset by other particular disadvantages, among which in the first place the serious lack of financial resources).**

1. **It should be noted that in the text that follows the term "institutional framework" is used in a broad sense, unlike in our writing.**
2. **JURGEN HABERMAS, Practical consequences of technical-scientific progress, «Quaderni Piacentini., VI, n. 32 (October 1967), pp. 72-91 (p. 87).**
3. **See E. GOFFMAN, *Asylums* I quote**
4. **The two researches we refer to are those of wc CAUDILL et al, *Social Structure and Interaction Process on a Psychiatric Ward,* «American Journal ofOrtopsychiatry ", 22 (1952), pp. 314-34, and that of j. F. LOFLAND and RA LEJEUNE, *Initial Interaction***

***of Newcomers in Alcoholics A-nonymus: A Field Experiment in Class Symbols and Socialization* , «Social Problems», 8 (i960), pp. 102-11 For a summary of both technical and "moral" criticisms of these two extreme cases of "participant observation" and others like it, see KT ERIKSON, *A Comment on Disguised Observation in Sociology* , "Social Problems", 14 ( 1967), PP- 366-73.**

1. **This position (on a more general scale) is explicitly illustrated by wj GOODE, *The Protection of the Inept* , «American Sociological Review», 32(1967), PP. > 19, especially in the last paragraph (significantly titled: *Utilization of the inept under industrialization* ).**
2. **On this last point, cf. DL PHILLIPS, Re; ection: *A Possible Consequence of Seeking Help for Mental Disorders* , «American Sociological Review,., 28(1963), pp. 963-72.**
3. **Particularly significant, in this context, is the reading of the "portraits" of informants to which the volume edited by JB Casagrande, *In the Company of Man is dedicated; Twenty Portraits by Anthropologists* , NewYork i960 (trad. It. Anthropological research, Turin 1966).**
4. ***Numerous* examples *of* this type (referring to native informants) can be read in the quoted volume**

**to the previous note. In the brief introduction to this anthology, it is possible to grasp the same basic misunderstanding, characteristic of all the social sciences, that *we are* trying to show on the subject of "neutrality". In fact, after having highlighted (p. 9) the profound asymmetry of power inherent in the relationship between ethnologist and informer (it is in fact compared to that between teacher and student, between employer and employee, between *psychiatrist and patient. ..* ), the author, forgetting the existence of this power, recommends to the ethnologist (p. 10) a position of equidistance and neutrality ...**

1. **DJ Levinson and EB Gallagher, among many others, took advantage of these recommendations in the preparation of a series of one hundred and sixteen questions for the mentally ill in hospital. This list can be read in the appendix to the work of these two authors, *Vatienthood in the Mental Hospital* , Boston 1964. We recall this work in particular because it represents, in many respects, a complete sample of the positions criticized here.**
2. **I refer to SEYMOUR PARKER, *Leadership Patterns in a Psychiatric Ward* , «Human Relations»,11 (19.58), pp. 287-301. The quoted sentence is on p. 292.**
3. **This definition of the deviant (in a therapeutic group) can be read in DOROTHY STOCK, RM**

**WHITMAN and MA LIEBERMAN, *The Deviant Member in Therapy Groups* , «Human Relations», n (1938), pp. 341-72, from which we also took the examples of "deviance" reported in the text.**

**43**  **The article is to be considered linked to the daily informal discussions with the treating staff of the Psychiatric Hospital of Gorizia, and to those with Gianni Scalia, Gian Franco Minguzzi and Franca Basaglia Ongaro, with whose collaboration the article *Dare il nome to oppression* , forthcoming in the journal «RechercheslO, Center d'Etudes, de Recher · ches et de Formation Institutionnelles, Paris l] ', I, z, -n.**

1. **F. FANON, Pour la révolution aricaine, Maspéro, Paris I9.:s4.**
2. **The italics are ours**

**WHAT IS THE**

**PSYCHIATRY**

**edited by Franco Basaglia**

**"The point that seems to me to make the reprint very topical - now that the asylums are closed and a different treatment of mental suffering is confirmed**

* **from. a volume in which the problems of closure, of opening, of the meaning of the institution, of work, of drugs, of the therapeutic nature of relationships, of the risk of freedom of the patient as the first element of reducing the power of the doctor, bounce from discussion in discussion in ward assemblies, in community assemblies, in the meetings of doctors and nurses, in the analyzes of operators who already foresee having to gradually "destroy the equilibrium reached to get out of what can become a new closed system" .. . " From the preface by Franca Ongaro Basaglia who edited this reprint thirty years later of *Che cose la psychiatry?* or from the start of the experience ofGorizia. New words then in the dark world where madness was locked up, a world above all of misery, violence and abuse.**

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**Appendix**

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