THE NEGATED INSTITUTION

Report from a Psychiatric Hospital

THE NEGATED INSTITUTION

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Fig. 1. Detail from Hieronymus Bosch, *Ship of Fools* (1490–1500)

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THE NEGATED INSTITUTION

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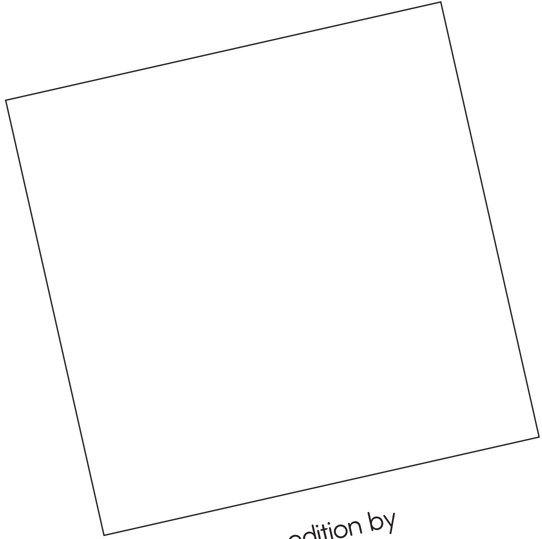

Original Italian edition by
Franco Basaglia

Edited and translated
by John Foot

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Note from the Editor and Translator

This is the first extensive English translation of the book *L'istituzione negata: Rapporto da un ospedale psichiatrico,* edited by Franco Basaglia and first published by the Turin-based publisher Einaudi in early 1968. It has gone through numerous editions since then and changed publisher. Some chapters and extracts have been translated into English previously, most notably in the collection edited by Anne Lovell and Nancy Scheper-Hughes.[1] This translation is based on the second Einaudi edition, which came out in April 1968 and included two new short chapters, published in an appendix, one by Franco Basaglia and one by Franco Basaglia and Franca Ongaro. Although the book was a bestseller in Italy and highly influential there, as outlined in the introduction below, and was translated into German, Spanish, French, Dutch, Portuguese, and other languages, it was never translated into English. The reasons for this strange "non-translation" are also discussed below.

Much of the language in the original text is clearly outdated, or we might say "of its time," in terms of the phrasing used, for example, around mental illness, but also with relation to gender, race, and other aspects of language. In the main, I

1 Nancy Scheper-Hughes and Anne Lovell, eds., *Psychiatry Inside Out: Selected Writings of Franco Basaglia* (Columbia University Press, 1987).

have translated these as they were originally written, but I have also removed some of the more obviously gendered language in order to be more exclusive, and where it obviously refers to men and women rather than only to men (the hospital in Gorizia contained both male and female patients and staff). I have added a number of notes with explanations or further references with regard to various aspects of the text. Where possible, I have tried to maintain the emphases in italics from the original text, as these were clearly an important part of the writing style of Basaglia and others. I have also checked the references cited in the text and updated them, correcting errors where they were present. One chapter from the original text has been removed altogether — that by the sociologist Gian Antonio Gilli. This was a decision dictated by requirements of space but also linked to the fact that this particular chapter was perhaps the least successful and interesting of those from the original text. The chapters and sections were not numbered in the original text and this style has been kept for this translation.

This was a collective book, put together in a few months in Gorizia by the *équipe* and others, and edited and knitted together by Giulio Bollati in Turin through ongoing discussions with those involved in the book (although Bollati was given no credit in the text). This process is also analyzed in the introductory chapter below. It has taken nearly sixty years to provide this fundamental text to readers of English — far too long — but it is hoped that this incendiary book will still be of relevance for those interested in mental health and mental illness today, and in the role of oppressive and violent institutions in locking up and stigmatizing those with mental health problems. It will also hopefully be of interest to those who want to understand how a tiny group of people in a remote physical and institutional setting sparked a revolution which led Italy to be the first country in the world to entirely close down its psychiatric hospital system. In an age where forced restraint and treatment are becoming more and more common and where there is even talk in Italy of returning to the asylum system, this extraordinary book could be seen as more important than ever.

In September 1968 the so-called "Miklus affair" rocked Gorizia. A patient on day release, Giovanni Miklus, murdered his wife and escaped into the nearby woods, before being captured. It is important to keep this "incident" in mind while reading this text, which seems in some ways to predict this kind of tragedy, especially the debates around the opening of the wards and the final, prescient piece by Basaglia in the new appendix concerning the "Possibility of an Incident." A court case would follow (all those accused were eventually cleared, including Antonio Slavich, part of the Basaglian *équipe*). The case became part of national debates, with many expressing solidarity with Basaglia and his team. For Basaglia, the case represented a kind of turning point.[2] He would drift away from Gorizia in 1969, moving to New York for some time and then to asylums in Parma and Trieste. The *équipe* resigned *en masse* in 1972 in protest at the lack of progress regarding new external clinics outside of the hospital. *The Negated Institution* would remain as a testimony to what had gone before, the revolution inside an institution which would influence psychiatry across Italy and beyond in years to come.

This translation has been a long time in the making. I would like to thank Claudio Fogu for his constant encouragement and persistence in terms of the copyright, Vincent W.J. van Gerven Oei for all his work on the text, punctum books, Baldini & Castoldi, and the late Enrico Basaglia.

2 See John Foot, *The Man Who Closed the Asylums: Franco Basaglia and the Revolution in Mental Health Care* (Verso, 2023), 200–217, and Ernesto Venturini, Domenico Casagrande, and Lorenzo Toresini, *Il folle reato: Il rapporto tra la responsabilità dello psichiatra e la imputabilità del paziente* (Franco Angeli, 2010).

INTRODUCTION

Reporting from an Overturned Institution

John Foot

In late 1961, a young psychiatrist from Venice and Padua University called Franco Basaglia became the director of the provincial psychiatric hospital in Gorizia, a small city on the edge of northeast Italy, right on the border with communist Yugoslavia. Today, in 2025, that former Cold-War border is open, and anyone can simply walk across it. But in 1961, it was closed and heavily guarded on both sides. Basaglia was a brilliant academic working in the field of psychiatry, with an interest in new ideas and approaches linked to phenomenology and radical politics. But he had failed to find a permanent job in academia and, married with two young children, needed regular income. He had never been inside a psychiatric hospital before.

What followed over the next eleven years in Gorizia was nothing short of a revolution. Basaglia's immediate reaction to the institution he was put in charge of was one of disgust and anger. He found a situation that was similar to almost all such "hospitals" across Italy and many across that world at that time. There was little sign of any psychiatry going on, and instead there was a large number of nurses and nuns who supervised the five hundred or so "patients." All were kept in locked wards, and physical containment was common. The vast, beautiful

grounds of the hospital were largely off-limits to the patients, and if they were allowed out at all, they were tied to trees and benches. Treatment of sorts was imposed upon those inside, without any discussion or consent, including electroconvulsive therapy. Institutionalized forms of torture were common. On the worst wards, which smelled strongly of excrement, Basaglia was reminded of his time in a grim fascist prison during the Second World War. Time appeared to have stopped.

Basaglia and his wife Franca Ongaro, who was not trained in psychiatry but played a key role in what followed in the 1960s, set out to change the situation. They didn't have a plan, but they knew that what they had found was unacceptable. Tying up patients was stopped; wards — slowly — began to be opened up. New, like-minded staff was hired thanks to the urgings of Basaglia, creating an *équipe,* as he called it. This took time and money, which the provincial administration, the government level which ran most psychiatric hospitals in Italy at the time, was reluctant to spend. Basaglia, Ongaro, and their *équipe* also looked to other experiences of "therapeutic communities" across the world in order to provide ideas for change. Humanity was reintroduced, work for patients was prioritized and paid, and a bar run by the inmates was opened, as was a newspaper. A patient leadership began to emerge. Meetings were held, not just *about* those inside, but *with* them — and then actually managed *by* them.

By the mid-1960s, Gorizia was becoming known as an experiment in how to transform a "total institution," following the influential term coined by the Canadian sociologist Erving Goffman.[1] Administrators, activists, journalists, and others began to visit and were welcomed in. Basaglia and the *équipe* wanted to talk about what they were doing. They wanted to change the whole system. In fact, Basaglia argued that the entire psychiatric hospital network should be closed rather than reformed. Gorizia's overturned institution was a means to an end, not an

1 Erving Goffman, *Asylums: Essays on the Condition of the Social Situation of Mental Patients and Other Inmates* (Anchor Books, 1961).

end in itself. In 1967, the *équipe* published a collective text based on their experiences in Gorizia, titled *What Is Psychiatry?,* with the help of a politician from the city of Parma who was trying to reform his local psychiatric hospital.[2] This book initially had a limited print run, but the student revolts and movements of the 1960s had begun to explode across Italy, and Gorizia began to be seen as a key part of "1968." In this context, a new volume was proposed. It would become a key text for those years, a famous book, the "bible of 1968."

In opening up the hospital, the *équipe* was aware of the risks they were taking, for themselves and for others. In September 1968, their worst fears became reality when a patient on day release murdered his wife and escaped. He was recaptured and interned in a criminal asylum for life. But the murder caused great disquiet within the *équipe,* in Gorizia, and in Italy as a whole. Basaglia and another psychiatrist, Antonio Slavich, were investigated by local magistrates, and Slavich was eventually sent for trial—and acquitted. This incident took place after *The Negated Institution* had been published, but it hangs over the text at various points, for example in the debates over the "dangers" of opening wards. In the wake of this murder, Basaglia left Gorizia as director—he was tired, burnt out. He spent six months in New York with his family, working in an asylum in Brooklyn. Meanwhile, the Gorizian experiment continued until 1972, before the entire *équipe* resigned in protest at the failure of the provincial administration to sanction the opening of mental health centers as an alternative to the hospital. In their collective resignation letter, the *équipe* claimed that all the patients within Gorizia at the time were ready to be released. But a new team was brought in from the outside, and although things didn't return to the 1950s, the psychiatric hospital went back to "normality," while the *équipe* moved on.

The history of radical psychiatry in Italy was then played out in other cities and hospitals across the country. Many places

2 Franco Basaglia, ed., *Che cos'è la psichiatria?* (Amminstrazione Provinciale di Parma, 1967).

had already started to reform and close their own institutions — sometimes in ways even more radical than in Gorizia, for example in Umbria in central Italy. Members of the Gorizian *équipe* were appointed directors of other asylums, which they quickly started to transform and dismantle: Slavich went to Ferrara, Antonio Pirella to Arezzo, Domenico Casagrande to Venice and Trieste. Basaglia himself was appointed director of the vast psychiatric hospital in Trieste, not far from Gorizia on the border with Yugoslavia, in 1971. There he would oversee an extraordinary series of experiments in radical psychiatry, building on the experience of Gorizia. In 1978, under the pressure of public opinion and a movement partly led by Basaglia, a law was passed — Law 180 or the "Basaglia Law" — which called for the closure of all psychiatric hospitals in Italy (apart from the criminal institutions) and banned the building of new institutions.

It was a victory, albeit a partial one. It would take over twenty years to close the entire system, something Italy did before anyone else in the world. Today, Italy has no psychiatric hospitals, and it no longer has any criminal asylums either. The genesis of this extraordinary fact lay in Gorizia, and in the text that accompanied that movement. Basaglia died in 1980, at the age of just 56. As an elected senator, Ongaro continued the struggle to implement Law 180 in parliament throughout the 1980s and 1990s. On the hundredth anniversary of his birth in 2024, Basaglia was celebrated and discussed all across Italy and beyond with a series of plays, TV shows, debates, and exhibitions.

* * *

> "Your book [...] is one of those rare examples of a book which builds on itself, it lives through the tensions which it produces within itself and it sustains itself through its own self-destructive tendencies."
>
> — Giulio Bollati to Franco Basaglia, January 26, 1968[3]

3 Letter, January 26, 1968, Giulio Bollati to Franco Basaglia, Franco Basaglia and Franca Ongaro Archive.

There are various stories of the genesis, production, and birth of the book that became *The Negated Institution.* Everyone agrees, however, that it was Giovanni "Gionni" Jervis — he had become part of the Gorizian *équipe* in 1966 along with his wife Letizia Comba — who provided the connection between the Gorizians and the book's eventual publisher: Einaudi.[4] Jervis had worked for Einaudi on a temporary basis from the 1960s onward. He started to make regular appearances at the celebrated Wednesday meetings of Einaudi's editorial committee in the spring of 1965, which was strictly by invitation only. These meetings in Turin were presided over by head of the publishing house, Giulio Einaudi, together with Giulio Bollati, the most powerful editor in the company. These meetings were the arena where book proposals and published books were discussed and editorial plans made.

Jervis had already been commissioned in 1962 by Einaudi to write an extended introduction to Herbert Marcuse's *Eros and Civilization,* and by the mid-1960s he had become the in-house expert on psychology, psychiatry, and psychoanalysis, areas which were attracting the increasing attention of publishers and readers.[5] Jervis also translated books from English and was invited to write an introduction to a new edition of the children's classic *Pinocchio*. His star was on the rise and he was often one of the first people to speak at these meetings. His angular figure can be spotted in group photos from those years, alongside Italo Calvino and others. In 1967, he was put on a permanent retainer by Einaudi with a pay of 150,000 lire a month.

This was the context in which Jervis decided to move to Gorizia to join the Basaglian *équipe* in 1966. In October of that year he wrote to Einaudi, giving his new address as "Gorizia, Ospedale Psichiatrico Provinciale," and in the same month he

4 This link is, however, often downplayed or entirely ignored in some accounts, probably as a result of the long-running disputes and bitterness between Jervis, the other Gorizians, and the Basaglians post-Gorizia.

5 He also translated and wrote a long introduction to the influential and much-cited book by August Hollingshead and Frederick Redlich, *Classi sociali e malattie mentali* (Einaudi, 1965).

referred in another letter to "my colleague and friend Franco Basaglia."[6] Part of Jervis's reason for joining the équipe was to connect Einaudi with the most exciting experiment in Italy at that time in terms of mental health reform and radical psychiatry. Soon before his departure to Gorizia, plans were hatched for a series of books based on what was happening there, and Jervis reported back on all this to Einaudi.[7] He quickly became a key member of the *équipe* and contributed to the first collective book about Gorizia, published in Parma in 1967. That book, *What Is Psychiatry?,* turned out to be a kind of trial run for *The Negated Institution,* and the two volumes are similar in terms of their structure, content, style, and tone. Einaudi later bought up the rights for *What Is Psychiatry?* and issued a reprint in 1973.

The connections between Einaudi and Gorizia were built up in a number of ways, at first through the presence of Jervis. As antipsychiatry quickly became fashionable and marketable, Einaudi, at Jervis's suggestion, acquired options on books by R.D. Laing, Erving Goffman, and others, and some of the translation and editorial work involved was assigned to members of the *équipe* in Gorizia, including Ongaro and Comba. Books that were important for Basaglia and the *équipe* were proposed via Jervis to Einaudi for translation, such as those by Maxwell Jones and Michel Foucault. In this way Einaudi, in the wake of *The Negated Institution,* published almost all the key texts for the Gorizian team. A Basaglian library, a set of texts, was built up after 1968.

The book that would become *The Negated Institution* was cited in February 1967 by Jervis as what "we are creating in Gorizia."[8] It was also clear at that point that this book was intended for the Nuovo Politecnico series where it eventually was to appear. What this also tells us is that work on *The Negated Institution*

6 Letter, October 31, 1966, Giovanni Jervis to Paolo Fossati, Einaudi Archive.

7 It seems likely that Jervis met up with Basaglia during the latter's holiday home in the mountains of Trentino in the summer of 1966 to discuss these plans.

8 Memo, February 1, 1967, Editorial Committee, Einaudi, Einaudi Archive.

must have started soon after Jervis's arrival in Gorizia in 1966, or even before that date.

There were also signs that other publishers were beginning to court the director of the Gorizian asylum. As Jervis warned Einaudi in April 1967, "A collection based on experiences in Parma and Gorizia is due to come out […] we are already talking about it […] and Basaglia has been contacted by Filippini in terms of future publications with generous financial offers. For other books, Basaglia will go with the best offer he receives."[9] This was a reference, presumably, to Enrico Filippini, who worked for the Feltrinelli publishing house in Milan. So in April 1967, then, Jervis suggested that he bring Basaglia to Turin to meet Bollati and the others at Einaudi.[10] Up to that point, Basaglia had not been in direct touch with anybody in the Einaudi publishing house, but this encounter would have hugely important consequences: for Jervis, Basaglia, Bollati, Einaudi, and Gorizia.[11] The

9 Letter, April 1967, Giovanni Jervis to Einaudi, Franco Basaglia and Franca Ongaro Archive.

10 Letter, April 22, 1967, Giovanni Jervis to Paolo Fossati, Einaudi Archive. With pen: "I will come to Turin on May 17 with Basaglia. Is that OK? Tell Bollati, perhaps." The meeting with Bollati was not confirmed until the last minute: "I would like to know if Bollati will be in Turin next Wednesday and if he is available to meet Basaglia. In any case I will be there." This is Jervis's later version: "I thought that a book of this kind could be very interesting before I moved from Rome to Gorizia in 1966 and I discussed this with Giulio Bollati and put forward a project to him. I also discussed this with Basaglia and after a few months I took him with me to Turin […]. I thus was able to insist that the contract for the book was signed by both of us and not by me alone, and that the front cover carried the phrase 'edited by Franco Basaglia.'" Giovanni Jervis and Gilberto Corbellini, *La razionalità negata: Psichiatria e antipsichiatria in Italia* (Bollati Boringhieri, 2008), 86.

11 In 1968, after the publication of *L'istituzione negata,* Filippini wrote to Basaglia congratulating him on the book and reminding him of their discussion about the project over a year earlier. His letter had a sting in the tail: "I would be a hypocrite, however […] if I did not tell you honestly, and in terms of any future relationship between us, that this is not the correct way to do things" (February 21, 1968). Basaglia replied with a partial apology. Filippini had been in discussions with Basaglia about a book in 1967, as the letters between them show.

meeting duly took place on May 17, and Bollati and Basaglia hit it off from the beginning. A further connection was provided by the role and interests of Bollati's wife, Piera Piatti, who would set up an organization working on similar themes as Basaglia called the Associazione per la Lotta contro le Malattie Mentali (Association for the Struggle against Mental Illnesses) in Turin in late 1967.

Bollati was immediately seduced by Basaglia's intelligence and radical passion. It was friendship at first sight.[12] Although they were both intellectuals, they were interested in getting things done in the real world and not just in abstract theorizing. Bollati was also a man with real power, and Basaglia understood how power worked. In the aftermath of this meeting, Bollati and Piatti visited Gorizia and Venice on a number of occasions, and Basaglia began to make regular trips to Turin. A correspondence started which also included Ongaro, who also struck up a friendship with Bollati. The three would remain close until Basaglia's death in 1980, and Bollati remained in constant contact with Ongaro until his own death in 1996.

The friendship between Basaglia and Bollati quickly took hold, as their letters show. On June 15, 1967, Basaglia wrote to Bollati about that first meeting: "It was a great pleasure to meet you."[13] Basaglia continued, "I am happy about the editorial possibilities which are opening up for me and for my équipe with the Einaudi publishing house."[14] That first meeting in Turin also included direct discussions over work on what was to become *The Negated Institution.* Einaudi, through Bollati, agreed to pay for the costs of recording and transcribing general meetings in Gorizia. This was a key idea behind the book, which was also referred to as a "spoken book."[15] From May 1967 onward, Bollati

12 Basaglia wrote to Bollati after he had visited Gorizia in 1967 that "I had the clear and pleasurable impression from our meeting that this could be the beginning of a friendship between us." Franco Basaglia and Franca Ongaro Archive.

13 Letter, June 15, 1967, Einaudi Archive, Basaglia Folder.

14 Ibid.

15 Letter, June 18, 1967, Einaudi Archive, Basaglia Folder.

became Basaglia's "minder" within Einaudi. Jervis was slowly sidelined, although he continued to report back to the editorial meetings. Proposals also arrived directly through Basaglia and Bollati and were discussed with Giulio Einaudi.

Editorially, the Bollati–Basaglia–Ongaro connection would lead to a number of books produced or recommended by the Basaglias.[16] Bollati's letters to Basaglia were also those of a friend, with an informal tone that was very different to the one that Bollati used with Jervis. For example, this is from November 10, 1967: "I would like to thank you from the bottom of my heart for the reception you offered me in Gorizia, and I would also like to thank your wife. I hope we can meet again soon, maybe in Turin. In any case I am certain that Piera will make sure that we keep in touch, something which I am very committed to, not only as a publisher, but as a friend."[17] The two men worked closely together on the publications being prepared in Gorizia.

In July 1967, Basaglia wrote to Bollati about the various projects emerging there. The first was provisionally entitled *Practical Overturnings: Report from a Therapeutic Community.* Basaglia wrote that "the title, it seems to me, corresponds perfectly with the conceptual meaning of the book."[18] For Basaglia it was important that the book was not seen or presented as psychiatric in any way: "Nothing about psychiatry should be included

16 Directly by the Basaglias, beyond the numerous editions of *L'istituzione negata* (1968), *Morire di classe* (1969), *La maggioranza deviante* (1971), a new edition of *Che cos'è la psichiatria?* (1973), *Crimini di pace* (1975), and the two volumes of the *Scritti* published posthumously in 1981 (republished in 2017 and 2023), should be added a number of introductions, prefaces, and translations, plus a series of projects that never saw the light of day. A new collection of Basaglia's writings was published in 2005 by Einaudi: Franca Ongaro Basaglia, ed., *Franco Basaglia: L'utopia della realtà* (Einaudi, 2005).

17 Letter, November 10, 1967, Giulio Bollati to Franco Basaglia, Einaudi Archive.

18 Further information on the development of the title can be gleaned from the material in the Franco Basaglia and Franca Ongaro Archive. The idea was still to have two books in November 1967. As Basaglia wrote to Bollatti on November 6, 1967, "Given that we will all be there I suggest the title 'L'istituzione negata' should be used for the spoken book."

on the cover […] given the overall 'antipsychiatric' or 'antiscientific' stamp of the whole work."[19] The second book proposed was a collection of Basaglia's writings, under the provisional title *The Negated Institution.* The third one was a more analytical book called *Psychiatry and Power.* The volume that eventually came out in 1968 as *The Negated Institution* was a combination of all three of these proposals.

In May 1967, Bollati reported back to the editorial committee on his meeting with Jervis and Basaglia about two of the publications ideas in a noncommittal way: "Jervis and Basaglia came to Turin to talk about the two books born from their experience in Gorizia."[20] Jervis added that the first was dedicated to psychiatry and power and was in development. The one which was more urgent and more ready was for the Nuovo Politecnico series and provided an analysis of the life and problems of a therapeutic community together with an editorial commentary, in the wake of the volume which had come out with the Provincial Administration of Parma. This book would be informative, but also stimulating. It would be ready in about three months.[21] *What Is Psychiatry?* had been published by a small ad-hoc publisher, with a limited circulation. *The Negated Institution* would be a different operation altogether. Eventually, these two ongoing projects, combined with a collection of Basaglia's writings, were merged into *The Negated Institution,* and the volume which was to be called *Psychiatry and Power* never appeared.[22]

But who was the author of *The Negated Institution?* This was a book unlike any other, a truly collective work, with a plurality of voices, authors, editors, and inputs. Its pages contained a range of statements, conversations, and debates involving patients, doctors, nurses, and the journalist Nino Vascon, as well as chapters by every member of the core *équipe,* including

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19 Letter, July 18, 1967, Franco Basaglia to Giulio Bollati, Einaudi Archive.

20 Letter, May 1967, Giulio Bollati to Einaudi, Franco Basaglia and Franca Ongaro Archive.

21 Memo, May 24, 1967, 404, Einaudi Archive.

22 Giovanni Berlinguer published a book with the title *Psichiatria e potere* in 1969.

Ongaro. Large sections were given over to the patients. During 1967–1968, there was a key debate about whose name or names would appear on the cover of *The Negated Institution.* This was not merely a practical issue, but also a philosophical and political one. Did the book actually *have* an author or an editor? The issue of authorship was seen as crucial. Basaglia originally wanted no name at all on the cover, or a collective term. He saw the book as a truly shared effort and was worried about the possibility of the appropriation and identification of the volume's author by the "cultural industry." But Bollati appears to have convinced him to change his mind. The experienced publisher argued that "the system" would identify an author in any case and that an anonymous book would just be seen as "Einaudi's": "Even if you are not the official author of the book, or Jervis, or Pirella, some of the public will still know that the book is yours, or Jervis's, or Pirella's."[23] Interestingly, this letter also shows that there were other possible authors/editors of *The Negated Institution.* Clearly, the book was a collective effort, while it also obvious that Jervis played a significant editorial role, as did Bollati, Basaglia, Ongaro, and others. Much later, Luca Baranelli, an Einaudi editor at the time, would argue that Jervis had been the "real editor" of *The Negated Institution.*[24]

But Gorizia itself would never have happened without Basaglia. It was his creation, and he was clearly its leader. His ideas ran right through the book. There was also a fear of (mis)appropriation, the worry that Gorizia would become fashionable and be made toothless by the power of cultural consumption. It might be eaten up by the "society of the spectacle."[25] Basaglia was particularly aware of this, hence his hesitation about the authorship of the volume, or the identification of the book with

23 Letter, December 18, 1967, Giulio Bollati to Franco Basaglia, Einaudi Archive, Basaglia Folder.

24 See also the version given by Jervis in his last published book, Jervis and Corbellini, *La razionalità negata,* 86–87.

25 Guy Debord, *The Society of the Spectacle,* trans. Ken Knabb (Rebel Press, 1992).

a single author.[26] In the end, the book was published with the byline "Edited by Franco Basaglia," and was identified immediately with Basaglia himself, as was (and is) the whole Gorizian experience. As a result, *The Negated Institution* has been attributed, on occasion, to one author alone, as if it was literally "by Franco Basaglia." In some ways, then, Basaglia's fears were justified. However, from a publishing point of view, and from that of the movement as a whole, Bollati's intuitions were correct.

The final title of *The Negated Institution* was decided at the last minute, and probably not until early 1968. There is some controversy over who came up with the phrase.[27] One earlier suggestion was for *The Practice of Overturning*, while Basaglia used the term *The Negated Institution* with reference to a collection of his own work that he proposed to Bollati in June 1967, which is an indication that he at least had a part in choosing the term.[28]

The contract for *The Negated Institution* was signed jointly by Jervis and Basaglia in February 1968, with all royalties assigned to the patient club in Gorizia. *The Negated Institution* appeared as Number 19 in the Nuovo Politecnico series published by Einaudi, which had been set up by Bollati in 1965 and was run by him. The first edition came out in March 1968, with a second

26 The question of authorship was a delicate one, however. After a piece in the magazine *L'Espresso* highlighted the role of Jervis, Basaglia wrote to the magazine to complain.

27 Maria Grazia Giannichedda, "Introduzione," in Ongaro Basaglia, *Franco Basaglia,* xxv: "When *Che cos'è la psichiatria?* came out, the Gorizians were already working on a new book, whose title came from an insight by Pirella." Jervis provides a different version of events: "Obviously we talked about the title, and perhaps it is symptomatic of things that a couple of years later Basaglia told me that I had chosen the title, while I seemed to recall that it had been suggested by him. Maybe nobody wanted to take responsibility for it [...] we both felt a little uneasy [...] because the book's title had become a little too triumphalist and too promotional." Jervis and Corbellini, *La razionalità negata,* 88. From the letters I have seen between Bollati and Basaglia the title was part of a discussion between them and the *équipe*. See also Oreste Pivetta, *Franco Basaglia: Il dottore dei matti. La biografia* (Dalai, 2012), 180.

28 Letter, July 18, 1967, Franco Basaglia to Giulio Bollati, Einaudi Archive.

edition released in April of the same year featuring a new appendix.[29] The Nuovo Politecnico series would become strongly associated with Basaglia and radical psychiatry as well as with 1968 itself, which it prefigured and shaped. This was a series with a strong identity and mission, and a title which hearkened back to Elio Vittorini's *Il Politecnico,* an influential cultural magazine that had run from 1945 to 1947. The Nuovo Politecnico series had a precise set of objectives:

> It was born from the need to give quick answers — and perhaps only in an intuitive or hypothetical way, but always in a well-informed and intelligent sense, to the questions posed by a society undergoing rapid evolution. There were militant essays, or books written "in shirtsleeves," but with strong ideas, as attempts to ask the right questions and to try and reach towards the first answers — in any field — and they were always aimed at a kind of ideal reader, someone with an encyclopaedic knowledge, almost a utopian personality — but someone we have always worked toward — we were convinced that we were working towards the modernization of the country.[30]

Previous books in this series included works by Roland Barthes, Ernst Gombrich, and Walter Benjamin, and Nuovo Politecnico would later host classic texts by R.D. Laing as well as numerous books by Basaglia and Ongaro. Many of the volumes in this series were explicitly linked to the ideas and movements of the

29 *L'istituzione negata* cost 1,000 lire. The Nuovo Politecnico series closed in 1989. See the comments of fellow Einaudi editor, Guido Davico Bonino in "Leggere come editare," *BAIG* 4, September Supplement (2011): 10, and in "All'Einaudi con Giulio Bollati," in *Giulio Bollati: Intermittenze del ricordo. Immagini di cultura italiana,* ed. Rosa Tamborrino (Edizioni Fondazione Torino Musei, 2006), 138.

30 Giulio Einaudi, *Tutti i nostri mercoledi* (Casagrande, 2001), 117–18.

student revolt, such as Hal Draper's *Berkeley: The New Student Revolt*[31] or Marcuse's crucial 1968 text *One-Dimensional Man.*[32]

The Negated Institution was not a short book. Its first edition ran to over 350 pages. Slavich later wrote of the day when Jervis arrived back in Gorizia with a pile of new books, smelling of ink. He then proceeded to hand them out among the *équipe*. Basaglia himself, it seems, had taken the manuscript to Turin. Nobody expected this technical, dense, and multi-authored book about an asylum in Gorizia to become a bestseller, although the publishers were well aware of its importance and power and the clear links to the explosion of worldwide protest in 1967–1968. An extensive promotional tour was organized involving various members of the *équipe,* and the book was reviewed all across Italy in a wide variety of publications. As Einaudi editor Paolo Fossati wrote to Jervis in February 1968: "This book is urgently required."[33] With the unexpected success of *The Negated Institution,* a whole world opened up for Franco Basaglia and the other Gorizians. The book's timing was perfect; its appearance "at a crucial juncture in the great social mobilizations of the late 1960s, quite suddenly made the Gorizia expe-

31 Hal Draper, *Berkeley: The New Student Revolt (*Grove Press, 1965). Published in Italian as *La rivolta di Berkeley: Il movimento studentesco negli stati uniti,* trans. R. Giammanco (Einaudi, 1966).

32 Herbert Marcuse, *One-Dimensional Man: Studies in the Ideology of Advanced Industrial Society* (Beacon Press, 1964). Published in Italian as *L'uomo a una dimensione: L'ideologia della società industriale avanzata,* trans. Luciano Gallino and Tilde Giani Gallino (Einaudi, 1967). According to Maria Grazia Giannichedda this book sold an incredible 220,000 copies in Italy.

33 There was also discussion, it seems, over the possible addition of a selection of letters that had been received. But this idea was not taken up. For the second edition, which was published in April 1968, the Basaglias added two articles as an appendix: one by Franco Basaglia and Franca Ongaro Basaglia, "Il problema dell'incidente," and one by Franco Basaglia alone, "Il problema della gestione." Since then, the text has remained unaltered. A new edition was published by Baldini & Castoldi in 1998 with a new "Nota introduttiva" by Franca Ongaro Basaglia and a new cover, a photo by Carla Cerati from *Morire di classe* (Einaudi, 1969).

rience famous."[34] It also made Basaglia into a celebrity, a star, one of the acknowledged leaders of 1968. Gorizia both reflected and helped to produce the Italian 1968 movement. *The Negated Institution* became one of the key texts from that time, "the first major publication of the new psychiatry"[35] to be found on the shelves of all self-respecting *sessantottini* ('68ers). When Slavich started work in Ferrara in 1971, he found that most of his team knew the book well: "Everyone had read it, and they were still passing copies around."[36]

For Jervis and his role within Einaudi, the Basaglia–Bollati relationship led to his marginalization. Although it seems that Basaglia never became a paid consultant as Jervis had been, his direct contact with Bollati meant that the latter took his ideas directly to the committee, or to Giulio Einaudi himself, leaving Jervis out of the equation. His own work had no chance of being published with Einaudi. A proposal for a critical book on psychiatry, based partly on his work post-Gorizia in Reggio Emilia, ended up with Feltrinelli in 1974.[37] Soon after 1968, Jervis and Basaglia had gone from being friends and close colleagues to rivals. Jervis continued working with Einaudi in Turin, and so did his wife Letizia Comba, but it was clear that his days there were numbered. By the end of 1971, Jervis's time with the publisher was over. His bitterness over this experience would be laid out fully in his frank account of his life up to that point, which would be published in 1977.[38]

After *The Negated Institution,* Basaglia himself could do no wrong as far as Einaudi was concerned. He was advanced a whopping 2.5 million lire to visit a series of South American

34 Michael Donnelly, *The Politics of Mental Health in Italy* (Tavistock, 1992), 48. Jervis used more or less the same phrase,"Gorizia suddenly became famous," in 1977. See Giovanni Jervis, *Il buon rieducatore: Scritti sugli usi della psichiatria e della psicoanalisi* (Feltrinelli, 1977), 23.

35 Donnelly, *The Politics of Mental Health in Italy,* xiii.

36 Ibid., 130.

37 Giovanni Jervis, *Manuale critico di psichiatria* (Feltrinelli, 1974).

38 This particular story was not told by Jervis in that text. See also Jervis and Corbellini, *La razionalità negata,* 86–87.

countries in 1969 in order to carry out research into anti-institutional movements there. The book that was promised about this trip, however, never appeared.

But what was actually in *The Negated Institution* itself? What kind of text was it? Its composition followed a working model that had already been used with *What Is Psychiatry?* in 1966–1967. It was written in parts, discussed and put together in Basaglia's flat in Gorizia and in the hospital in the city with input from the whole *équipe,* as well as Ongaro, Bollati, and others. Of the writing process itself there is no detailed account. It was like a jigsaw, made up of voices, articles, and debates. Basaglia's own writings were cut and pasted into the book at various points. Each member of the *équipe* had their own piece in the volume, and there were also outsiders involved in key roles, such as the sociologist Gian Antonio Gilli and the RAI journalist Nino Vascon.

* * *

> "The hospital begins to have a history — we could also say that history comes to the hospital — when society enters the asylum, breaking its isolation."
>
> — Letizia Comba[39]

> "It seems to me that if a revolution needs violence, our violence is the opening of a ward."
>
> — Franco Basaglia[40]

> "We have started to work together on a project which is outside of all scientific parameters. We have come up with a practical hypothesis — that an institution of that kind had no right to exist — and we have started to work in that direction."
>
> — Agostino Pirella[41]

39 This volume, 266.
40 Ibid., 298.
41 Franco Basaglia et al., *La nave che affonda: Psichiatria e antipsichiatria a dieci anni da "L'istituzione negata": Un dibattito* (Savelli, 1978), 103–4.

> "The reality of the asylum [...] has been overcome, *but we don't know what the next stage will be*."
>
> — Franco Basaglia[42]

The cover of *The Negated Institution* was simple and stark, a small red square on a white background. The subtitle was direct and effective: *Report from a Psychiatric Hospital.*[43] Basaglia was named as the editor on the cover, although the work was presented as collective, as that of the *équipe* as a whole, plus the patients and others. The title also made a direct reference to the very first book in the Nuovo Politecnico series, the celebrated study *Rapporto da un villaggio cinese: Inchiesta in una comune agricola dello Shensi* (*Report from a Chinese Village: Inquiry into an Agricultural Commune in Shensi*).[44] *The Negated Institution* was a combination of all the key traits of Italy's 1968. It was an account of radical anti-institutional practice mixed with large doses of revolutionary and Marxist rhetoric, as well as a sense of "counterinformation." It also intended to give a voice to the oppressed (the patients). The whole series had a Maoist tint to it, as in the famous slogan "Chi non fa inchiesta non ha diritto di parola" ("No investigation, no right to speak") and the idea of "barefoot doctors."[45]

Its 356 pages in the first edition are made up of various sections, including historical and sociological studies, philosophical accounts, analyses of meetings in Gorizia, as well as reflections on the work of others. *The Negated Institution* is a

42 This volume, 54.

43 Basaglia and other Gorizians were clearly influenced by Maoist thought at this time.

44 Jan Myrdal, *Report from a Chinese Village,* trans. Maurice A. Michael (Pantheon Books, 1965), first published in Swedish in 1963; published in Italian by Einaudi in 1966. Basaglia had noted the similarity between the two titles in a July 18, 1967 letter to Bollati, Einaudi Archive. This was almost certainly not a coincidence. Myrdal's book went through seven editions by 1977.

45 Mao Zedong, "Oppose Book Worship" (1930), in *Selected Works of Mao Tse-tung,* vol. 6 (Kranti Publications, 1990), https://www.marxists.org/reference/archive/mao/selected-works/volume-6/mswv6_11.htm.

book with a plurality of voices, a kind of babble, a chorus, a patchwork, a work in progress. Inside, on its pages, there are patients of all kinds, doctors, nurses, psychologists, journalists, and others in a variety of settings such as meetings and one-to-one interviews. It contains real characters, with names, genuine life experiences, discussions transcribed verbatim. The book reproduces the sense and the dynamism of life within the therapeutic community with its lively and yet interminable debates, dialogues, confessions, and high levels of verbosity. It is also a collage of texts, ranging from high theory to graphic accounts of torture. Some parts of the book are obscurely written, highly theoretical and complicated; other parts are hard-hitting and straightforward. Some sections are deliberately shocking and graphic. Parts of the book make little reference to Gorizia itself. There are no historical studies of the patients, their origins, or of the context in which the hospital has been built and had functioned until the 1960s.

The Negated Institution is also intended as a text that will lead to extra study. It provides its own bibliography as a guide to further reading. It has no overarching narrative and its very form is that of the 1968 movement, the *assemblea* (assembly), which, in some ways, Gorizia helped invent. It transmitted a sense of radical change, change that was actually happening (or had already happened) here and now.

The journalist Nino Vascon,[46] who also had produced a documentary about the hospital for Italian broadcaster RAI, set the scene. Gorizia's psychiatric hospital was a complex made up of nine buildings set in a huge and beautiful wooded park, which also contained a small church, a bar, and a farm. Inside, there were five hundred or so patients, hundred fifty nurses and nine doctors, as well as a chaplain, several nuns, a psychologist, and some social workers and volunteers. In certain ways, it was a strangely beautiful place: "This park is something which cannot be described — beautiful, magnificent."[47] The asylum was situ-

46 Basaglia knew Vascon from his school days.
47 Isman, "Hanno discusso tranquilli in assemblea."

ated on the edge of this small city, across from the enormous mass of the city hospital. A large building opposite the main gates housed the offices of the staff, and the park stretched out behind. When Basaglia arrived the area was rigidly divided by gender: men on the left, women on the right. But this was an asylum which, by 1968, had become "open to all [.... O]nce you are through the gates, which are never closed, the occasional visitor walks through the avenues of the park." This hypothetical visitor, according to Vascon, would have been unable to tell the patients from the "normal" people. "There aren't dangerous people here," wrote Vascon (slightly optimistically, perhaps, in the light of events to come that year). Was this a psychiatric hospital at all, or something very different, something new, revolutionary even? There were no "bars, gates, straitjackets, or means of coercion that generate violence."[48] Vascon then plunged the reader straight into something that seemed very strange in a psychiatric hospital: a mass meeting of patients. And this was not an isolated or purely symbolic event: "The entire life of the hospital is governed by meetings."[49]

Vascon was describing a place that seemed unique.[50] This psychiatric hospital was open, it had no visiting hours, most of the patients moved freely on the grounds, and they could even go out into the city itself. The patients also had their own bar, which they ran themselves. Few of the doctors wore white coats, or even described themselves as doctors. The patients were paid with real money for work. None of the wards were locked at this stage (the last closed wards had been opened by the end of 1967). General, ward, and other meetings decided on the key issues involving the management of the hospital, as well as on outside visits. Everything was discussed, openly and at great length. Gorizia's asylum appeared to Vascon as a place where mental illness had been "placed in brackets," and where the roles

48 This volume, 70.
49 Ibid., 72.
50 Although experiments had been attempted in various places and were ongoing in Perugia.

of doctor, patient, and nurse had also, to some extent, been put on hold. Everyone inside the institution was well aware of their objective status, but most were trying to free themselves of their prejudices and of their past. As Letztia Jervis Comba said about herself: "I am trying to free myself from a technique that objectifies a patient."[51] This was one of the key ideas in the book, and of the movement itself. The mad were real people, like you and me, and the aim of the staff was to "make contact directly with mental hospital inmates."[52] One of the other messages coming out of Gorizia was this: ordinary people needed to be listened to, as people, not as schizophrenics or alcoholics. As Pirella put it, there was a constant sense of "the confrontation with reality."[53]

Basaglia's opening "Presentation" hinted at how this celebrated volume had been put together. It began with a radical and bold statement of intent. This was a work in progress, an ongoing project, a manifesto, something that was unfinished. What kind of institution were we dealing with? "[A] reality which can only be violently negated."[54] There was no need for debate (at least on this issue) and no room for compromise. This asylum (and all asylums) simply had to be destroyed, as Basaglia had first written back in 1964.[55] There was no other way forward. In many ways, the form of the book was like 1968 itself: patchy, experimental, open-ended, a weapon in the hands of the movement. It used collective terms — "we" — and was inspired by a collective movement, which included the patients of a psychiatric hospital. The words themselves were also that of 1968: "contestation," "institutional violence," "antipsychiatry." And the

51 This volume, 114.
52 Michael Donnelly, *The Politics of Mental Health in Italy* (Tavistock, 1992), xiii.
53 This volume, 258.
54 Ibid., 53.
55 This paper was originally given in English in London and later published in Italian: "La distruzione dell'ospedale psichiatrico come luogo di istituzionalizzazione: Mortificazioni e libertà dello 'spazio chiuso.' Considerazioni sul sistema 'open door,'" *Annali di neurologia e psichiatria* 49, no. 1 (1965), reprinted in Ongaro Basaglia, *Franco Basaglia,* 17–26, and Franco Basaglia, *Scritti*, 1:249–57.

method outlined in *The Negated Institution* was not just applicable to asylums. It could also be applied to all kinds of other institutions. In fact, Basaglia argued that this extension of the struggle, the battle against institutions, was absolutely necessary. Institutions such as the asylum needed to be overturned, rejected, revolutionized, and in Gorizia this had already taken place. *The Negated Institution* was a theoretical and practical blueprint for radicals, a guide for how to change the world.

The Negated Institution was music to the ears of a growing movement beyond Gorizia (and beyond Italy). Institutions were violent and oppressive. They could be overcome, contested, negated; and "we" were all in this struggle together: intellectuals, doctors, teachers, pupils, psychiatrists, patients, prisoners, nurses, the working class, the "sick" and the "well" (whatever those terms meant). Moreover, it was not enough just to destroy these institutions, but society itself needed to be transformed. As Basaglia argued, "How can we not move from the excluded to the excluder?"[56]

Basaglia's "Presentation" was the most radical and '68-esque of all the material in the book, and its most far-reaching. It was almost a manifesto for what 1968 would become, with the contestation of all institutions linked to the exercise of power — a declaration of intent for an anti-institutional and antiauthoritarian movement. Following Vascon, Basaglia's piece "The Institutions of Violence" linked up a series of social and political organizations: "Family, school, factory, hospital — all are institutions based on the rigid division of roles."[57] This piece was a collage of Basaglia's writings from 1964 to 1967, a sort of primer that also outlined the evolution of his ideas. For Basaglia, "[v]iolence and exclusion underpin all social relations in our society."[58] Patients were seen here, starkly, as victims of institutional violence. The movement everywhere, like that in Gorizia, needed to move forward, or it would simply create new forms

56 This volume, 54–55.
57 Ibid., 159.
58 Ibid.

of these institutions, or help them to survive. "We must force ourselves," Basaglia wrote, "to constantly evaluate our work and push it forward."[59] This introduction was clearly connected in spirit to the radical critique of the school system that had been developed by a priest in rural Tuscany, and which led to another key Italian text from 1968, *Letter to a Schoolteacher,*[60] and to David Cooper's *The Death of the Family.*[61]

Also the other members of the *équipe* contributed at least one chapter to the book, often accompanied by real-time transcribed debates amongst patients, staff, nurses, nuns, and others. Lucio Schittar looked at the issue of the "therapeutic community," drawing on a wide range of discussions, often in English. Antonio Slavich deconstructed the myths of how the hospital actually worked, including those created by the *équipe* itself. Letizia Comba, the only official female member of the *équipe,* and the only psychologist, examined the crucial question of the last "closed" ward and the debates around opening it, or not, and what that opening meant. Domenico Casagrande unpicked the issues which had arisen with the "alcoholics ward," which he was in charge of. Agostino Pirella's chapter was typically thoughtful and well-documented, while Giovanni Jervis contributed a trenchant and fascinating chapter on the crisis of psychiatry in general. Finally, in an appendix published in a later edition (the book was quickly reprinted due to sales) Basaglia and Ongaro dealt with two further questions. These small pieces became famous, especially the Basaglia couple's short essay on "the incident," which seemed to prefigure the crisis in the *équipe* after a patient murdered his wife on day-release in 1968. One chapter from the Italian edition was omitted in this English translation for reasons of space: a discussion by the sociologist Gian Anto-

59 Ibid., 189.
60 Don Milani, *Lettera a una professoressa* (Libreria Editrice Fiorentina, 1967).
61 David Cooper, *The Death of the Family* (Penguin, 1971), translated into Italian as *La morte della famiglia: Il nucleo familiare nella società capitalistica,* trans. Carla Costantini Maggiori (Einaudi, 1972).

nio Gilli, which seems particularly dated and somewhat unconnected to the other pieces.

According to Mario Colucci and Pierangelo Di Vittorio, "[t]he publication of *The Negated Institution* had a formidable impact on public opinion […]. The book became a reference point for the whole movement."[62] Basaglia was providing a blueprint for action and his language was revolutionary. Moreover, he was not simply indulging in empty rhetoric. Change had really happened in Gorizia. It could be seen there and, by contrast, in every other asylum in Italy, which, with a few notable exceptions, had not changed at all. Theory and practice were working hand in hand. Something could be done, even if only through the work of a tiny vanguard of intellectuals and militants. A few dedicated people could change the world, even in a place like Gorizia. Yet, there were dangers in this message. The idea of the revolutionary vanguard was abused time and again as the decade wore on, as was the sense that all state institutions (plus the family) were to be contested *tout court*. *The Negated Institution* told its readers that you did not need a mass movement to overturn any institution. Sheer willpower and ideas could be enough. But this strategy could only get you so far. After 1968, there was a lot of talk about "engaged intellectuals" and "organic intellectuals," but very few actually got their hands dirty, as the Gorizians had done.

Thus, the practical lessons of Gorizia were often ignored or overlooked in favor of its theorizing. Sartre had said that "if you want to see a place where practical knowledge is being formed, go to Gorizia,"[63] but this was not necessarily the way that Gorizia was read or understood.

The fragmented nature of *The Negated Institution* allowed for many different readings of this text. This was not a book that was read cover to cover. Only a smattering of people (most of

62 Mario Colucci and Pierangelo Di Vittorio, *Franco Basaglia* (Bruno Mondadori, 2001), 207.

63 Cited in Valeria Babini, *Liberi tutti: Manicomi e psichiatri in Italia, una storia del Novecento* (Il Mulino, 2011), 178.

them specialists) had heard about what was happening in Gorizia before 1968. Yet, by the time *The Negated Institution* came out, many of the protagonists of that experiment were on the verge of leaving. They had also concluded that what they were doing had reached something of a dead end. While *The Negated Institution* was a revelation for those who read it, for the Gorizians themselves it marked the beginning of the end. These aspects of the book were often ignored, as Colucci and Di Vittorio wrote: "It is also — and perhaps above all — a book written against the idea of the therapeutic community and attempts at 'institutional reform,' but this aspect has remained somewhat in the shadows."[64] Thus, at the same time as the very success of *The Negated Institution* set Gorizia up as a model — despite the book's claims that "[w]e refuse to propose the therapeutic community as an *institutional model*"[65] — most of the Gorizians had already moved on. In fact, they saw what they had done there, in part, as a trap, a "golden cage," a way of providing a sophisticated and humane veil to mask new forms of oppression. There was a deep ambiguity at the heart of this book and the controversy that surrounded it. The revolution in mental health care would be carried forward elsewhere, close to Gorizia itself, in Trieste, but also in other cities across Italy. It was a "book which discusses a crisis and which brought the Gorizia experience to a point of crisis — this is what makes it original, a sense of genius,"[66] but this is not how most people read or understood it.

Basaglia and his *équipe* were happy to be seen as outsiders. They identified with their patients (and with all the excluded). Psychiatrists, if they acted as psychiatrists had always acted, were part of the problem, not the solution. The same was true of university lecturers, teachers, and others. Power should only be exercised in order to negate that power. The first words of *The Negated Institution,* significantly, were given to a patient, a blind man called Andrea who had experienced the hospital

64 Colucci and Di Vittorio, *Franco Basaglia,* 179.
65 This volume, 189.
66 Colucci and Di Vittorio, *Franco Basaglia,* 179.

before Basaglia's arrival: "Because, before, those who were here would pray so that they could die."[67] Then, it had been a place without hope, where the only possibility of getting out was death itself (or escape, which never worked). Andrea, a kind of patient leader, underlined how much the hospital had changed. During the early assemblies, of which he was one of the first presidents, nobody had had the courage to speak. Andrea also described how Slavich would take some of the patients from C ward for trips outside the hospital. This was the first time many of these inmates had left the asylum, or even their wards, since their internment. Other patients quoted in the book told of the removal of barriers, of an end to physical restrictions. There were stories from the past of torture, of forms of waterboarding (*le maschere,* a wet cloth placed over the mouth to simulate suffocation), of straitjackets, of cages with locks placed over beds. All the patients who spoke out insisted on the sweeping changes that had taken place inside the asylum and were grateful to Basaglia and his *équipe* for this transformation. One particular patient, referred to in the book as "Margherita," was adopted in a certain sense by Basaglia and Ongaro and helped out in their flat at times. Margherita was able to work for the first time in the 1960s (inside the hospital). *The Negated Institution* also included an interview with Carla, a patient who was also an Auschwitz survivor. Most of these testimonies were permeated by a feeling of radical change, and this was true of the doctors and nurses, as well as the patients. A nurse summed up this sense of transformation:

> When we see that the sick person comes here and seems lost and must be helped, helped, helped, and we help him and then we can say, "here they are, finally they can operate on their own. For us it is a satisfaction."[68]

67 This volume, 57.
68 Ibid., 116.

Gorizia was completely different to most other psychiatric hospitals:

> Here a young doctor feels that in some way, with their work, with participation in numerous group meetings at all levels, they achieve the double aim of a, let's say, professional activity and a daily battle of ideas, with the latter certainly more rewarding than the former![69]

Although *The Negated Institution* was not an abstract, theoretical text like so many others which were to emerge in the late 1960s and throughout the 1970s, it did contain sections that were challenging. Much of the book was immersed in the reality of Gorizia's asylum, in the words of its patients, in the rituals of its institutionalized and deinstitutionalized practices. But there were also moments of high theory, and the level of the writing was uneven. The debate over the opening up of the last closed wards inside the hospital, which dominated a large part of the book, showed how different positions were taken up within the *équipe*. Slavich was more pragmatic. What was the point of opening up the wards? What were they trying to achieve? Basaglia, meanwhile, wanted to push forward and then judge the consequences and outcomes. There was no point waiting any longer. Other *équipe* members took up various intermediate positions. By the time the book came out, these wards had been entirely opened up.

* * *

> "One of the most important medical books from the post-war period."
>
> — Giulio Alfredo Maccacaro on *The Negated Institution*[70]

69 Ibid., 132.

70 Giulio Alfredo Maccacaro, "Lettera al Presidente dell'Ordine," in *L'umanità di uno scienziato: Antologia di Giulio Alfredo Maccacaro,* ed. Enzo Ferrara (Edizioni dell'asino, 2011), 146.

The Negated Institution flew off the shelves, going through "eight editions of which two during 1968 and 60,000 copies sold in Italy of which 50,000 between 1968 and 1972."[71] The book sold 12,500 copies in 1968 alone, making 690,000 lire for the authors, all of which was donated directly to the patients' club in Gorizia once the publisher's costs had been deducted. *The Negated Institution* told people what they wanted to hear, but it also created new currents of opinion. Its title was perfect: a slogan, a call to arms, and not just for psychiatrists (and perhaps not for them at all). Suddenly, Gorizia was headline news, a mecca for the 1968 generation, a place with its own bible. *The Negated Institution* both produced and reflected 1968. Journalists flocked to Gorizia to write pieces for all kinds of magazines and newspapers, and other visitors simply turned up to see things with their own eyes: the miracle of the mad discussing how to manage their own hospital, the spectacle of a group of lunatics who really had taken over an asylum, as their doctors sat around without white coats and made occasional comments. Sergio Zavoli's powerful documentary, *I giardini di Abele* (*The Gardens of Abel*), aired on national TV in early 1969 and watched by millions, was the icing on the cake. A gloomy mental asylum in the middle of nowhere had, unexpectedly, become one of the key sites of the 1968 movement in Italy, and to some extent in Europe.

The publication of *The Negated Institution* turned Basaglia suddenly into big business. Thousands of copies sold for a book of this kind was something of a miracle. It was widely reviewed in a whole series of publications. Basaglia and Gorizia had become a brand. The difficulties presented by this sudden fame could also be seen in the reaction to the special Viareggio Prize

71 Giannichedda, "Introduzione," xxv. The publisher reported a sales figure of 12,500 for the first three editions of the book in 1968. By the end of 1972 this figure had risen to around 27,000 copies, through five editions (Einaudi Archive). In December 1975 sales of a further 25,000 or so copies was reported, giving a total of over 52,000 in seven years and seven editions. This gets us close to the overall total of 60,000 that is often given as the official sales figure for Einaudi over eight editions up to 1974.

that was awarded to *The Negated Institution* in July 1968.[72] The jury had decided that the prize for a first work for poetry was not to be awarded, and with the money left over (a million lire) an extra Premio Speciale was assigned to *The Negated Institution* and to the entire *équipe,* a decision which bent the rules for the prize, which was meant to go to individual authors. The jury wrote that the book was "a kind of critical diary where documents, testimonies, debates all come together alongside practical reflections, and dialectical considerations."[73]

There followed a fierce debate inside the *équipe* about whether to accept the prize, and a further discussion over what to do with the million lire which came with it (which was eventually handed over to the patients).[74] This discussion was complicated by the fact that Italo Calvino, Einaudi author and one of its key consultants and man of the left, had turned down his own Viareggio Prize with a polemical telegram, throwing the whole idea of literary awards into crisis. Calvino's telegram arrived just as the preparations for the prize distribution were being finalized in Viareggio and read as follows: "Given that I believe that the epoch of prizes is over, for ever, I do not intend to accept this prize because I do not want to provide support for these institutional forms which are completely lacking in meaning. In my desire to avoid any press sensation, please do not announce my name as one of the winners. In friendship, Calvino."[75] At first, the organizers of the

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72 This was not the main non-fiction prize, which went to Giuliano Procacci's book *Storia degli italiani.* Subsequent accounts have ignored the arguments around the prize and usually simply state that *L'isitituzione negata* won the saggistica (essay) prize at the Premio Viareggio. See, for example, Giannichedda, "Introduzione," and Ernesto Venturini, Domenico Casagranda, and Lorenzo Toresini, *Il folle reato: Il rapporto tra la responsabilità dello psichiatra e la imputabilità del paziente* (Franco Angeli, 2010), 122, 171.

73 Gabriella Sobrino and Francesca Romana de'Angelis, *Storie del premio Viareggio* (Mauro Pagliai, 2008), 83.

74 See Isman, "Hanno discusso tranquilli in assemblea come adoperare il milione del 'Viareggio.'"

75 Sobrino and de'Angelis, *Storie del premio Viareggio,* 84–85; Renzo Ricchi, "Premi contestati e qualcosa da fare," *Il Ponte* 24, no. 8 (August 31, 1968), and 24, no. 9 (September 30, 1968), 1091–93. See also Santino Salerno, *A Leonida Rapaci: Dediche del '900* (Rubbettino, 2003); *Viareggio: 50 anni di*

Premio Viareggio thought the whole thing was a joke, but eventually responded furiously at this public embarrassment. After all, the prize winners had already been announced to the press,[76] and Einaudi had submitted Calvino's book for a prize in the first place. The organizers then issued a press statement where they called Calvino's actions "demagogic and an insult to his own dignity and that of the other candidates."[77] Calvino's refusal of the 3-million-lire prize became front-page news and put pressure on the Gorizian *équipe*. Because his radical choice of words, he made anyone who accepted a prize look like a sell-out. One journalist wrote:

> The fact of being given a prize created a sensation of being amongst the conservatives, and an accomplice in terms of the power of the publishers, and these prizes ended up being a problem rather than a pleasure.[78]

In the end, the idea of such a large sum of money going straight to the patients was decisive, and a somewhat grudging telegram was sent to Viareggio "in which it was written that the *équipe* who edited the book *The Negated Institution* heard about their victory 'with great surprise' and had decided to hand over the money to the poor patients."[79] The telegram also said that the prize had "not been asked for" by the authors. This was later dubbed a "nonrefusal."[80] Nico Pitrelli wrote that "At first, Basaglia and his team decided to refuse the award, but later they changed their mind and accepted it. These disagreements had

cultura italiana (Edizioni delle autonomie, 1979); and "Calvino premiato rifiuta il 'Viareggio,'" *L'Unità,* July 13, 1968.

76 This led to a somewhat farcical series of articles and corrections. See Armando La Torre, "A Calvino, Procacci e Vigolo la 39a edizione del 'Viareggio'" and "Ultim'ora: Il premio a Bigiaretti," *L'Unità,* July 13, 1968.

77 Sobrino and De'Angelis, *Storie del premio Viareggio,* 85.

78 Ricchi, "Premi contestati e qualcosa da fare," 1091.

79 Ibid.

80 *L'Espresso* wrote that Basaglia "refused" the prize and simply "sent the cheque" to the patients ("Una Montessori per i matti," *L'Espresso,* March 3, 1968).

important consequences for the *équipe* — and are probably part of the reason why Basaglia left Gorizia, which is one of the most difficult questions to resolve in historical terms."[81]

Once again, the organizers of the award were incandescent with rage. They issued yet another press release, accusing Basaglia of a publicity stunt:

> The doctors in Gorizia […] led by Franco Basaglia, by justifying their non-refusal of the award with a desire to help the poor economic conditions of their patients, show that they want to take with one hand what they have refused with the other. Franco Basaglia, by taking part in the ongoing protests with such a low sense of expediency and measure, has created this doubt in our mind: perhaps his scientific merits are not immune from the desire to court publicity.[82]

The president of the jury, Leonida Rèpaci, repeated his accusations during the ceremony itself, arguing that the Gorizia telegram was written with "poison ink."[83] A cheque for a million lire was sent to Gorizia. The reply was minimalist: "We have received the million lire — a letter will follow — The Director of the Hospital." In some ways, this award confirmed some of Basaglia's worst fears about the book. It was too popular. Gorizia's fame had its own downside, as Basaglia told a journalist in September 1968: "Many people come and visit us, we are trendy, a center of attraction and curiosity. This is not what we are interested in."[84]

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81 Nico Pitrelli, *L'uomo che restituì la parola ai matti: Franco Basaglia, la comunicazione e la fine dei manicomi* (Riuniti, 2004,) 82. However, Pitrelli does not cite any source for this affirmation.

82 Sobrino and de'Angelis, *Storie del premio Viareggio,* 87.

83 Ibid. According to Sobrino and de'Angelis, Calvino later admitted that he had refused the prize under pressure from Giulio Einaudi: "We were in 1968, in the middle of the student protests." Cited in ibid. See also Italo Calvino, *Letters, 1941–1985* (Princeton University Press, 2013), 359–61, 579.

84 Isman, "Hanno discusso tranquilli in assemblea come adoperare il milione del 'Viareggio.'"

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The history, biography, and practice of Franco Basaglia and the movement he partly led and inspired has, with a few exceptions, been consistently misinterpreted in the English-speaking world, in particular in the UK.[85] Let us take, for example, the judgments of two of the leading historians of madness and asylums. In 1994 Roy Porter referred to Basaglia as "Enrico Basaglia" and labeled him a "boisterous anti-psychiatrist,"[86] while in 2002 he wrote that "[i]n Italy, leadership of the movement was assumed by the psychiatrist Franco Basaglia, who helped engineer the rapid closure of institutions (chaos resulted)."[87] Andrew Scull's judgement on Basaglia was similarly brief, in 2010: "In Italy, led by the charismatic Franco Bassaglia [sic.], the political left led the charge."[88]

The origins of these snap and inaccurate judgments lie in several areas. First, Basaglia's work was not translated into English, including (and most importantly) *The Negated Institution*. This book had been, however, quickly and successfully translated into German, French, and numerous other languages. There are no convincing explanations of this failure to translate the work into English, although there are various accounts available.[89] The lack of an English translation of *The Negated Institution*

85 One exception is Shulamit Ramon and Maria Grazia Giannichedda, eds., *Psychiatry in Transition: The British and Italian Experiences* (Pluto Press, 1988).

86 Roy Porter and Mark Micale, "Introduction: Reflections on Psychiatry and Its Histories," in *Discovering the History of Psychiatry,* ed. Mark Micale and Roy Porter (Oxford University Press, 1994), 20.

87 Roy Porter, *Madness: A Brief History* (Oxford University Press, 2002), 210.

88 Andrew Scull, *Madness: A Very Short Introduction* (Oxford University Press, 2011), 113. A more balanced and well-informed account (with some errors) can be found in Tom Burns, *Our Necessary Shadow: The Nature and Meaning of Psychiatry* (Allen Lane, 2013), xlvi, 148–49, 183. However, even here Basaglia is described as a "Gramscian Marxist."

89 Some claim that R.D. Laing himself blocked a translation, but I have found no evidence to back up this claim. See Frederick Alexander Jenner, "On the Legacy of Ronald Laing," *Janus Head: Journal of Interdisciplinary Studies in Literature, Continental Philosophy, Phenomenological*

became something of an issue for the ex-*équipe* and perhaps, in particular, for Basaglia. They wanted to have an influence in the English-speaking world, a world that had been an inspiration for them and their practice. Basaglia's writings and those of the *équipe* were only translated into English in piecemeal fashion *and* usually in hard-to-find or largely academic publications, and often well after the events described in his work had taken place. The Scheper-Hughes and Lovell collection/study is from 1987, and a short and much-quoted article appeared in David Ingleby's *Critical Psychiatry* in the early 1980s.[90]

Furthermore, Basaglia was the subject of a series of extremely hostile but influential studies in English in the 1980s in the wake of the Basaglia Law and debates in the UK about the closure of asylums.[91] These articles then led directly to critical comments on Basaglia and the Basaglia Law in important books about psychiatric reform and the meaning of mental illness, particularly in the light of attempts to regain the ground lost to R.D. Laing and the antipsychiatry movement.

Psychology, and the Arts 4, no. 1 (2001), http://janushead.org/wp-content/uploads/2020/07/F.-A.-Jenner.pdf.

90 Nancy Scheper-Hughes and Anne Lovell, eds., *Psychiatry Inside Out: Selected Writings of Franco Basaglia* (Columbia University Press, 1987); Franco Basaglia, "Breaking the Circuit of Control," in *Critical Psychiatry: The Politics of Mental Health,* ed. David Ingleby (Penguin, 1981). Other bits and pieces of Basaglia's work were translated over the years. See, for example, "What Is Psychiatry?," *International Journal of Mental Health* 14, nos. 1–2 (1985): 42–51. See also the short piece "Crisis and Identity: Extracts from the Theory of Franco Basaglia. Selected by Maria Grazia Giannichedda," in *Psychiatry in Transition: The British and Italian Experiences,* ed. Shulamit Ramon and Maria Grazia Giannichedda (Pluto Press, 1988).

91 Kathleen Jones and Alison Poletti, "Understanding the Italian Experience," *British Journal of Psychiatry* 146, no. 4 (1985): 341–47. See also Kathleen Jones and Alison Poletti, "The Mirage of a Reform," *New Society* 70, no. 1137 (1984): 4–10. For a further discussion of Jones and Poletti, and of the "missing" British translation of Basaglia, see Tom Burns, "The United Kingdom's Rejection of Basaglia," in *Basaglia's International Legacy: From Asylum to Community,* ed. Tom Burns and John Foot (Oxford University Press, 2020), and Benedetto Saraceno and Sashi Sashidharan, "Basaglia's International Influence," in ibid.

First there was a notorious article published by Kathleen Jones and Alison Poletti in the *British Journal of Psychiatry* in 1985. This article was six pages long and led to a major debate in the journal, including a flurry of critical letters.[92] In this piece, Jones and Poletti set out to analyze what they called the "Italian experience." They defined this as the implementation of Law 180 from 1978 and made only perfunctory reference to what had happened before that date. The only Basaglian text examined in any detail was a talk he had given in the UK in 1979. The authors claimed that the passing of Law 180 (the "Basaglia Law") had been seen as one of the "great success stories of psychiatric history" in Italy, and that they wanted to present a more balanced picture. Their study was based upon research into published sources and a study tour of Italy in 1984. On this tour they had visited a series of mental health institutions "chosen at random." They claimed that Law 180 had lost support and was due to be repealed (as I write, in 2025, this has not happened). The analysis was blunt, to say the least. Basaglia was again described as an "anti-psychiatrist." It is beyond the scope of this introduction to examine in detail the effects of the 1978 law. However, what is interesting for us, here, is the way in which the Basaglia Law was blamed for a whole series of problems on the basis of flimsy evidence, and that part of this blame was transferred back to the ideas and practice of Basaglia himself. But this was at least nuanced to some degree. As Jones and Poletti wrote,

> A third reason [for the failures of Law 180] is a possible confusion between the thought of Franco Basaglia, the current

92 Jones and Poletti, "Understanding the Italian Experience." The articles were heavily criticized by the Italians. Franco Rotelli, in "Changing Psychiatric Services in Italy" in *Psychiatry in Transition,* ed. Ramon and Giannichedda, 190n4, called the original article "comic," while Benedetto Saraceno, in "La 'Distorsion Anglaise': Remarques sur la réception de la pensée de Franco Basaglia," *Les Temps Modernes* 668, no. 2 (2012): 56n5, dubbed the series of articles as "sinister." Saraceno explains this process through the resistance of Anglo-Saxon psychiatry to phenomenological and existential thought.

> aims of Psichiatria Democratica, the intention of Law 180, and the outcome. The politico-social theory, the pressure-group campaign, the legislative provision and the state of the services seven years later are causally and temporally linked, but not identical. Basaglia, who cared about the condition of his patients, might have taken a very different view in 1985 if he had lived.[93]

Jones and Poletti's 1985 article led to something of an outcry, and they were forced into a clarifying article in 1986. This involved further trips to Italy, and this time they visited Trieste. In this second article, the picture they painted was detailed and positive (about Trieste), while they also argued that the hospital had not really been closed at all and questioned the real content of services in the city.[94]

This kind of analysis was continued in Martin Roth and Jerome Kroll's *The Reality of Mental Illness* (1986). This book was intended as a rejoinder to antipsychiatrists and was widely read at the time. Roth and Kroll appeared unaware that Basaglia had died in 1980 when they wrote that "Basaglia is a Marxist."[95] They went on to argue that Basaglia's analysis of mental illness was "ideologically driven and very naïve and, in a sense, very callous."[96] Basaglia was accused in no uncertain terms of throwing asylum inmates onto the streets for political reasons, and the

93 Jones and Poletti, "Understanding the Italian Experience," 347.

94 Kathleen Jones and Alison Poletti, "The 'Italian Experience' Reconsidered," *British Journal of Psychiatry* 148, no2. (1986): 144–50. See also Shulamit Ramon, "Understanding the Italian Experience," *British Journal of Psychiatry* 147, no. 2, (1985): 208–9; Michele Tansella, "Community Psychiatry without Mental Hospitals—The Italian Experience: A Review," *Journal of the Royal Society of Medicine* 79, no. 11 (1986): 664–69; Shulamit Ramon, "The Italian Psychiatric Reform," in *Mental Health Care in the European Community,* ed. S.P. Mangen (Croom Helm, 1985); Simon Lovestone, "Community Care: Italian Style," *British Medical Journal* 297, no. 6655 (1988): 1042–43; and Michele Tansella, "Misunderstanding the Italian Experience," *British Journal of Psychiatry* 147, no. 4 (1985): 450–51.

95 Martin Roth and Jerome Kroll, *The Reality of Mental Illness* (Cambridge University Press, 1986), 17.

96 Ibid., 23.

Basaglia Law was described as a "disaster" in social and human terms. The conclusion was that mental patients were "exploited [...] as pawns in an ideological struggle."[97] Roth and Kroll ended their comments by giving their support to moves to repeal the Basaglia Law.

Even though there was wide-ranging debate among practitioners, activists, and researchers in the UK about the Basaglian experience and especially about the impact of Law 180, with both positive and negative evaluations of the Italian case, only one side of this debate appears to have been picked up by many commentators. It is not true that reaction in the UK to the law and its aftermath was universally negative, but it does seem as if the negative aspects and arguments have survived the debate, while the other points and discussions have been forgotten or marginalized. Thus, it becomes possible that Basaglia can be simply dismissed as an antipsychiatrist and his reforms equally dismissed as simply leading to "chaos." While it is clear that many activists and practitioners were inspired by the Basaglian experience, and especially by Trieste, the historical discussions that have followed have not, with very few exceptions, taken this into account.[98] The lack of key texts in English, especially *The Negated Institution* and *What Is Psychiatry?,* certainly impoverished the debate that took place. This publication is, in part, an attempt to rectify this situation, and provide the Basaglian movement with historical background and content from the period before Law 180 was passed.[99] With most countries in the world still locking up people with mental health condi-

97 Ibid., 24.

98 One exception is the work of Nick Crossley, who details the impact on many UK activists in particular of Trieste and Basaglia's legacy in *Contesting Psychiatry: Social Movements in Mental Health* (Routledge, 2006), 147–51. Crossley argues that Basaglia and his movement provided an inspiration to a whole series of social movements (in particular those involving patients) that developed in the 1970s and 1980s in the UK. Trieste became a "working utopia" and was visited by many campaigners and activists.

99 There is also a consistent strand of anti-Basaglia literature in the academic world (outside of medical academia). For example, Lola Romanucci-Ross and Laurence Tancredi, in *When Law and Medicine Meet: A Cultural View*

tions in closed institutions, and widespread reports of abuse and violence inside these systems, this book is still important, and relevant. Are we destined to treat mentally ill people in this way forever? Is there an alternative to locked doors, abuse, and torture? Basaglia and his colleagues thought there was, back in 1961, and they set about dismantling an entire system. Today, Italy has no psychiatric hospitals, nor does it have criminal asylums. Is this possible in other places in the world as well? Let the debate begin!

(Springer, 2007), 11, describe Law 180 and the Basaglia movement as an "experiment which failed" and a "great cultural error."

THE NEGATED INSTITUTION

Presentation

Franco Basaglia

The material in this volume is a collection of documents and notes which aims to provide a concrete analysis of an institutional reality which is in the process of being overturned. This is a contradictory process.

It is not by chance that the testimonies included here (from the mentally ill, nurses, and collaborators) have a polemical and subversive edge to them. Our acts took their cue from the asylum itself — a reality which can only be violently negated. The overturning of this dramatic and oppressive situation can only take place through a polemical form of violence in the face of that which we wish to negate, which confronts those values which allow for this reality to continue to exist.

Thus, our anti-institutional, antipsychiatric (in the sense of antispecialist) arguments cannot remain within the specific field of our practice. Our attack on the institutional system moves outside of the psychiatric sphere and toward those social structures which support it, forcing us into a critique of scientific neutrality, which acts in favor of dominant values, and becoming a form of contestation and political action.

It would perhaps be easier to remain within our own limited field of action and research and thus to maintain a form of distance — which is crucial for scientific study — between the investigator and the object of research. Scientific work, as long

as it remains within certain acceptable limits, is seen as serious and respectable insofar as it cannot be contradicted and negated by reality. But if practice is based on an understanding of reality and its contradictions, without wanting to construct a model that simply confirms and codifies its own ideas, it attracts criticism and accusations of a kind of unrealistic amateurism with respect to everything that is outside of the usual way of doing things and creates a contradictory and dialectical situation, which is constantly in movement.

This is the form of institutional overturning which doctors, psychologists, sociologists, nurses, and the mentally ill have taken forward and inspired in a psychiatric hospital, challenging the asylum in practical terms. With reference to some experiences beyond Italy (in particular that of Maxwell Jones in the UK[1]), the reality of the asylum has been negated — through a series of critical positions and actions. This has created an ambiguous form of community or microsociety that has attempted to build foundations in terms of practical and theoretical premises in opposition to dominant values.

We have arrived at a moment that justifies bringing this situation toward a crisis: the reality of the asylum — with all the practical and scientific implications that derive from this — has been overcome, *but we don't know what the next stage will be.* In those experiences beyond Italy which we referred to at the outset, the same contradictions, the same inadequacies, can be seen, although they have not been explicitly recognized as such. The only possible alternatives — for them, and for us — is either to return to the closed world of the institution, which implies an inevitable retreat in the face of a dynamic movement which will become fixed and crystallized, or to try to extend our activity to forms of discrimination and exclusion within society which have been imposed on those with mental illness. How can we

1 This is a reference to Dingleton Hospital in Scotland, an open psychiatric hospital run by Maxwell Jones, which Franco Basaglia visited in the early 1969s, and which was also visited by his wife Franco Ongaro and other members of the Gorizian *équipe,* including Lucio Schittar.

not move from the excluded to the excluder? How can we work within an institution which creates and determines this exclusion?

The debates, the arguments, and the notes collected in this book have this precise meaning: the analysis of a situation which can only be overcome by moving away from a specific field and working on that of the contradictions in society itself.

The psychiatrist's condition is, in our reality, more evident than others, in the sense that direct contact with conspicuous conditions of violence, abuse, and exploitation requires violence against that system that produces and permits them: *either one is complicit, or one must act and look to destroy.*

This radically critical attitude to what science has done thus far with regard to the mentally ill can be considered as anarchic because it refuses to label itself, and utopian because it rejects all definitions and classifications. But it also convinces us to use terms such as "revolution" and "vanguard" that may in other contexts sound hollow and tired. The brutal nature of the reality in which we work transmits to us this sense of violence and allows us — forces us — to use these terms. We are certain that we are not part of a kind of "literature of revolution."

The meaning of this book is to be found in its analysis of a series of problems, which are not particularly psychiatric ones, in order to show how a specific form of practice, marked by contradictions, is possible within an *institution of violence,* and how this practice refers back to the global violence of our social system.

It is easy for the psychiatric *establishment* to define our work as unserious and lacking in scientific respectability. But we are proud to be labeled in this way given that it connects us, *finally,* to the lack of seriousness and respectability which has always been attributed to the mentally ill and to all the *excluded.*

Documentary Introduction

Nino Vascon

> Because, before, those who were here would pray so that they could die. When someone died here in the past, they would always ring the bell, but they don't anymore. When the bell rang everybody said, "oh God, I wish I was dead," they would say, "I'm so tired of this life in here." So many died who could have been alive and healthy, but they were disheartened, there was no way out, they stopped eating. The staff would force them to eat with a tube inside their nose, but it didn't work, because they were locked inside and they had no hope of leaving. The people here were like parched plants without water with their leaves withered.

This short account came from a blind man, whom I will call Andrea, a long-stay patient in Gorizia's Psychiatric Hospital, a leader of a small group of older inmates, and someone who has passed most of his life inside the walls of the hospital. These older men are Italian, Hungarians, Slovenians, Austrians, representatives from countries which were part of the Austro-Hungarian empire as it fell apart; confined fifty to sixty years ago by the "Royal Imperial Government" along with stamps and signatures here in a remote corner of society: that reserved for the excluded. Andrea is tall, an old man. He is blind and when he was young, he worked as a builder. He is one of the

oldest patients in Gorizia and commands respect from the others, over whom he exercises some authority. As he is blind, he always walks with his head held high, his chest puffed out and his shoulders back, with his hands and arms in front of him, stretched out. In a haughty way, he seems undefeated. A witness to events from a distant past, he has a good memory, and, like a war veteran, he makes a blessing of his past sorrows.

His words come spontaneously, because he didn't know that I was recording him.[1] As he was blind, he didn't see the microphone and the recorder, and because he is old, he knowns little of such things, and, although he has heard of them, he is not inhibited by them. His story can be seen as authentic.[2] This statement is useful as an opening in its description of a new psychiatric situation in Gorizia. Andrea's words were also used for the beginning of a radio documentary which I made for the RAI, some time ago, taking advantage of interest in this subject, which was linked to stories I had heard about Franco Basaglia's professional work.[3] Since then, I continued to keep abreast of this experience now and again, with moments of varying interest. I was both attracted and repulsed by this topic.

My first spontaneous interest in it was nothing more than the logical outcome of a professional attitude and desire: an enquiry into something new. Gorizia was a unique experiment in Italy, and it seemed like a good idea to examine the way it worked and was organized, a good subject for journalistic investigation and engrossing for listeners.[4] But there was more. There was also

1 Certain ethical issues were not noted or recognized at the time, especially around consent.

2 Obviously, there are clear ethical issues here around consent which were not seen as such by this journalist, nor by the editor or the other authors, or at least they were never documented. See also Anna Maria Bruzzone, *Ci chiamavano matti: Voci dal manicomio (1968–1977)* (Il Saggiatore, 2021).

3 The RAI is the Italian state broadcasting company. It has not been possible to find a copy of this documentary or to discover when or even if it was broadcast.

4 It is not clear how "unique" Gorizia was. In Perugia, for example, very similar trends can be seen within the psychiatric hospital from 1965 onward (and in fact the movement for change in Umbria and Perugia was often

the chance, of entering a *manicomio* (mad house, a term I use deliberately) and to encounter that specific type of mentally ill person whom I presumed were to be found in such places. I shared most people's opinions about what provincial psychiatric hospitals were like,[5] and I had thought of them, in a superficial way, as a mix between a prison and a convent — strange places that solicit the subtle pleasure of violation. Looking back at my past views, it could be said that the average citizen thinks of a mentally ill person — when not in terms of fear or disgust — in a generically positive way linked to certain clichés: the genius of madness, a touch of craziness and a sense of flair, etc. And this was true for me as well in terms of my initial interest in the asylum. I hoped to see some of these features in the mentally ill people I was about to meet, which might justify, or gratify, my benevolent interest in this group. I had already experienced this kind of feeling, without any critical analysis, when I saw some pictures created by the mentally ill that were exhibited in an art gallery and in the workshop of a madhouse. I interpreted these works of art as exciting examples of unfathomable expressions of spirit and wonderful products of an uncontrolled imagination, as well as something vaguely and pleasantly disturbing, obsessive and haunting. Only after I had actually seen Gorizia did I begin to realize that these mechanisms are no different from those which are used by white people to exclude Black people in countries where racial coexistence is either impossible or has

"ahead" of that in Gorizia). Gorizia from 1961–1965 was certainly different from many other psychiatric hospitals in Italy thanks to the activities of Basaglia and others.

5 Most psychiatric hospitals in Italy at this time were run by provincial governments, not city administrations. Provinces covered a bigger territorial area and were linked to specific functions. By law, from 1904 onward, each Italian province had to have a psychiatric hospital. But some of these places had a longer history, being originally built under different national governments. This includes Gorizia, which was first opened by the Austro-Hungarians, while others had different and older histories, sometimes run by Catholic organizations or charities. There were also a smaller number of criminal asylums, which were very similar but had the added feature that those inside had been convicted of crimes.

never existed. There the cultivated white person confronts the "Negro problem" by giving free rein to a sense of guilt — I suffer for the condition of the Negro and perhaps much more than the Negro — and alleviates this feeling through acceptance, knowledge, and admiration for Negro poetry, for Negro singing, for the Negro elite. At the bourgeois level the Black poet, musician, writer is — Fanon would say — less Black than the porter, the carpet-seller, the African peasant. At the same moment when a white man thinks they are breaking down barriers they fail to realize that they are actually reinforcing forms of exclusion. In the same way as a great musician and a famous Jewish scientist were saved before the others, snatched from the Nazi's wrath, because they were more deserving, more representative than the shoemaker or a rag-and-bone man from the ghetto.[6]

In reality the situation of the mentally ill in Italy is a disgrace. These are the only ill people who have no right to be ill because they are defined as "a danger to themselves and to others and a public scandal."[7] We lock them up with bars and gates and, in order to ignore their problems, we transform them into a "parce"," in the words of one patient from Gorizia. In short, we make them into an object-person whose future is entrusted to chance. If they have money, they are looked after in a series of clinics and avoid the shameful mark of a criminal record. If they are poor, they will end up in the ghetto of the excluded.

We are all aware of how neglected and dirty the village idiot is — treated more like an animal than a person — laughed at by the little boys and mocked as a big bad wolf to scare the little ones. But when we enter a madhouse there is that incredible smell that comes from the locked wards (the smell of the madhouse), a cacophony of voices, the split and dribble on the mouths of the inmates, the grey shirts, the shaved heads — this

6 This passage is clearly of its time and displays a problematic attitude to race which was quite widespread across the Italian left in the 1960s and 1970s.

7 A reference to the 1904 law.

is the landscape of the mentally ill in a country which has the Uffizi, Portofino, the Camera degli Sposi,[8] Capri, Venice, Rome.

Some testimonies of former inpatients are useful in terms of describing the state of affairs in Gorizia a few years ago, but they also relate to the situation in many current Italian psychiatric hospitals. One consideration is useful here: psychiatric hospitals are the poorest hospitals of all. The poor are admitted to these Italian provincial institutions because families who can afford it and want to help their relatives pay for them to go to private clinics or keep them at home. But when the family budget does not allow it or when the cohesion of a group is lacking, and there is no common desire to assist a relative, the psychiatric hospital can also become the final place of refuge for a patient from a "good family."

The budgets of provincial administrations are certainly not abundant, and in any case more attractive, more showy, and often more electorally valid expenses often have the priority over funds for asylums.[9]

Andrea was the first patient we interviewed. He has been hospitalized in Gorizia for years.

QUESTION [Q]: Well, you say that now the situation here has changed....

ANDREA: There's a big difference. Yes, because once we were closed in, closed with a fence and not only this, some eighty of us would also be put in the living room without enough seats, we had to lie or sit on the floor. We couldn't even go to the toilet. Then ... at five in the evening we had to have dinner and immediately go to bed, even in summer, the height of summer, when there were still three hours of

8 A famous frescoed room in the Castle of San Giorgio in Mantua.

9 The provincial administration managed and financed psychiatric hospitals at this time. They were extremely expensive and often took up a big chunk of the budgets of the province, which usually tried to enforce limits on any extra spending. Basaglia fought constant battles with Gorizia's provincial administration over spending in various ways, including the employment of staff.

sunshine. And they sent us to bed, with food in our mouths. I went out to get some air in the courtyard and immediately someone came to get me and take me back.

Q: But in what sense have things changed … ?

ANDREA: Completely. Because when we first started these meetings, in fact I was President for a month or more, no one said anything, everyone was intimidated, frightened.…[10] They didn't have the courage to speak, and I, as President, begged them: do you have something to say? Speak up, we are here for this reason, if you have any complaints, make them; but nobody opened their mouths. This is because they were scared after being locked away for so many years.… It was the director[11] who did these things.… But the first to act was Dr. Slavich[12] who came to ward C and said: "Go ahead, choose ten or fifteen patients and take them for a walk around the farm."

Q: Was that the first time you went out [of the asylum]?

ANDREA: Yes, it was the first time we had left the asylum, Dr. Slavich was there and the director. Everyone went for a walk. And the people were reborn. There was another spirit, another inclination, a doctor would pick up someone with

10 Hospital-wide meetings, open to all, and run by the patients, began in Gorizia in 1965. Ward meetings had been taking place before that. It is not clear which kind of meetings Andrea is referring to here. The hospital meetings had a rolling patient president who presided over them and took minutes.

11 Franco Basaglia was the director at Gorizia from 1961 until 1968. At the time, an asylum director had considerable power within the hospital.

12 Antonio Slavich, psychiatrist. Basaglia had met him in the late 1950s or early 1960s. He was the first like-minded psychiatrist to join Basaglia in Gorizia in 1962. See John Foot, *The Man Who Closed the Asylums: Franco Basaglia and the Revolution in Mental Health Care* (Verso, 2024), 73–79 and *passim,* as well as his own account in *All'ombra dei ciliegi giapponesi: Gorizia 1961* (Alphabeta, 2021). He later went on to work in Colorno's psychiatric hospital and was director of Ferrara's psychiatric hospital before also working in Genoa. See also Luigi Missiroli, Adello Vanni, and Marco Turchi, eds.., *Il manicomio di Via della Ghiara: Antonio Slavich a Ferrara* (Ogni Uomo è Tutti Gli Uomini, 2023).

the car and take them for a walk around the farm while chatting and every day we would be sent out for a walk.

Q: So, do you think that this spirit of freedom was good for you?

ANDREA: Great, [it was] great, because, before, those who were here would pray so that they could die. When someone died here in the past, they would always ring the bell, but they don't anymore. When the bell rang everybody said: "Oh God, I wish I was dead," they would say, "I'm so tired of this life in here." So many died who could have been alive and healthy, but they were disheartened, there was no way out, they stopped eating. The staff would force them to eat with a tube inside their nose, but it didn't work, because they were locked inside and they had no hope of leaving. The people here were like parched plants without water with their leaves withered.

Q: Even for the [mentally] ill [these changes were] good....

ANDREA: Of course! There are many here who don't want to go home now. They are fine here. Once the doctor and everyone were on their rounds: "Please, doctor," [they would say] "send me home...." It was like they had been condemned... to pray. But the doctor went on his way, without even noticing [them].

Another testimony that immediately struck me was that of Margherita.[13]

Q: So tell me, what was the hospital like?

MARGHERITA: The hospital was sad, we were sad.

Q: Were there bars, closed doors?

MARGHERITA: Yes, there were fences. He [Basaglia] started with our ward and removed the bars, he took off our straitjackets, in short, he did various things....

13 An important patient in terms of the account of Gorizia, who later worked in the Basaglia family home for a while, and whose story was fictionalized in the later TV program shown on Italian TV.

Q: But did you have these straitjackets on all day?

MARGHERITA: All day long, from morning to evening and even into the night, they tied us to the bed by our feet, the shoulders, everything, like the Lord on the cross....

Q: And this hurt you....

MARGHERITA: It really hurt me! Because even for a person who is really lost, I think it's not good for them to be like this.

Q: Did you never go outside?

MARGHERITA: No, we never went out. I didn't even go to work at that time, because they were afraid we'd start to complain....

Q: Not even in the gardens?

MARGHERITA: Yes, we went to the gardens, but we were tied up in the gardens too. When the sun was shining, they tied us up in the gardens. I was tied up many times to benches, to the trees in the courtyard. They always tied me up there.

Q: Why did they tie you up?

MARGHERITA: Because at that time there wasn't the type of care that there is now, yes, there was but you can see that the previous professor [director] didn't use it. Instead, now Basaglia has come and the treatment he is giving has improved the hospital one hundred percent.

Q: Now everything is open, can you come and go when you want?

MARGHERITA: Yes, now yes, whereas before I couldn't, they wouldn't let us.

Q: But how did they tie you?

MARGHERITA: With a straitjacket. After that, they even bound our feet. They bound my feet with leather thongs.

Q: Why?

MARGHERITA: Because I jumped about, I was naughty, I jumped a lot, I liked doing it, in short, they thought I was very ill and tied me up. At that time you couldn't accuse a doctor. If you said, "look, that nurse is mistreating us," they immediately tied us up, we had to let them treat us as they wanted and keep quiet. Now, however, everything is different.

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

MARGHERITA: Yes. Because we were also afraid of being tied up and afterward they even did "the mask" on us. . . .

Q: What do you mean?

MARGHERITA: They put a wet sheet around our faces and then they squeezed hard, hard, and they threw water on our faces, it was something that could kill you![14]

Q: Did this happen to you too?

MARGHERITA: Yes, to me too, unfortunately it happened to me. And then I also slept in a closed cage at night.

Q: What do you mean, in a cage?

MARGHERITA: Because we had beds with nets around them and there were padlocks linked side by side, and I was locked inside.

Q: Like a bird or a lion. . . .

MARGHERITA: So sometimes I rebelled as I was tired of being restrained, and since there were ropes and I started to untie the net to escape, because they didn't want to open it for me. . . .

Q: And how much time did you spend inside this cage that covered the bed?

MARGHERITA: All night long. We went to sleep at six in the evening, until morning.

Q: What state of mind did being inside the cage give you?

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

Q: So what did you do, did you shout?

MARGHERITA: Yes, I screamed and then I undid the net to escape, I walked with the net, I carried it with me. . . .

Q: And the more you did, the more the others thought you were sick?

MARGHERITA: Yes, and then they tied us up. If we did anything else they tied us up so we couldn't move. . . .

14 A form of torture similar to waterboarding used in psychiatric hospitals on a regular basis at the time.

Q: So when they removed the nets. . . .

MARGHERITA: We thought it seemed strange after so many years to find ourselves like this and all of a sudden it changed, we felt relieved.

Q: Are you happy?

MARGHERITA: Happy and how!

Q: Did you find it strange to leave the hospital?

MARGHERITA: Yes, it's also strange because [we were] always inside, inside, inside, and after seeing that the fences have been removed, we are able to walk. . . .

Q: And now what do you do in the community?

MARGHERITA: I also go singing twice a week. In the afternoon I go to school and for work I go to do the electroencephalogram (EEG). In the administrative block. I put the headset with the different electrodes onto people's heads. Like a kind of electrocardiogram (ECG) only done on the head.

Q: And do you do other jobs?

MARGHERITA: Here in the ward I always knit, because I can't stay idle or I get nervous.

Q: Do you work on the EEG as a clerk, as an assistant?

MARGHERITA: As a technical assistant.

Q: You learned well then. . . .

MARGHERITA: Yes and I like my job, I don't want to teach anyone else to do it because I like it.

Q: So that is your job, but in your free time do you go to the music therapy sessions?

MARGHERITA: Yes, I go to music and twice a week we sing and on Saturdays there's the cinema and on Sundays we dance and we go on some trips. . . .

Q: In your opinion, why did they tie you up in the past?

MARGHERITA: They used to tie us up because there wasn't the type of care that we have now. Or rather, there was but they didn't use it.

Q: Now that you are being looked after, they now longer tie you up. So are the pills like a straitjacket to you?[15]

MARGHERITA: I think so, because those keep you calm. If one isn't enough, give them two, three, and in the meantime the person calms down....

Q: So if there weren't the pills it would be like before....

MARGHERITA: It would be like before. Just see how one word is enough and they immediately start jumping around....

Q: Listen, do you take pills now?

MARGHERITA: I don't.

Q: And you were once tied up. So?

MARGHERITA: Once they did much more to us, they gave us electroshocks....

Q: But don't you think that the fact of being free, of going to work, of no longer being tied down, of being forced to do things, was it this that helped you?

MARGHERITA: Yes, it was.

Q: Or the medication?

MARGHERITA: No, it wasn't because I no longer take medication and yet ... I feel better.

Q: Then one must think that it was a sense of freedom....

MARGHERITA: Yes, a sense of freedom, because a person who finds themselves locked up gets anxious even if they are not anxious, finding themselves locked up, seeing that they cannot do this and cannot do that and instead they want to do things....

Q: Are there other sick people here who were restrained like you?

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

15 A reference to antipsychotic drugs which were available and freely prescribed from the late 1950s onward. Their role in the possibilities of opening up psychiatric hospitals has not been the subject of serious research in Italy.

And here is the interview with Carla,[16] one of the best known and most influential patients in the hospital.

Q: You have had a very complicated and difficult life.... You have also been in a concentration camp.... [*Two or three phrases from the interview are cut here due to technical problems with the tape recorder*]

CARLA: ... in the concentration camp where I was, there was also poor Princess Mafalda.[17]

Q: Listen, which concentration camp was it?

CARLA: Auschwitz.

Q: You have been here for some time, when the methods were different....

CARLA: Very different because we were all tied up with straitjackets. Some around trees, others around a bench and they didn't untie us until the evening. So yes it was [difficult], you can see under what conditions we lived. We were all dirty. In the evening they untied us and put us to bed tied at the wrists and ankles.

Q: Do you have any duties in the community?

CARLA: Yes, as the secretary [of the General Meeting]; that of being at the [front] table in daily meetings. When there are committee meetings, I also have to attend those of the doctors and report ...

Q: As a kind of bulletin ...

CARLA: Yes, the daily bulletin and in addition I do the monthly one for *Il Picchio*.[18] I also had to interview all the doctors and the only one who didn't answer me — and I won't give

16 Carla Nardini. Deported to a concentration camp during World War Two (it is not clear precisely why). She was a key figure in Gorizia in the 1960s and appeared in Zavoli's documentary.

17 A reference to Princess Mafalda (1902–1944), the second daughter of King Vittorio Emanuele III of Italy. She died in Buchenwald. Carla Nardini said she was in Auschwitz, a different camp.

18 *Il Picchio* was the patient newspaper; see Foot, *The Man Who Closed the Asylums,* 131–37.

> his name — said “no comment” and I was a bit upset about this.[19]

The Gorizia community is located within a vast green area, with centuries-old trees providing shade, among which there are nine two-story pavilions, other buildings, a church, and a farm. The wall around the hospital is part of the Italian state border with Yugoslavia. There are about five hundred patients here, one hundred and fifty nurses, nine doctors, plus a psychologist;[20] a chaplain, some nuns, social workers, and volunteers complete the staff of the institution. The inmates wear civilian clothes and not the grey uniform still in use in many Italian hospitals, so that everyone is free to wear what they want according to their taste and their means.

It is rare to find a hospital located in such a beautiful, large, and well-kept park, with the sounds of thousands of birds of all species, and it is sad to think that until a few years ago this grass, trees, flowers, and birdsong served to only make the lives of patients even sadder.

Now the area is in practice open to everyone, because instead of the frequent: “it is strictly forbidden to enter unless etc. etc.” [signs], there is a sign inviting people to visit the sick when and in whichever way they want.

For some time now, having overcome their fear, some teams of amateur soccer players have trained on the hospital pitch.

Once through the gates, which are always open, the casual visitor advances along the avenues of the park, maybe heading for the community bar which is located three hundred meters from the entrance. During this walk, the visitor will come across numerous people, men and women who stroll around, who are seated outside the pavilions, those who play bowls and

19 Despite Basaglia’s arrival there were still psychiatrists working in a traditional way within Gorizia. This may be a reference to a psychiatrist called Vittorio Ali who was seen as a particularly intransigent opponent of Basaglia inside the hospital.

20 The psychologist was Letizia Comba; see Foot, *The Man Who Closed the Asylums,* 87–88.

those who knit. Arriving at the bar, they will find a small crowd around the tables outside under a large canopy, or in a noisy and smoky room like that of all working-class bars. At this point they might begin to feel very uncomfortable, because they will no longer be able to distinguish who is sick from doctors and nurses. Then in an attempt to reestablish terms of comparison they will inevitably ask: "Where are the dangerous people?"

[But] there are no dangerous individuals; there is nobody who shouts, becomes agitated, tries to attack doctors, nurses, or visitors, because since there are no bars, gates, straitjackets, or means of coercion that generate violence in this community, one does not experience that climate with high levels of anxiety typical of similar institutions.

But the visitor's question is justifiable, indeed legitimate, because it falls within the logic of their own culture and attitudes. In a general hospital, the sick are in bed, or they walk the corridors in their dressing gowns or pyjamas. The nurses are dressed in white, the doctors too, but with different styles of gowns or coats: those of the nurses are in a hygienic-military style, while those of the doctors are longer and professorial or short and coquettish? Thus it is very easy and less tiring to distinguish the different types; as in a barracks, in a prison, in a school, and in the same way that officers are marked out from ordinary soldiers, prisoners from guards, pupils from teachers. Here these external signs are missing, that which is generally considered as a comforting indication of a preestablished order, a correct kind of distinction. A more embarrassing fact for the occasional visitor, or rather just an embarrassing fact in general, is that which has its origins in the difficulty of deciphering the various categories and makes it difficult to choose the kind of language with which to start a conversation with these people: am I speaking with deference to a nurse, while have I been overly familiar with a doctor and have I now mistaken a good nurse for a mad person? This is why the first approach to the community is generally a silent one and the first few hours are punctuated by questions asked in a quiet voice to a friend, a search for complicity between healthy people, and between those who are from

the outside. The release of this curious, cold relationship takes place with the beginning of community activities and above all with the general meeting of the community which opens every morning at 10.[21]

This general community meeting brings together sick people, doctors, nurses, and social workers every morning in the largest hall of the hospital, which is actually the refectory of a ward. Inpatients help nurses set up the room for the meeting by arranging the chairs in a semicircle and put them back in their place at the end of the session. The assembly is a spontaneous event, in the sense that there is no obligation to be present, and people can enter and leave the meeting when they wish, and no lists of the absent or present are drawn up. At least on the surface there are no formal or substantial distinctions between the members of the community. Doctors, patients, and nurses take their place in the room, all mixed together. The occasion leads to types of behaviors which are common to all public gatherings: the most casual and extroverted are in the front row, and the leaders are spread out in a strategic way in key places within the semicircle, while in the innermost corner, defended by a wall without openings (the others have windows, doors, and a large glass door) are the most backward or those who, while taking part, are still in a polemical or critical attitude toward the assembly. Two or three patients (who take turns in these roles) sit at the presidency table, those responsible for running the meeting, who have some remarkable qualities in their management of the event and display a dialectical approach, selecting and framing the topics to be discussed. It is not infrequent that a sick person going through a bad time wants to sit at the central table, disturbing the work [of the meeting] and generating tensions within the group with their attitude. In this case these provocations or nonsense are tolerated or deflected by the patients with extreme tact. In fact, these individuals are reproached for their behavior not in terms of their illness, but rather through

21 On this meeting and its importance, see ibid., 145–57.

points which invoke the importance of community relationships, mutual sensitivity, etc.

In this sense it should be noted that many of those present are workers and peasants: their language has developed over time and their behavior in discussions is, in Italy, even with respect to similar external institutions, almost exceptional. This is due to the fact that some have actually learned a different and better way of maintaining relationships by noting the behavior of others (nurses, doctors, patients) toward them and have been conditioned by this behavior to improve and adjust their own. Gorizia psychiatric hospital meetings go against the grain of a widespread phenomenon in Italy: the near impossibility of developing a coherent and positive management of a public meeting at any level. As a negative point, I would point to a certain tendency toward mimicry on the part of some, while the attempt to fix discussions around certain topics highlights key themes for the community and therapeutic purposes: wages and the organization of trips.

Wages are very modest and are decided upon at an administrative level — the patients receive them weekly for their services. This pay should provide meaning to the work of the patients, except that in many institutions and in situations similar to that of psychiatric hospitals they are simply another form of exploitation (just think how coveted prison production contracts are). However, those few hundred lire a week rightly have an economic importance within the hospital and it is therefore understandable that wages, their possible increases, etc. are frequent topics of discussion. As far as trips are concerned, these are seen as opportunities for fun and as an alternative to the monotonous life of the hospital as well as opportunities for more contact with the outside world.

The entire life of the hospital is governed by meetings. In fact, each day is marked not only by traditional moments (visits to the wards, breakfast, the opening of the bar, etc.) but also according to the rhythm of meetings; I would even say that by now the conventional deadlines of hospital life are secondary with respect to community needs. There are over fifty meetings

during the week; they don't always involve the same people at the same time but push all the members of the community into a kind of constant mutual availability. A typical morning begins at half past eight with a meeting of nurses, nuns, social workers and medical staff. This meeting ends at 9. From 9 to 10 the doctors visit the wards. At 10 the general meeting begins and lasts an hour or an hour and a quarter. At 11 or 11:15 the doctors, nurses, social workers, and patient leaders (be they spontaneously seen in these roles, or more traditional, or in some senses improvised) gather to discuss the outcome from the general meeting. At 1:30 the incoming and outgoing nurses of each ward meet, in turn once a week. In the afternoon there are ward meetings (daily for the admissions and alcoholic wards, fortnightly for other wards), doctors' meetings, committee meetings. Often, visitors will participate in these meetings.

Before starting to record some of the meetings on tape, I posed some general questions to the hospital director [Basaglia].

Q: If the life of the hospital is regulated by meetings, and we can conclude that they are the most important community event of all. Are they necessary, useful, or therapeutic? What is their purpose? Is it essential that they are so many of them?

BASAGLIA: Our meetings cannot be considered as a form of group psychotherapy, that is, they have no psychodynamic basis in terms of their development or interpretation. They should rather be seen in terms of the general meaning of group dynamics, without specific reference to any particular type of psychotherapy. In other words, the meetings held during the day have two essential meanings: 1) they offer patients, in the hospital, a series of alternatives (they can come to the meetings, work, do nothing, stay on the ward, or take care of other secondary activities); 2) they create a space for discussion and common forms of verification. When a patient participates in meetings, it means that their level of spontaneity is quite high, because they accept confrontation with others. Instead, group psychotherapy

usually involves a certain obligation to participate and the groups are stimulated and animated by doctors. Here, on the other hand, the aim is to ensure that the life of the community, daily life, is not regulated by doctors or medical expertise, but is the result of the spontaneous activity of all those who participate, in any way, in the daily life of the hospital. As you will have seen, doctors, for example, do not always attend all meetings. This is probably because they are too busy to do so, but it can also be the case that they want to avoid expressing some form of personal tension or aggression in meetings; and it is the same for nurses. These examples highlight how the very presence or absence of the characters and roles of institutional life have their own meaning in themselves. Meetings have value and weight only to the extent that the presence of a person is the expression of a decision, of a choice between several alternatives. This is perhaps the main meaning of all the activities that take place during the day, activities that are partly spontaneous and partly organized by medical staff. The basis of our work is to ensure that choices are made. The people who work in this context must find the possibility to decide personally, without being organized in specific ways and for particular outcomes. It is important that all members of the community, doctors, and nurses participate in these events as a result of spontaneous choices, without, of course, trying to create an artificial reality that does not consider context, social roles, and the status of patients which is different from that of doctors and nurses. Unfortunately, the patient is still linked to a social reality that recognizes them as individuals without rights. We place this fact that they are not considered a "person" within brackets, just as we put the illness itself into brackets.

Q: The impression from the outside is that these meetings are the driving force of the community.

BASAGLIA: This is true, but only if the meetings are understood as an occasion in which the members of the community can

gather together and discuss things: that this is their only meaning.

[But] the fact that patients have a specific level of social status, and a different role from nurses and doctors, is often a subject which is discussed and argued about in meetings. It is also a reason for confrontation and challenges through which each person clarifies their own position to themselves. The patient sees doctors and nurses as "free" people, whom they challenge in terms of the power they wield in the institution. Therefore, faced with a form of power that excludes them, they begin to see their condition as that of the excluded. On the other hand, doctors and nurses, besides the limit of reality for the patients, represent for themselves a refusal to be the excluders, through the dialectical negation of the role society has entrusted to them. This social role of the psychiatrist and that of nurses consists in being objectified and determined in the task of being jailers and those who defend society from the [mentally] ill. In a certain sense, albeit to a different degree, psychiatrists themselves are also excluded: they find themselves unconsciously playing the game of the ruling class. On this basis, there is a level of reciprocity that validates and makes possible a kind of confrontation.

Q: So in order to provide the patients with new or renewed social status, especially vis-à-vis the outside world that denies it to them, it must be given in a constant way....

BASAGLIA: Constantly and independently of any kind of psychodynamic interpretation of meetings and groups. We must keep in mind that the patient's main sense of reality is that they are people without rights and we try to begin with this reality. Rehabilitation is only possible if we start with this fact: the patient is a person without rights and we discuss with them this fact of being without rights. The patient is an excluded person and we discuss this exclusion with them.

Q: The sensation you get from the outside is that you ignore the illness, it is almost as if the illness does not exist.

BASAGLIA: It's not that we ignore the illness, but we believe that to have a relationship with an individual, it is necessary that we understand this regardless of the label that defines it may be. I have a relationship with a person not because of the name he has but because of who he is. Therefore, when I say, "this individual is a schizophrenic" (with everything that, for cultural reasons, is implicit in that term), I relate to them in a particular way, while thinking that schizophrenia is an illness for which there is nothing that can be done. My relationship in this way will only be that of someone who expects something "schizophrenic-like," and only this, from their interlocutor. It is therefore understandable how, on this basis, old forms of psychiatry dismissed, imprisoned, and excluded this patient, for whom it believed there were no means or instruments of treatment available. For this reason it is necessary to approach the patient by putting their disease in brackets, because the definition of a syndrome has now taken on the weight of a value judgment, of a labeling that goes beyond the real meaning of the disease itself. A diagnosis has the value of a discriminating judgment, without denying that the patient is ill in some way. This is the meaning of our bracketing of the disease, which is bracketing of the diagnosis and the labeling. What matters is to be aware of what this individual is for me, what is the social reality in which they live, what is their relationship with this reality. That is why these meetings are important, because they are the place where a confrontation is possible beyond forms of objective categorization. These are individuals who are in the hospital because they are ill, and through their constant confrontation with reality there is a possibility of understanding something about their illness.

Q: You talk about depsychiatrization of your work.

BASAGLIA: Depsychiatrization is our leitmotif. It is the attempt to put every form of categorization between brackets, to act in a space which is not yet codified and defined. To begin with, we can only negate everything that is around

us: the disease, our social mandate, our roles. That is, we negate everything that can give a predefined connotation to our work. When we negate our social mandate, we reject [the idea of] the sick person as an irrecoverable patient and therefore our role as mere jailers, guardians of society's peace; by negating the idea of the patient as irrecoverable, we negate their psychiatric connotation; by denying its psychiatric connotation, we negate the idea of illness as a scientific definition; by negating their illness, we depsychiatrize our work and we begin to operate in a new setting.

Q: What are the considerations from which this all began?

BASAGLIA: We started with an encounter with the reality of mental hospitals, which is tragic because it is oppressive. It seemed inconceivable to us that hundreds of people lived in such inhuman conditions just because they were sick, and it was inconceivable that we, as psychiatrists, were this situation's creators and accomplices. The mentally ill person is "sick" above all because they are outcasts, abandoned by everyone; because they are without rights, against whom everything is possible. For this reason we deny and negate, dialectically, our social mandate which would require us to consider the sick person as a nonperson and, by negating it, we deny the [idea of] sick person as a nonperson. On a practical level, we deny the dehumanization of the patient as the ultimate result of the disease, attributing the level of destruction to the violence of the asylum, of the institution, of its mortifications, abuses, and impositions, which then take us back to violence, to prevarications, to those mortifications on which our social system is based. All this was able to happen because science — usually at the service of the ruling class — had decided that mentally ill people were incomprehensible patients and, as such, dangerous and unpredictable, with a kind of living death as their only possible future.

The General Meeting of May 17, 1967

Note: many people are here, there is a widespread sense of tension and anxiety. Renato is going through a crisis: he is aggressive and provocative. Giovanna presides.

GIOVANNA: Are you interested in what procedures must be followed to obtain this subsidy?[22] It seems to me that this concerns everyone.

MASO: The procedures are not very difficult; you basically just have to fill out the application. I filled it out, but it was rejected. I did it again and we'll see what the outcome is, the procedure is not difficult. Well, I believe that it is the understanding that is lacking, the will to apply this law:[23] this article says that you are entitled to a subsidy, but there are those who interpret it in one way or another, and so we are left with nothing.

GIOVANNA: What was wrong with your application? Did they tell you why it was rejected?

MASO: Yes, they told me. They told me that I certainly don't enjoy any privileges, but that my next of kin, like my father and my sister, have a house, a piece of land, as if they were landowners. Then they said that I don't need the subsidy.

LUCIA: You're not a child who has to live off your relatives.

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

ANDREA: Because if your relatives work they give you a bowl of soup, otherwise they tell you to make do, try to earn a living, you're no longer with us, you've left.

RENATO: For example, I came here eight years ago and the director and the doctors gave me fifteen rounds of electric shocks, they broke all my upper teeth, is this ok? I will

22 This is a reference to support for patients provided by local and national authorities and the procedures required to obtain it.

23 The 1968 Mariotti law.

report you all to the authorities. It's their fault. (He swears, curses).

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

GIOVANNA: I listened to everything that Mr. Maso said and I understood everything he said, but I would like to say a few words. He says that he asked for this pension, that his family members are ok at home and that they could take care of him. But he was hospitalized, and he is not free. We have a law and I don't know if it's right, but I don't think so, and it says that when we are discharged, we are always entrusted to someone who has to sign for us. This is because people don't ever trust us. We are like a parcel, a parcel must be looked after, but woe betide if that package is opened, moved around somewhere, or something is missing. Here, this is like the sick person when he goes home, and his relatives look after him. But I say this, in this case it is useless for me to get out of here; if someone makes a gesture to me and I react, if I start to react with that one, to react with that other one, then the relatives who look after me say, "this person is causing us trouble, we'll put her away."

MASO: This is poor reasoning and let me do it. I have had one message from society, from magistrates, in big offices, that the law of evil practically exists: big fish eat small fish and small fish must let themselves be eaten.

GIOVANNA: This is in the outside world, outside, among the workers and the rich and the poor, where there are those who take advantage and who exploit people, I agree with this. But we are sick, let's admit that we are sick, then we must be protected, perhaps for a period, then it changes, like children when they are young.

ELDA: I say that it is absurd to think that we are like children who need to be protected when we leave the hospital. Small children will be fine in nursery schools, but we are grown-ups and at our age we have our own rights, not like toddlers.

RENATO: Now I'll tell you that we cannot have our rights. When someone is a repeat offender from the hospital, when

someone has been in a psychiatric hospital for five years he has no civil rights.

BASAGLIA: Precisely for this reason Mrs. Giovanna said that when a person leaves the psychiatric hospital they are like a parcel.

GIOVANNA: We are similar to a parcel, because I know when my son comes to pick me up he has to sign [for me], at home he won't treat me like this for many things, he won't do it because he sees that I'm thinking, "thank God," but in certain ways I see that we are the same as a parcel.

VOICE: We are not all the same please, there are two families: the brothers of Rome[24] and the workers.

SLAVICH: Mr. Maso has been discharged. Does he feel like he is a parcel?

MASO: I started going to school in 1946, I went to Trieste every morning, I lived in Trieste and I would return there at 9 or 10 pm, sometimes even at midnight, with two periods in Aurisina and Monfalcone[25]; after school I went to do my military service and left home again, then I went to work on the railways, I left home and went back to Venice, I've always managed on my own, I've never needed my mother or sister, I've always had to do everything alone, that's why it is fine for me to be alone.

GIOVANNA: He doesn't feel he needs it, but I don't think the others are calm when they are outside, because there's always that tension, because they wonder where they have gone, who knows if they are coming home, who knows if they are drinking…

PIETRO:[26] I agree with all this, then you need to have a family. When you don't even have the chance to live, when they refuse even a little help, without that little support, how could I support a wife, pay rent, pay electricity, taxes, and

24 I am not sure about this reference.
25 Two towns fairly near to Gorizia.
26 A patient who was interviewed in the Zavoli documentary transmitted in 1969.

everything else? How could it be done, without work and without anything, how can it be done, can you explain to me how it can be done? Who wouldn't like to have a family, what do you think that while I had my mum, my dad, my sister, do you think it wasn't good? I felt like a great gentleman, I have never felt so good and I think I will never feel so again, not even if I take a Sisal.[27]

GIOVANNA: Listen Mr. Pietro, now I don't want to offend you, you must speak without offense, you have been discharged, you are out now, but still you come back here, so you have acquired the strength of the habit of being here, you feel safe here, is that right? You feel good here, you feel good here.

ANGELA: I find peace and comfort here and here I feel safe. Yesterday was my birthday, and I came here and I know that when I feel like it I can go out, but if I go out and make a mistake, they have to take me back inside, instead I came first to make sure I don't make a mistake and so I can go out afterward. As usual, like yesterday, we had a party at home for my birthday, we had something to drink. . . .

VOICE: So, Mrs. Angela, do you feel safe staying in the hospital during the day?

ANGELA: Yes.

VOICE: So there's no point in discharging people if they all come back here later.

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

ELDA: I haven't been home for fifteen years and the director always says it will happen in August or Easter, and that day never comes.

ANGELA: Yesterday three ladies came to look for me at home and with all this going on I came here.

RENATO: What did you come to do in here, stay outside, freedom is beautiful, they'll put you in a cell.

ALDO: She came here because she can drink outside, and she's afraid of drinking. . . .

27 This appears to be a reference to gambling.

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

BASAGLIA: Listen, Mrs. Giovanna, I ask you: "Why is a person admitted to hospital?"

RENATO: Because the others laugh at us. How many years have you been in here?

ANDREA: I don't even remember.

RENATO: I've been around the asylum for eight years, not a month or two. Now lately they've been teasing me, it's time to stop. The nurse accompanies me every day, did I kill someone?

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

RENATO: Too little, another ten and [then] you'll be inside again. You won't get very far....

PIETRO: If I was so busy I wouldn't be able to come, but I like to thank the good people, even the patients themselves, I always enjoy seeing them.

RENATO: My heart is sick, not my head, that is worth remembering. And let the director remember it too, my heart is sick, not my head.

BASAGLIA: What do you mean by a disease of the heart?

RENATO: I see all these poor unfortunate people.... I've been here for years, when do I go home? Tomorrow, for Easter, for Christmas, for the August holidays, it's horrible in here. We need more seriousness in here, more seriousness and more severity.

VOICE: I believe that if you had heart problems, right now you would be in a normal hospital, in a medical department, not in a psychiatric hospital.

RENATO: They want to send me here, I'm crazy, no! I have something wrong with my heart, I cry every day, you know?

VOICE: However, seriousness also involves rules, it involves many things, severity and other things also take over in the same sense and we would not find ourselves in these conditions we are in today, seriousness should not be considered only as seriousness ... practically the others

"serious" hospitals, as you say, practically don't have what we have.

RENATO: I've been in here for two months, I'm in C and the Sick Fund[28] pays me not to eat like the pigs in C and that's all.

ANGELA: But you say you have a heart disease, I have a liver disease and I was in ward C for four years, I had to be in ward C because the infirmary is there, you can't expect another ward with your heartache.

A long silence.

ELDA: I have observed that nurses have a large salary because they receive a lot of money. . . .

GIOVANNA: Nurses don't have a large salary; a family man has little. . . .

ANGELA: And they have a lot of responsibilities, if someone is sweeping [the floor] and then hits someone with the brush in the head, the nurse is responsible. . . .

VOICE: So he should sweep up instead! This morning I swept the stairs and I missed the snack with all the bread, just to make life easier for the nurse! And I'm not crazy, I'm wise, I'm in a mental hospital because of crimes!

OTHER VOICE: The responsibility never lies with just one person, just as the fault never lies with just one person, it belongs to everyone.

GIOVANNA: If you approach a sick person in a nice manner, that sick person will not react.

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

ANGELA: Sir, don't think that you have to tighten your belts until noon. If you want to eat something, if you need it, I come from outside, but if I ask for a bowl of milk they give it to me.

28 Another reference to subsidies provided to certain patients.

VOICE: Me too, but I have to ask! I didn't need to ask, because I had something to eat! And the other day they stole my snack, but if I found out who did it, I would make sure they suffered, whether it was a nurse or a patient!

ANGELA: But it doesn't have to be like this, it must have been someone without malice. I must thank the doctors, the nurses, the patients who helped me, but if I had to go to another hospital, because of my illness, I would prefer to be in here. The doctors and the director know what a sacrifice it costs me to enter here, I came one evening at 9 pm to pray that they would accept me because I couldn't take it anymore, how many times have I prayed, help me, I can't take it anymore! I asked everyone on the street, if Mr. Antonio wants to talk he can do so, how many times have I prayed help me, help me, I can't take it anymore. The Cassa didn't want to do any more paperwork or anything for me, there was no other way than to abandon a twenty-two-year-old boy in bed with a fever of thirty-nine and come in here, I was at home, I was crying, I was screaming. My son came home, he was in the army, he came home and was ill, I have always been happy here, I cannot complain and accuse the doctors, I only ask you one thing, I will still need you, instead of giving me pills that are not for my stomach, give me something else. I also have to point out one thing: Mr. Director, last Sunday 1300 lire was stolen from me, naturally I didn't accuse anyone; but it didn't just happen to me, it also happened to another patient. I am not accusing anyone, not the nurses nor the mother superior, because the poor mother superior cannot take responsibility, I am not mentally ill.

OTHER VOICE: These are things that need to be resolved within the ward.

ANGELA: I wanted to say that both in the women's ward A and in men's ward A, Mr. Director, we need cupboards to lock up the things we have, because otherwise we can't keep them with us. We don't even have a chair near the bed, a locker to put our things in. I don't want to accuse anyone,

even the patients, they are sick, they don't do it on purpose, forgive me, they don't know what their stuff is, it happened to me the other time I went out with Irma. He took an item of clothing; he said it was his and he wouldn't give it back.

RENATO: [*much calmer*] What does this stuff have to do with this meeting?

ANGELA: It has something to do with it, we are fine in here, we eat, we drink and sleep and if I didn't have children, I'd sign up to stay here. I am well, I am very well, I have never been so well and I owe it to the director and to Dr. Slavich who I met before him.

BASAGLIA: When a patient is discharged, he is entrusted to a relative and is entrusted as if he were a parcel.

GIOVANNA: I don't take back what I said.

BASAGLIA: We also need to hear if the others also they agree with this.

GIOVANNA: Yes, but not everyone, apart from those who come for a month or two months, who undergo treatment, but those who have been here for many years; even you yourself, before handing over the patient, you give him advice, as in … try to do this and not that, because if it's something that's no longer safe, then a signature is needed.

VOICE: There are many who live in the outside world and don't come here.… They live outside and are happy!

GIOVANNA: It means that they reacted to their situation, they behaved in a good way and that's fine, but this is not the case with all of them, it must be ten percent. It will be ten percent who are good and behave well.

RENATO: We should send them to work, outside, not keep them closed in here and feed them. We should take in more sick people, there are more sick people outside than inside. We rot in here; we need to work.

GIOVANNA: But I already said last time that it's not a factory here. You must remember that this is a hospital and if they give you a job in here, they give you a job to pass the time and what's more you also take this money and have some fun during the day. Because the day is long, especially for

men and you have that satisfaction of earning those 500, 800, 1,000 lire a week, which for you is also an allowance, a great relief. I'm sixty years old and I work morning and evening and I'm happy when I work, work makes you forget many things, Renato. There is no need to get angry.

RENATO: Meanwhile they have increased the price of the beer, they have increased the price of the coffee, etc.

GIOVANNA: They had to.

RENATO: Where is this money?

GIOVANNA: … in Bled.[29]

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

GIOVANNA: Why is there no money? Nobody told us that there is no money.

TOMMASO: Yesterday it was me and it almost seemed like Mr. Furio was mocking us, he refused to let us know how much money is left in the club's[30] coffers for trips and the rest.

GIOVANNA: It's not true, he doesn't know.

JERVIS COMBA: It's not a refusal Tommaso, because I don't know either.

FURIO: I can give you an estimate. It will be something like 400,000 lire, I don't know. I can tell you how much was spent on the circus, 47,000 lire were spent, I can tell you this because someone told me.

ANDREA: Do you think it's a good idea to spend 47,000 lire to go to the circus?

GIOVANNA: That was a mistake on my part, I immediately said no.

BASAGLIA: Look, then what is the money for?

GUIDO: The money is needed to go on trips.

ANDREA: Going from one cage to another, was that a trip? In your opinion, was it a trip?

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29 Presumably this was a possible destination for a patient trip to a lake in then Yugoslavia, about 140 km from Gorizia by road.

30 The patient club was a self-managed institution within the hospital that organized trips, ran the bar, and so on.

BASAGLIA: I think so, it was fun.

ANDREA: For those of you who are free, but we are here like dogs, like slaves. A beer costs 150 lire, a Coca-Cola 150 lire, how can these poor people afford it, do you think that's ok? Why don't you take a trip to Castelmonte or Barbana?

BASAGLIA: If they wanted to go to the circus, I don't understand why you're against it, they wanted to go, we didn't force them to go.

CASAGRANDE: There were 125 people who wanted to go. Anyone who didn't want to go didn't go.

ANDREA: If we had to pay [for the trip] not even twenty would go.

RENATO: I think that we should decide whether or not we can go on one trip a month.

ANDREA: Now let's take a trip to either Capriva or Cormòns.[31] The club pays and no one is ruined by this. At least you can have lunch, you drink something during the trip, but 150 lire for an ice cream, 150 lire for a small Coca-Cola? Instead, if they go on a trip, at least they have lunch, they eat [and] at least they have a steak. Director, all five hundred went without paying, but if you had to pay not even twenty would go.

RENATO: Even on a trip, if you had to pay for the trip, no one would go.

ANDREA: But the trip is always a trip, you eat on the trip.

RENATO: But you have to pay if you want to eat well.

VITTORIA: Yet you were there, you had fun and now you are protesting.

BASAGLIA: What does Vittoria say?

VITTORIA: First they went, they put a lot of effort into it and now they find themselves regretting it.

FERRUCCIO: We don't regret it, it was nice.

FURIO: It seems to me that the decision to go to the circus was made right here and I think it's appropriate that if anyone had any different ideas they should have mentioned it first.

31 Typical tourist destinations not too far from Gorizia.

RENATO: I wasn't here, I was sick.
GIOVANNA: Now there will be two trips, in June and July.
FURIO: The problem of trips, it seems to me that a way of choosing how to do them needs to be established. How do we organize them, that is, should we go in large groups, in small groups, where should we go, what is the route. . . .
RENATO: We always say this, we repeat this every day, what are you talking about, you meathead!
ANDREA: Now if you have to take a trip, let's go to Cormòns or Capriva — not far away.
RENATO: And how long do you think I'll be here for — two years?

Long break, small group discussions.

ELDA: Since Professor Basaglia and I have known each other for several years, I would like to ask him a favor, that he send me to Ward A, because I don't want to sleep with those women, is that okay? I won't sleep with other sick people because they disgust me, okay? Please let them send me back to ward A, there will be a little place for me there, they kept me there for eight years and all the nurses were very kind to me, I never got into a fight or anything; so, can I go there?
FEMALE VOICE: Listen, we aren't so disgusting. . . .
ELDA: You really are disgusting!
MALE VOICE: So when are we taking the trip, Giovanna?
GIOVANNA: We need to discuss how, when, and where, not just the trip itself.
MASO: Let's sort this out and take a nice trip to Venice.
ANDREA: No, not in Venice, it's too far away, Venice is for the beach, we don't go to the beach.
GIOVANNA: For a trip you have to do things perfectly, discuss it, not in this way.
MASO: In my opinion, after what I heard on the radio, with the arrival of the new system of psychiatric hospitals, there will probably be some improvements. I believe, and I am almost

certain about this, that services will also be improved, the treatment of nurses will be improved and this will also lead to an increase in spending, perhaps of a few billion, or of some 500 million which will also be for these poor sick people; I am almost convinced of this, because when something changes, it will lead to well-being for everyone. Then we will also be able to do other things, even for these sick people.

BASAGLIA: Why are these kinds of sick people different from others? Why are they seen as the last in the queue?

MASO: Are they different from the others?

RENATO: Because we are slaves in here, not [seen as] sick.

MASO: Among the people I have met in here, there are many who are scared of war, many have been left disabled like me, my life got much worse after a road accident. Many, however, were born like this, but they are just a few. It is, so to speak, the malaise that reigns in society that leads people to get sick and then admit themselves to these hospitals, because naturally someone who is fine, naturally he doesn't indulge in drinking or strange behavior, it's very difficult, it's poverty that leads to all these things.

BASAGLIA: There are also rich people, you know, who suffer in this way. . . .

MASO: But there are very few of them, there are other reasons that bring them here, other motivations.

ANGELA: It's also an illness, because I know people who are well, who have comforts, who have everything they want, and yet they still drink.

GIOVANNA: It becomes an illness.

MASO: Yes, but the rich, the millionaires are sent to clinics, they do not lose their civic rights and they are not given a criminal record.[32]

ANGELA: I also say that it is human misery that brings us in here.

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32 A person's presence in an asylum was noted on their legal record, even if they had committed no crime.

RENATO: I've been in this hospital for eight years trying to get well, why don't you send me to another clinic?
GIOVANNA: Now there are all social classes in this hospital.
BRUNO: Yes, of course, but from what I have seen, observed, you can see here that there are six hundred or seven hundred of us in this hospital and they are all poor people and the same is true in other hospitals. Maybe out of six hundred there will be fifty who are well, it will be five percent and the others are all poor people who are really driven by poverty. I see when a poor wretch only has 100 lire in his pocket, he can't buy himself a sandwich, what does he do? He goes to get a flask of wine, and without eating, of course. Sooner or later, he ends in here. Instead, if someone has something to eat, it doesn't even cross their mind to drink, they will drink a glass and that's it!
GIOVANNA: But if he has the money to buy a glass of wine, he also has the money to buy food.
BRUNO: When money is tight, one basically says: "What can I do? I can't get a meal, I can't even buy a sandwich," [but] with 100 lire they can drink a flask of wine and so they settle for a flask of wine, they get drunk and then the decline begins, constantly, the nerves weaken, yes it weakens the mind and does not think about their poor state. And even if they don't drink, bad luck and sorrow make them ill.
MASO: But you, sir, can stay here as long as you want, because I've never seen anyone eat as much as I've seen you eat. You can stay, because outside, to support someone like you, it takes at least 3000 lire a day.
RENATO: When you know that life outside is like this, you don't go out if you don't have some kind of support. . . .
ANDREA: You like being here, because here there is enough food, whatever you want, but outside, you have to work.
MASO: Even those who drink, if they drink something regularly and also eat, in a certain sense the wine is then like a medicine.
BASAGLIA: What are the problems of other sick people — those who are not mentally ill?

MASO: I don't know, I'm not a psychiatrist, you should know that. It is possible to change a state of nature, I'm certain of this. I think that those who get sick are treatable, then it's up to you, in and your own capacity.

The flagship for the liberalization of the hospital was for a long time the male ward B, which was the first to be run in a "community" way. The liberalization of B was also possible thanks to the common will of the nurses in the department. The following testimony is transcribed from the recording of a meeting which included some doctors and nurses from B. The meeting took place sometime later and was focused on the question of the role of that first pilot department and its current situation.

BASAGLIA: I would say that this discussion could represent the judgment of the nurses in ward B, keeping in mind that these nurses were the first to completely open up a ward. Since the sense of community has then spread from this ward to the rest of the hospital, I think it would be useful to discuss this problem.

DIZORZ: I think that the other wards have not yet reached the point where we were at the time.

BASAGLIA: Do you think that a ward is more or less community-based with respect to the type of patients it has? It seems to me that this is your point of view. In other meetings you pointed out that ward B had been set up in a particular way, where a group of around fifty patients had reached a reasonable level of rehabilitation and represented a particular type of patient, etc. Afterward, these patients were discharged, and others were admitted, and this changed the makeup of the ward.

DIZORZ: I told you what my point of view was. Now we are not at the level we were before; those twenty-five patients who were discharged were special patients. . . .

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

SLAVICH : Ultimately, I think that every ward is really made up of the people within it. The things that are done, those that are not done, depend on whether the people participating do them or not. I think the ward is now very different compared to 1964, perhaps the question to be discussed is whether it can be said that it is worse, that is, different does not always mean "worse."

DIZORZ: I think it's worse for us nurses; for you, from your medical point of view, it may be different.

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

DIZORZ: I'm not saying worse, I'm saying that now there are problems that weren't there before. Before we were worried because it was something new, because the gardens had never been opened, we were worried [and] we tried to be careful, there was a need to know where the sick were, what they were doing. This is what we are trying to do even now. But now they are no longer the same sick people as before, they knew each other, some had been together for years, many were long-term patients.… It seems to me that we don't have the security we once had.…

SILVESTRI: In the meetings it is always the same two–three who speak, the same twenty–twenty-five patients who argued, who protested, were discharged; now there are only Massi, Lucchi who are left.…

STURM: They are more dull, less active, they don't participate.…

DIZORZ: We have adopted the policy of letting things happen. In the beginning almost everyone went to work, and all of them had a weekly salary. Then some no longer had work or didn't feel too well, [and] they were paid anyway, and the others said that it wasn't worth working because they were paid in any case.

BASAGLIA: In your opinion, was it our policy to let things happen, or was it instead an attempt to start a different type of life in the community?

DIZORZ: We need to see how far we want to go; it was a test case, an experiment, an attempt.... Everything was going well, we were all satisfied, we still are.

BASAGLIA: I have the feeling that the nurses in this ward feel mortified in some way compared to the rest of the hospital, and I don't know why this happens, this mortification. That is, this ward was set up with fifty patients and a very small group of nurses. These nurses rehabilitated fifty people, twenty-five of whom were discharged; in place of these twenty-five, another twenty-five people were brought in, and the ward changed. Now I have the impression that all the members of this ward see this new job as mortifying.

MIAN: No, I wouldn't say that we were mortified, twenty-five were discharged, and we are very happy about that.

BASAGLIA: But the ward as it is now is a ward that no longer provides much satisfaction.

MIAN: Certainly it's different.

STURM: Once upon a time the ward was more alive, but now it seems dead.

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

DIZORZ: It's like when you paint the walls and the doors remain ugly. The doors are still the same, but the walls are better, so we remain the same as before compared to the other wards. It seems to us that we have taken steps backward.

BASAGLIA: And yet it's always the same situation.

JERVIS: Perhaps there is also a third factor, that is, when there is a renewal in a ward everything goes forward, there is a transformation; then at a certain point this renewal may stop, at least there are no longer any great innovations, and when the innovations are lacking the drive is also lacking. In short, when there is something that is changing, there is

enthusiasm, when a result has been achieved, new results are sought, new transformations are sought, something completely new. If instead people believe that results have already been achieved then practically everyone sits back for a while, and I believe this happens everywhere. Many times, in taking certain initiatives I realized that things were going well as long as we were moving forward, if everything was on track. Then when you thought you could slow down, this actually made everything collapse a bit, as if things could only move forward by rushing. I think this is quite common in a job like ours.

DIZORZ: The director said before that it seems that we are humiliated.

BASAGLIA: Yes, I have the impression that all the staff in ward B feel a little mortified compared to the rest of the hospital. Ward B was the ward where this new type of approach to the patient was first tried out, and as the rest of the hospital opened up and adapted to ward B, ward B felt a bit like it had remained in a queue.

SILVESTRI: This crisis of the ward, of us too, is due to a crisis linked to work, of occupational therapy. Because once upon a time there was more work, they were busier.

DIZORZ: We are rather dissatisfied.

SLAVICH: I think that the crisis derives not so much from the fact that the ward has changed from better to worse, but rather from the fact that, being different, there is now the feeling that the tools needed to adapt the team's activities to the new composition of the ward are missing, especially since the numerical composition of the team had been designed according to the composition of the patients who had been chosen for that ward. Once the patients have been changed, and certain methods have disappeared, of which some feel the need for more, and others for less (generally all nurses think that work is a very important part of hospital life), these methods have changed, and since the percentage of nurses compared to patients has

become insufficient, parts of the medical team may feel uncomfortable.

BASAGLIA: I also think it's different now. Nurses are not seeing fast enough results.... This is certainly not a very rewarding situation for nurses.

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

DIZORZ: Yes, also because a pensioner who, for example, has no commitments, he doesn't have a reason to get up in the morning, and feels that he is here a lot! If perhaps every day he says to himself, "I must go to the Isonzo bridge[33] for a walk," he has a reason to get up. The sick no longer feel this need.

BASAGLIA: It seems to me that you are saying that the patient today, in their ward, has no alternatives. They can either be idle or they can run away. These are the alternatives that the patient has, that is, they do not have the choice to work or not work. Since they don't have the possibility to work, they can get up at seven or ten in the morning....

SLAVICH: There are thirty of them working, right?

DIZORZ: Yes, thirty–thirty-five. Like Brizzi. This morning, I said to him, "are you going to work?" He replied, "yes, I go from half past nine until half past eleven, isn't two hours enough?" I said, "if you can't do more, even two is enough!"

SLAVICH: Does Brizzi have this choice, whether to work or not work, or not?

DIZORZ: This is someone you can talk to; with some you can't!

SLAVICH: The problem concerns precisely the other thirty who do not work. In 1964 there were three who didn't work, one because he was blind, another because he had hemiplegia [post-stroke paralysis], and the third just didn't work. Now there are thirty of them and they populate the ward and

33 A river running through Gorizia.

hang around. The fact is, however, that they are no longer hanging around the walls or sitting on the bench, instead they are perhaps in small groups, two or three, talking. This is still something that goes on in the ward, it seems to me, I don't know what it seems to you, there is still a certain level of social life.

DIZORZ: This isn't really much use to us, because we were used to something better.

BASAGLIA: Do they feel frustrated by this situation?

MIAN: We also feel guilty because we are unable to run the ward as before.

SILVESTRI: I also think it's a question of money. They say, "on Saturdays we get this amount, if we work and if we don't work!" And so, they limit themselves to working that hour in the morning and that hour in the afternoon, some don't even do this. . . .

BASAGLIA: It seems to me that Mian has raised a very important topic. Perhaps we feel guilty, because we tried to rehabilitate these new patients as we had done with the others. We were able to do this with patients who were certainly in a better situation than this group, and we are not able to deal with these [patients] and so we feel guilty.

SILVESTRI: Why aren't we able to help them?

SLAVICH: The way in which the initiative of the third "flying" nurse was welcomed by the nurses is interesting. This third nurse does not increase the number of nurses in the ward, but moves around the hospital all day, talks to people, . . . collects viewpoints, discusses them with the others, so this also partially solves this problem. Everyone is more willing to do this job of creating connections.

BASAGLIA: The argument that Mian posed seems very interesting to me.

SILVESTRI: It may be our fault, but it may also not be our fault.

BASAGLIA: We were able to rehabilitate fifty percent of the patients we had before, which is a huge result. Now we have changed the type of "customers," so to speak, and we are not able to tackle the problem in the same way

as before. What is the reason for this? Are these patients whose rehabilitation is impossible? Does it take longer? Is it anxiety about what you would like to do and are unable to do, or what you have done previously [but] more quickly?

DIZORZ: It's also about age. I took an average day, and I concluded that our patients are on average sixty years old. So, saints once did miracles, now they don't even do them anymore!

JERVIS: The average age of sixty is very high.

SLAVICH: It is probably no coincidence that, while in 1964 everyone was physically well, four years later there are now various medical and internal problems.

BASAGLIA: It could then be said that this type of activity with sick people in their sixties is very frustrating . . . because if we tend to try to rehabilitate even those who perhaps cannot be rehabilitated. . . .

SLAVICH: Perhaps the fact is this, that it is not so much that fact of working with elderly people, but of seeing them age before your eyes. A ward of elderly people is one thing, but a ward of people who ten years or five years ago, when we started, were fine and now they are still here, and they are starting to have heart problems, and they can't be discharged if for no other reason than this. And one might think that our efforts were in vain.

BASAGLIA: That is, the ward would have been transformed into a care department for elderly patients. It would no longer be a ward for rehabilitation as it once was, but it would be a ward in which assistance is provided.

JERVIS: There are many causes in terms of this discontent on ward B, but I believe that the fact that the patients in the ward have changed in this way and that there is now an average age of sixty years, in a certain sense is enough to explain many things. It seems impossible to me that in conditions of this kind we can continue with our previous work as before, I believe that there is a different and more difficult reality, it is a new problem.

SLAVICH: A new problem, and in my opinion the difficulties concern this new problem, which is difficult to take on, and not a comparison with the past, a nostalgia for the "golden times."

BASAGLIA: Nurses make this comparison. When they can't achieve what they used to be able to, they naturally feel frustrated, because they see their efforts as in vain. This is my hypothesis. When someone is dissatisfied, they are dissatisfied with something.

DIZORZ: Because we work and we do things, I think what I'm saying is that is everyone's aspiration is to be satisfied with their work, and yet in this period it seems to me that we don't have any of this.

BASAGLIA: What do you mean by job satisfaction?

DIZORZ: The results. For example, seeing Pilati come out of his bedroom every now and then, seeing him talking, something, I don't see this now. . . .

BASAGLIA: Would this be a result?

DIZORZ: For me, yes.

BASAGLIA: And the ill? There are twenty-five left. Do they feel humiliated, frustrated by the fact that they are no longer connected with the others?

SILVESTRI: I think so. There were several who went home, and they were angry about that; and while others went home, they stayed, for family reasons or other reasons.

SLAVICH: This is, indeed, a disastrous year for discharges from ward B.

STURM: Also in terms of work, doctor. They go out, they go into the city on Saturdays, they go here and there, they see things and understand the importance of money. And so I think that for this reason they don't like work very much, as they know how much they earn, their miserable salary, and they compare it with the [salaries in the] outside world and see that it's a small amount of money and therefore they say, "why do I have to work so much if they just give me just this income?"

SLAVICH: For some time, at least this year, those who have gone home are those who haven't been here long and were previously in the observation ward. Yhey stay there for two or three months, and if we talk about discharges now we are talking about this group, and not about those who were hoping to be discharged instead.

MIAN: It was a great satisfaction for us to see Marri and others being discharged after many years of hospitalization.

BASAGLIA: However, the discharge of fifty percent of patients is already huge.

JERVIS: And then? Are only the scraps left behind? It means that the situation in the ward can create serious problems.

DIZORZ: The sick people who have been discharged, they come to visit us, they tell us their problems, all this pleases us, and makes us think about what was done in the past and what cannot be done today.

BASAGLIA: That is, what *was* done?

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

BASAGLIA: This is the fact, if we can't give anything, or if we are no longer capable of giving, this seems to me to be an important topic of discussion. We need to examine what the reality is. That is, the ward is made up of sixty people of which three quarters are people over the age of sixty.

VASCON: How did it happen that there was such a concentration of elderly people or that all the replacements inevitably took place, in this ward, with elderly people? Young people were discharged by agreement, but then the replacements have almost always taken place with older people, to have had such a high average.

SLAVICH: Because those who "fester" now in hospital are always elderly people. The other major source of origin of the patients who came to ward B was ward C. When this ward was closed, in four months it sent about fifteen people

to department B, and they were all elderly people. It is the whole hospital that is old. It is old both because the years pass for those who do not go home, and because today, among the new entries, only elderly people stay.

VASCON: This could be a positive thing.

SLAVICH: Looking at it from the outside, this could be right; but as an experience from the inside, we must consider the sense of impotence that can derive from this situation....

BASAGLIA: The fact is that if the ill are not "things." They are not things for us, and we are not things either. We are not an object that is used to treat the ill; we are people and therefore we have emotional and psychological repercussions in ourselves. If we don't consider the sick as things, we shouldn't consider ourselves as things either.... This state of anxiety, of suffering that we have about a ward which has changed, is perhaps an example of our projection toward the patients, which is a mistake. We are anxious because we can't do what we want to do—and the results in terms of the patients are not good.

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

DIZORZ: Of course, we have less than we used to.

BASAGLIA: This always happens when working in a long-term care unit. In the other wards the situation is more satisfying, because the patients are admitted, leave after a month, and are better, so we all feel good because we manage to care for them and discharge them. A long-term care unit where seven–eight people leave in a year, if they leave at all, is a very frustrating and burdensome task. Since ward B managed to discharge many people in a short time, it was in a certain sense comparable to the observation ward.

SLAVICH: And this indicates a little how satisfaction is created through the hospital's production of discharges.

BASAGLIA: That is, in making... "healthy" people.

SLAVICH: And it seems as if this is the only goal, in the absence of a dismissal it feels like everything will collapse.

SILVESTRI: But I think that a certain discontent in our ward was also because too many promises were made a year or two ago. Twenty-five were discharged, twenty-five remained, perhaps they too could have been released, but then family reasons took over. . . .

BASAGLIA: We are not omnipotent.

SILVESTRI: They were not kept here because of the hospital, but due to family reasons. . . .

DIZORZ: I think it is because of the occupational therapy that they were allowed to go.

SLAVICH: Often the nurses and the doctor, when they see a patient who "behaves well" and therefore "is well," in quotation marks, feel the urge and the need to discharge this person who they have with them all the time, perhaps more than a patient who is away all day and works, in an orderly manner, here or there around the hospital. I therefore think that it is not so much a question of work, but perhaps what is in crisis is the mechanism for truly putting the patient in contact with the outside world, naturally not just in the sense of going for a walk around the city.

JERVIS: When we consider a patient who digs the earth all day at the farm, we don't really see him, for us he is not a problem, also because he is there, we know what he does, he is settled, in a certain sense he has found his solution: he digs. If the same patient stays in the ward all day, we say, "well, what does he do, he doesn't do anything, something needs to be done." it creates a crisis for us.

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

JERVIS: Without a doubt.

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

DIZORZ: Because we are talking about inclusion in society, I think that work will also be needed, because not everyone

will be lucky enough to leave here and live in a comfortable way. . . .

JERVIS: Yes, but work means training. Certainly one of the most necessary ways of integrating a sick person into society is to train them, that is, to give them knowledge that allows them to carry out semispecialized or specialized work. Now I don't believe that work activities in hospitals are qualified activities, at most they require a laborer, and a laborer is no longer something which leads to a qualification today, it is of no use.

DIZORZ: The ill, the men and women, are what they are. . . .

JERVIS: I think that there is a difference compared to twenty–thirty years ago. Twenty years ago when we could say, "this patient works in an agricultural sector in the hospital, he knows how to dig, he is an agricultural laborer, he then finds work on a farm, in the outside world." Today the same person no longer can find a job on a farm, so this job must change.[34] It may be that digging the earth is useful, but it does not help to reintegrate an ill person into the outside world. Someone who works as a bartender is already better off, yet I don't think a bartender finds it very easy to work outside.

BASAGLIA: Danieli has found work outside.

JERVIS: But we were lucky [in that case].

VASCON: But now I really believe that it is a question to be considered from the outside; whoever directs the activity of the agricultural farm in a hospital has never imagined more modern forms of work, which would also be a pedagogical vehicle, that is, by using fruit crops (for example strawberries which are inexpensive, but which you have to learn to grow), in such a way that whoever worked on this type of cultivation would have a possible job on the outside, in a straightforward way but also in ways that

34 In this period Italy was rapidly transforming from an agricultural to an industrial society, which is the context for Jervis's remarks about agricultural work.

are already slightly specialized. Perhaps this is a general-run agricultural area, like a farm, without thinking that agricultural work that is also therapeutic could be done with minimal cost. The link between agricultural changes and therapy seems distant but it may exist.

JERVIS: I am sure that such a development can take place. I believe that an agricultural "colony" like this one [in the grounds of the hospital] is identical to something from the last century, both from the point of view of therapy and from the point of view of its productivity.

VASCON: In the countryside, currently, there are places where a laborer no longer is needed, but there is, for example, the role of an orchard worker who must be a specialist, replacing an old-style laborer. They are already specialists and must know some specific things, so perhaps here agricultural work done in a certain way could be productive.

BASAGLIA: Yes, but we are always on two different points of view. Either everyone works because by working they have a certain kind of rehabilitation, because they "forget" that they are sick, or because they get through the day. Or the so-called community aspect is emphasized, work is seen as an opportunity for meeting people, discussions, etc. These are really two different ways of approaching the work of ill people.

JERVIS: There is no contrast between occupational therapy, activities, and debates, that is, there is a contrast between older concepts of occupational therapy and the creation of a new form of activity. And this work activity can be used to discuss and problematize things. The contrast between work and discussion doesn't seem correct to me.

BASAGLIA: Maybe we can agree on this. What do people think about this? Do you see work as the only alternative, that is, work done from morning to night, or do you think it should be considered as a topic for discussion and meetings?

DIZORZ: I understand, Mr. Director, or at least I think I understand what you are saying. I know that this discussion is very important, and I don't want to raise a criticism,

yet the meetings we have every day, even with someone who had the intention of working and doing something, are constantly interrupted, and then rather than interrupt these discussions which seem more useful to you, we let the occupational therapy slide.

SLAVICH: Sorry Dizorz, but in my opinion a problem arises here that we have already discussed at length. At a certain point, why can't you do both? That is, if we consider that occupational therapy is connected to the hospital as a medical initiative, then I don't see why it should be done twenty-four hours of the day. Perhaps it is a question of organizing it so that there is a period of the day in which we work and another period of the day in which we discuss, or we discuss while working. But ultimately an eight-hour day in the hospital has nothing to do with "ergotherapy," it only has to do with the fact that the general services [of the hospital] tend to carry out eight hours of work, that is, these eight hours do not depend on a therapeutic need, but meet the requirements of the hospital.

JERVIS: It seems to me that eight hours are too many anyway, I don't see any reason why one should work eight hours, and thus grow old over time, and daily work undoubtedly limits opportunities for interpersonal contacts and community participation.

VASCON: It is probably a question that you have already asked yourself, an external question: according to the experience you have had, for those who have worked, what possibilities do they have regarding the community's activity, that is, did they find their way of being only in the workplace and did they then alienate themselves from the rest of the community?

DIZORZ: No, they also had community experiences, they also spoke and willingly attended meetings, and they also spoke to each other.

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

DIZORZ: I don't know, [but] people understood things, they said, "you have to work, even if you leave here you have to work," and so they worked and participated.

In the spring of 1967, the C wards, both male and female, were something the community was ashamed of. They were the only wards still closed in a hospital without bars, they represented the old institution. They were something the *équipe* was ashamed of as well, anxious as they were to speed up the stages of total liberalization, and these wards made the "free" patients who reluctantly passed alongside the cage-pavilions feel uneasy. The community had already implemented transformations and improvements in those wards but had not yet opened the doors or torn down the metal fences. The oldest and most regressed among the sick also ended up in ward C, so that the environment there earned the label of the "snake pit." These were dirty, drooling, shouting sick people, ready to fight over a cigarette, or there were those who had been silent for years, petrified, who only with the gesture of the hand or a movement of the lips revealed the long-suppressed presence of hidden images and words. They were more things than people. On the other hand, all the liberalization had taken place gradually and it was logical that there was a final phase, following the others. Furthermore, the opening of the C wards was dependent upon the total adhesion and conviction of all members of the community. Nonetheless, this moment was experienced by everyone with considerable impatience. The following interview was recorded with the doctor in charge of the men's C ward shortly before it was opened.

Q: Can you give me an example of what happens in the closed ward and an example which is also valid in terms of its "dramatic nature" to understand how C can be compared to other wards within the community?

PIRELLA:[35] The closed ward represents in a certain sense the preservation of those hierarchical relationships that we consider antitherapeutic, a conservation which is also exasperation because they concern not only the treatment team, but hierarchies amongst the patients themselves. That is, there is a structure of patients within this closed structure, and this closed institution is separated from the larger community. Patients live with each other in a way that is marked by a kind of ranking. For example, there are patients who can enjoy a cigarette to the full, if they smoke it calmly, despite the pressing requests made by the other patients, and there are patients who cannot smoke a whole cigarette because they have to give it up to another patient who is begging or demanding. Then there is another type of patient whom others ask for a cigarette butt and usually do not ask for a cigarette. There are even patients who line up for this second butt, that is, for this very thin butt that passes via the lips of the latter. I believe that this is a sign of the legacy of an institutional context that we inherited and against which we are still struggling.

Q: Does this hierarchization of the cigarette butt, so to speak, occur according to the degree of illness of the patients?

PIRELLA: I think that it is largely independent of illness and that it has instead a relationship on the one hand with the fragile personalities of certain patients who have suffered more from the pressures of the closed institution, the violence of this form of closure, and on the other hand with an aspect that I would say is socioeconomic. We in this ward, and this is quite significant on a social level, have over fifty percent of patients who do not receive visits. Some are Yugoslav citizens and others are people who no longer have

35 Agostino Pirella, key figure in Gorizia and in the movement as a whole. See Foot, T*he Man Who Closed the Asylums,* 66–82; Caterina Pesce, *Pratiche di liberazione: Il manicomio di Arezzo negli anni di Agostino Pirella (1971–1978)* (Pacini Editore, 2023); and Massimo Baioni and Marica Setaro, eds., *Asili della follia: Storie e pratiche di liberazione nei manicomi toscani* (Le ragioni di Clio, 2023).

relatives or who have relatives who no longer come to visit them, who are not interested.

Q: They are abandoned. . . .

PIRELLA: They are abandoned and do not have the possibility of having much money, they are very inactive, and therefore I think that they have more easily accepted this practice of requesting cigarettes.

Q: All this stands in an incredible contrast with the rest of the hospital and the community, and therefore it perhaps becomes even more dramatic. . . .

PIRELLA: Yes, the problem of the closed ward exists mainly as a relationship between this legacy of an institutional reality and the rest of the hospital that has changed. Precisely in this regard, a significant effort has been made to concentrate our attention on this ward, and results have been obtained in this first year of extra commitment, which suggest that there are possibilities in modifying this situation quite profoundly.

Q: Are the patients in the closed ward, ward C, sicker than the others, do they have lesions so that their disease manifests itself in a more violent, more dramatic way?

PIRELLA: I mentioned the fragility of the personality of these patients; undoubtedly some of these patients have organic lesions, are seriously demented, cerebropathic,[36] and it could be said that their abandonment in a closed situation has more easily led to such regressed behavior. For other patients, however, this does not apply; they are patients who we think are the outcome of a therapeutic failure, of what we often call the failure of institutional psychiatry.

Q: So you think that by knocking down the wall, knocking down the bars, in short, opening up the department, you would get results?

PIRELLA: The removal of the physical barriers of the ward and therefore the opening of the ward is conditioned by

36 Cerebropathy, including stroke or cognitive dysfunction, is one of the most serious complications in diabetic patients.

a series of commitments that in our opinion are not only those of the staff, of the medical team, but also of the entire community. I think that if the community, and therefore also the patients in the open ward, do not collaborate and do not make a commitment so that these last two closed wards can be opened, we will not be able to obtain further results.

Q: What are the feelings in the rest of the community about the closed ward?

PIRELLA: It is a significant issue, so much so that there were long discussions in the general meetings about doing something for these wards and this from time to time led to fragmented changes until things took on a more precise form. That is, it was established that a small tax on consumer goods at the bar would benefit these two closed wards and now a monthly sum is paid to these wards. Moreover, we can say that while this sum testifies to the interest of the patients of the open wards toward the patients of the closed ward, it also allows us to overcome some of the problems mentioned above in a concrete way, such as with, for example, the lack of money on the part of some patients in the closed wards.

Ward meetings take place before or after lunch between 5 pm and 7 pm, outdoors or indoors, depending on the season. On average, fifteen to thirty people are present. The discussion takes place spontaneously and is not set down beforehand. In long-stay wards there are often long silences, pauses, and fractures in speech, but there is rapid progress among patients in short-stay wards. General topics and ward problems are discussed. The stories of relationships with families, the work environment, and society in general and the discussion of permissions to leave dominate conversations. These permits are, in fact, granted during ward meetings, after the group, including doctors and nurses, has examined the patient's condition, discussed them with the patient and received assurances about good behavior once outside the hospital, their self-control, and respect for

deadlines.[37] These assurances are particularly important for the alcoholic ward, where those in recovery dominate the situation and involve everyone in discussions. The doctor in charge of the ward told us about the situation there.

CASAGRANDE:[38] The community considers the success or failure of others as its own success or failure. For example, very often a person gives their word and makes promises that they then don't keep. Upon their return, sooner or later, even after some time, the community reminds them of their responsibilities. The person feels noticeably frustrated, also because they feel they have betrayed others. However, when a person asks another not to drink and the other person leaves the hospital and doesn't drink — and when they return they haven't got drunk — they feel the other's success as their own success, because they see that they too have a chance if the other has succeeded in doing the same thing. So, I would say that this is a factor that keeps these people connected, the fact of having a common problem and facing it together. As I said before, this creates a bond that, however, is not enough on its own and this is why relatives are also often invited to intervene. Once or twice a week there are meetings with family members, they also often go out on trips alone or with their nurses, trips that they themselves decide upon, trips in which they very often will be fed, and where they mutually commit to fighting this battle of theirs outside the hospital. Often many of these people, on a trip together with the others from the hospital, did not have a drink and if it happens that sometimes someone drinks or they drank a quarter liter of wine, the first thing they do on their return is to discuss this fact, not

37 This was one way in which patients were allowed out of the hospital, although these permits were often for a very restricted period.

38 Domenico Casagrande, psychiatrist. See Foot, *The Man Who Closed the Asylums,* 78–79, 88–89, and *passim.*

just accuse the other of having had a drink or not, but to understand the reasons why they did so.

Q: It is essentially a reassumption of responsibility.

CASAGRANDE: And then they are used to making small choices, continuously. A very recent example comes to mind of a person who started drinking again. He came to the community and wanted to be hospitalized;. Hospitalization was not possible for specific reasons (he had a trial coming up and the lawyer did not want him to be hospitalized right at the beginning of the trial). Then the community offered him help in other ways, but these had to engage with his sense of responsibility. At this point the community confronted him with his own responsibility, not the doctor, but the community. They said, "we are willing to help you if you do this." And what was asked of him was to come to the hospital every day and to commit to coming every day and he said, "let's postpone it until Thursday." The community said no, we want to know now, we are willing to help you, but we want to know now. This demand greatly embarrassed this person, it was a very small choice they had to make, and they didn't know how to make it. In the end they were almost forced into it. They accepted what the community offered them after having examined various possibilities; and they tried to favor them as much as possible, but then they were faced with an either/or situation. In this way they had to choose and now they do what they promised; they are now doing well. These are small everyday choices that prepare an individual for a greater possibility of choice and help them understand their own situation.

Q: Do you have this feeling every day, of having patients in the ward who are coresponsible with medical acts. . . .

CASAGRANDE: Yes, I would say that they are constantly faced with actions linked to responsibility. In the open hospital, where there is a lot of freedom of movement, there is a possibility of making everyday choices, for example whether or not they take part in other people's work, or going out for a drink — because in some ways this is quite

easy — or not going out, or looking to have wine brought inside the hospital or not, participate or not in activities, etc. In these cases it is the community that continually brings the person back to their responsibilities, in the sense that there is participation in all the activities at the same time, if someone is not there, this is noticed and they are reminded of their responsibilities, but naturally the same people who remind others of their responsibilities must also somehow make themselves responsible, because they know that one day they too might receive these kinds of reminders. And it is no longer a mother, or a father, or a doctor who does this (the doctor could be seen merely as a form of authority figure), but it is the others, the others with whom the patient has contact, the others whom they manipulate but by whom they are also manipulated. Sooner or later a person, by dint of manipulating others and being manipulated in turn, enters into a crisis, and they find themselves at a point where they somehow must make their own choices. Seen up close, this empowerment of the group is an exciting moment even if it is very much the opposite of a perfect outcome, given that it takes place in a difficult and suspicious environment, which suffers from moments of irresponsibility, regression, and costs sick people, as well as the treatment team, a great deal of effort. After all, the situation varies from one ward to another. In the women's ward which collects all the new patients and is mainly made up of short-term patients, group interrelations are more fluid.

Q: You hold ward meetings with the patients, I see. Were you able to see any differences after these meetings?

JERVIS: I've never really asked myself this, but you also must know which outcomes you're looking for. The meetings are daily, and when by chance we stop them for a few days, we feel the need for them again. Moreover, the structure and climate of the ward changes in line with various factors, most of which are not directly controllable. Think of the network of emotional dynamics that binds patients,

nurses, and doctors together. The whole ward is marked by unconscious factors that affect many people and cannot be examined except in very crude terms, and often the evening meeting merely brings people together. When you see that something is changing in the structure and climate of the ward, it is difficult to understand exactly what it was the main cause of these changes. It is certain, however, that ward meetings are very important from this point of view.

Q: Do you lead these meetings?

JERVIS: Not always, but I lead them more than I would like to. The patients often refer to psychiatrists in a direct way, attributing to them a power that they do not and cannot have, and this is naturally one of the most frequent topics of discussion. The ideal outcome would be to have more informal meetings, in which the presence of the doctor is not decisive, or even ends up becoming marginal. Sometimes it seems that we succeed in this, but in practice the presence of the doctor in a patient meeting is always decisive, whether we want it to be so or not. Bear in mind that meetings of this kind are mostly designed for large groups of twenty or thirty people, and not psychotherapy meetings or work meetings. The meeting is easily divided into smaller groups, and sometimes many patients in the ward are absent. The dynamics are very varied and often exciting.

Q: This is a short-stay ward, and this is where a patient enters when they arrive at the hospital. In general, do you notice that there is a certain difficulty in settling in, for example with regards to these meetings?

JERVIS: It's difficult to give a general answer here. It largely depends on the methods of hospitalization, and the greatest difficulties evidently arise with forced hospitalizations, with patients who arrive here in ambulances, perhaps tied up, or are brought here through deception. However, there are also hospitalized patients who are voluntarily supported by health insurance, sometimes with neurotic family problems that do not seem to improve except with

hospitalization, and who perhaps come from slightly more well-off backgrounds. With these people there are difficulties in breaking down their tendency toward isolation, or we see an attempt at a privileged interpersonal relationship with the doctor. Meetings are often avoided in the first days of hospitalization. Then the problem arises of whether to encourage a personal relationship with the patient, or whether to push them toward informal groups and meetings.

Q: If I understand correctly, you prefer a group approach to an individual one?

JERVIS: I don't know if that's the issue, although I would agree. The doctor–patient relationship is in a certain sense unavoidable, and its complexity must be understood. On the other hand, any relationship, whether individual or group, risks being just a technical relationship in which the doctor accepts being considered omnipotent, or merely "good," or "just," or "punitive." In short, ghosts are created. For this reason, if possible, I always try to involve other people in this relationship: the patient's relatives, a nurse or two, other patients, depending on the case itself and how the situation pans out. It's not a real group, but the informal nature of these meetings makes them seem more real. Sometimes it is better to be alone, but the psychiatrist–patient relationship can be just as artificial and falsified in a one-to-one situation as in a standardized and cold "group" approach.

There is a full-time psychologist working in the Gorizia Psychiatric Hospital. Here too, the definition of her role is very different from a traditional one.

Q: You came to work here as a psychologist. What does your work consist of?

JERVIS COMBA: It is not easy to describe a job that for a long time did not have, so to speak, "positive" characteristics, but was only "negative," and was almost suspended in a void for

several months. I did some tests, of course, but only a few, and at first not even those.

Q: But in what sense do you call these characteristics negative?

JERVIS COMBA: It might be better to talk of "denial." Mine was a privileged condition, because I was able to choose between bringing with me the traditional paraphernalia of clinical psychology and trying to use them "in a new way,"not bringing anything with me and simply entering the field and trying to act. I chose this second alternative, which is why I spoke of "remaining suspended." You see, doctors have their traditional role to destroy in terms of a reference point, they constantly compare themselves with something that they do not want to be, and this is inevitable because "technical" performances are required of them which they must provide. My choice was different: to compare myself with their position by following another path.

Q: So you looked for a different path, completely abandoning the techniques of your specialty.

JERVIS COMBA: I would say that it would be illusory to think of being able to abandon all techniques. One can choose not to use certain tools, but one certainly always acts in a situation in ways that each person's specialization makes them absorb, that they display alongside techniques. My choice was not to use the traditional role as a term of comparison, and to try to compare myself with people in other ways, or at least see if it this is possible. After all, many psychologists are searching for a role in the psychiatric institution, and there are many uncertainties and many disagreements on this point. In France, for example, they addressed this problem in an issue of *Information Psychiatrique,* which concluded that psychoanalytic training is the key for the psychologist who truly wants to enter the psychiatric institution.

Q: I don't think you have the same opinion.

JERVIS COMBA: I am trying to free myself from a technique that objectifies a patient, and I think that before embracing another technique it is necessary to verify what the rejection of a technical objectifying attitude means.

Q: Have the experiences of these first months of work given you any indications?

JERVIS COMBA: Yes, of course, but I think they are still ambiguous. On the one hand, the lack of reference points to help me "place" myself leads some to conclude that I am a sort of incomplete doctor, because I do the same things as my psychiatrist colleagues without prescribing drugs and, obviously, without dealing with the general medical aspect of patients, which they sometimes must take care of.

Q: Is this reaction of the patients difficult to change?

JERVIS COMBA: I wouldn't say that this comes just from the patients. In fact, I would say that this attitude is perhaps more that of colleagues or nurses, and even from myself. There is a fear that all this effort in not comparing oneself with the traditional role of the psychologist will be reduced simply to comparing oneself to doctors. In fact, many patients immediately grasped these new aspects I have adopted and try to assign a new identity to me and asked me several personal questions — and there were no techniques there to act as mediators: medication, tests (indeed I could say, more correctly, the test context).

Q: In this way a new type of relationship with the patients was created.

JERVIS COMBA: An alternative to the traditional stereotype of the psychiatrist has been evident. Being defined by the patients and constantly trying to overcome this definition with them is the first anti-institutionalizing act of my work here; for a psychologist, at least! Naturally there are big risks: of not realistically analyzing this "new" relationship and falling into the spontaneities of daily practice, which is also disconnected from technique and therefore completely uncontrolled. Or there is a danger of a false kind of reciprocity which allows one to have good conscience, and which justifies the effort of losing one's identity within a role, adopting a different outlook, and of being forced to constantly reinvent oneself in comparison with others.

> "When we see that the sick person comes here and seems lost and must be helped, helped, helped, and we help him and then we can say, 'here they are, finally they can operate on their own. For us it is a satisfaction.'" This is what the nurse Di Lillo has said and with this simple and spontaneous phrase he summarizes the state of mind of the majority of his 150 colleagues, both men and women. In particular, the younger ones are satisfied and proud of the results achieved by the community and of their new position. For some years now their function has completely changed. They were the people who held the chains. "We were jailers," they say. Now, they are in constant contact with patients in wards, during walks, at the bar, during card games, and they have a possibility to approach patients and can connect with individuals in relation to the general situation and vice versa. They therefore have an indispensable intermediary role between the patient and the medical team, a lens that can focus or confuse the relationships between the parties. Some have remained indifferent to the changes that have taken place in the hospital, while others are even nostalgic for previous times when it was enough to lock people up and make sure the sick did not escape, there were few responsibilities then, no satisfaction. In essence, if there is a small opposition group among the nurses, I believe that it is fueled by a disappointed expectation of economic betterment, expressed by the equation: greater responsibility, greater pay. Unfortunately, this type of improvement cannot be implemented by the microsociety to which they belong, but by a larger society via its rules, employment contracts, trade union struggles, and the evolution of the general conditions of the Italian hospital sector.

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

Q: Basically, by implementing current methods, are you having more difficulty than you used to?

JERMAN: I would say no. It's no longer hard. This is a new working situation, which is completely different from the previous one in which the nurse, instead of being a kind of guard, is a member of the community.

Q: Can you give some examples?

MAREGA: For my part, the important thing is to assist these sick people, but not so much in terms of assistance as in instilling in them the self-confidence to be included in society again. And that's something that I think everyone here has understood.

Q: How do sick people react?

JERMAN: Sick people react well, I would say, if they are approached appropriately. That is, when the approach between nurse and patient is as free as possible. Therefore, if the nurse has been given trust and responsibility in their work, they will be able to instill this in the sick to the same extent. Therefore, the freer the nurse is, the better the relationship with the patient will be.

Q: And how do you deal with those who come here for the first time?

MAREGA: Let's try first to understand them, and to stay close to them as much as possible. But they settle in so quickly because it's such a free environment here. . . .

Q: But don't they already have prejudices toward the hospital when they get here?

MAREGA: Yes, they arrive with prejudices, but they settle in immediately upon their first contact with us and with the environment. As soon as they look around, they immediately settle in.

JERMAN: More than prejudice. I would say that this is precisely the struggle that the hospital must face: that of the prejudice within external society toward the mentally ill. The mentally ill person who comes here for the first time is already full of preconceived ideas [about the hospital].

Q: And after this do they change?

JERMAN: Yes, because they have an opportunity to see that they are not being treated as they thought they would be.

MAREGA: As in the cliché of an old-style psychiatric hospital....

JERMAN: Society always thinks of the psychiatric hospital as it was several years ago and conceives of the classic sick person through jokes. However, here there is something else entirely. Here everyone lives freely; it no longer feels like a hospital. The patient finds themselves to be free and see that they can help themselves.

Q: Have you witnessed visible progress with any sick person?

JERMAN: Regarding all the sick I would say that the progress is visible. I have been working in this hospital for five years and I have practically lived this experience from the beginning. I arrived when the straitjackets no longer existed, or the mechanical restraints, but the wards were still locked, so I had the opportunity to see the first ward that was open.

Q: And what happened?

JERMAN: Nothing happened, absolutely nothing in the sense of what you might think. We thought everyone would leave.... Instead, what happened was discontent amongst many nurses and some doctors who did not think that this method was suitable and thought that it was not possible to have improvements by opening up the hospital, in practice by freeing the patient. While many of these now, in fact, everyone changed their minds because the improvement is so evident....

Q: And was there confusion among the sick?

JERMAN: I wouldn't say so. The biggest problem was to shake them from their apathy. As far as escapes are concerned, their frequency has not increased at all, and if anything has decreased.

Q: Why were they apathetic?

JERMAN: They were apathetic because they had been shut away, abandoned, forced into seclusion for many, many years, and consequently they had no opportunity to put any kind of personal initiative into practice.

Q: Do you find it difficult to meet patients?
BENOSSI: Especially in the first days of hospitalization. We try in every way to encourage their inclusion in the community, in groups. I think this is a great method, which also simplifies our task.
Q: Is there satisfaction in holding meetings?
BENOSSI: A lot. Opinions and desires are heard, and everyone, even the nurses, are free to express their thoughts, and this is very important. I have already been here for about twenty-four years and have been able to follow this progress personally.
Q: A visitor, like me, a layman, walking around the hospital does not have the sensation of being in a psychiatric hospital.
BENOSSI: I agree especially when entering some wards, like ours, where everything has been modernized, including the walls and furnishings. But above all it is the environment and the atmosphere that have changed, it is a family environment.
Q: A week ago I saw a boy who was showing signs of a strong aggressive nature, now I have seen that he has already calmed down. What does this improvement depend on, in your opinion?
BENOSSI: Above all from the contact with others and the environment he found. You see, we are trying in every way to ensure that this community truly exists, not only in words, but in deeds.
Q: Do you too, Troncar, believe that connections are made easier [in this way]?
TRONCAR: Talking in groups is a good thing, because you are dealing with real things, you can discuss various problems and give advice, understand. . . .
Q: My impression is that you struggle much more this way than otherwise.
TRONCAR: In any case it all takes much more effort, because you are more committed to this work. However, there is more satisfaction, seeing the progress you make and seeing

that you are useful. You know, once upon a time we were a bit like jailers. You did a job, you came here to get your pay, and off you went.

Q: In essence, you now have a more precise function. . . .

TRONCAR: A little more precise, and in any case also with more responsibility, because you are always a little anxious: did I do well, did I do badly? Previously, responsibility was more limited, because one locked the door with the keys, made sure the sick did not fight each other, gave out the pills, organized the therapy ordered by the doctor. In short, we were under "orders," and when one had followed these orders their conscience was clear. The improvement of the patient was considered only to be the work of doctors. Now you can see someone improving, see them improve before your eyes, by being close to them. . . .

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

TRONCAR: Once upon admission someone was undressed, bathed, and placed in a small room, properly called a cell. Now, however, you talk to them, you invite them to the clinic, then you take their blood pressure, you ask him where they are from, to make friends and give them a little trust so that they feel more at ease, at home, with family. Then little by little you introduce them to your colleagues, you invite them into the room where there is their bed, and if their companions are there you introduce them. In short, we try to reassure them, and they gradually settle in. In the evening, they are invited to the ward meeting, so they get to know everyone else, we talk, and little by little they integrate into the community of the ward.

[However], the legacy of the mental hospital atmosphere of the past can still be seen in certain cases.

The interview which follows was with a nurse (Orlando Andrian) on the last closed male ward (C) which took place shortly before it opened and indicates an awareness of the situation at the moment in which it was undergoing a transformation.

Q: I saw that you are very actively involved in the life of the ward. . . .

ANDRIAN: Yes, it is the most difficult ward. It is a mixed ward of patients with different illnesses. But we are trying to create a better solution. We made this division which is a bit [*he points to a door that divides the department*] of a tiny reform.

Q: In what sense?

ANDRIAN: Dividing the ward in two: the most backward on one side, the others on the other. This did some good. For some time now we have started doing what is done in other wards, . . . having ward community meetings. We have seen that there is not the same participation as in other wards, but there is a certain interest. Something is happening, and this gives the patients a sense of meaning, it makes them more responsible.

Q: They are almost all old.

ANDRIAN: They have been here for thirty years, the hospital has been open since 1933. Some were already patients in other hospitals.

Q: Here there are people who are eighty.

ANDRIAN: The average is fifty-five–sixty years old. It can be said that there are several who have spent almost their entire lives in this hospital or others.

Q: Is it therefore particularly difficult to help these sick people?

ANDRIAN: There is a certain difficulty, because they are now institutionalized, they have been abandoned for a long time. Before this new direction and community work was begun, we limited ourselves to what was direct assistance, but there was no attempt to stimulate the patient, to make them responsible for something that would give meaning to their life. We tried not to let them hurt themselves, not hurt others. . . .

Q: And do you believe that if this ward were opened despite the very regressed patients that are there, would some results be achieved?

ANDRIAN: We have already seen some results with the music therapy group. There was one with whom, as far as I remember, we could almost never communicate. Now, instead, he answers us, calls us. It also helps us in internal work. In short, we see that there is something happening, not much, but it is something.

From the beginning of the liberalization of the hospital until the summer of 1967 the nuns did not participate in general and ward meetings. Since the Gorizia Psychiatric Hospital encourages visitors to publicize its activities — as based around the idea of relationships and exchange — it was surprising within this environment never to meet any of the nuns, who have been ever-present in hospitals around the world. This category preferred to work separately while maintaining their traditional role in the women's wards, in ways which were both charitable and authoritarian. In doing so they carried out their roles, without failing in their duty, and were always willing to work and toil. The rest of the community, on the other hand, acted with the nuns according to the logic of the community: they would not be forced to do anything, and would be allowed maximum freedom and spontaneity in terms of their attitudes. The result, however, is a situation of stasis, marked by misunderstandings so that when I asked the Mother Superior for her testimony and that of the other nuns, I heard her reply: "Are you sure that the director agrees?" For some time now, the nuns have been taking part in the first meeting of the day, the one at half past eight.

Q: Have you been here in the hospital for a long time?
NUN: Several years, thirty-two years. And I am pleased with this renewal of the hospital, we can see the reality of the renewal, and now more attention is needed.
Q: That is, do you think things are more difficult now?
NUN: Not in terms of effort, but we have much more responsibility now that the wards are open, when they were closed there wasn't much surveillance that was needed, whereas now you must keep up with it a lot.

NUN: The sick are less agitated, they don't have that agitation they had years ago, and they require less attention. We get along well.

Q: Was there more tension in the past?

NUN: The sick were locked up, and there was a different form of therapy and so on and they experienced periods of agitation and now they there is another way of doing things, and the ill have calmed down a bit.

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

NUN: Of course there is a difference, probably for the better. But what we could see was that once the ill, when they were active, conscientious, they were better suited to work, perhaps they had more strength. While now they are less strong, more apathetic, less inclined to work, less willing, [and] they focus more on sleeping.

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

NUN: I think so, once upon a time when a sick person was agitated it was possible to slow them down with somewhat strong means as was customary in those days. But not now. Once in the past in the good times they were beautiful, they were smiling, while now they are always a little melancholic.

Q: Does it mean that there were a greater number of people working?

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

Q: The bar has been open for three years and is managed by the patients. This is a good initiative in my opinion.

NUN: Yes, the ill behave well, it's even better for the ill people, because before when they didn't even receive a small amount money, a little reward, maybe they exchanged other things, the men were given cigarettes to smoke, the women were given a much lower salary and now they find

themselves happier in this situation. Because there are the trips now, and we nuns had already started these with the sick women, and they were happy because once a year they went on a pleasurable trip, and it was paid for with small contributions and there was food available. Nowadays, things have improved a lot, because they are paid more by the provincial administration and it is much better, to tell the truth.

Q: That is, there is a certain difference between then and now. Look, once upon a time did you use more old-fashioned methods, so to speak, coercive methods?

NUN: Yes, they were isolated, perhaps they were kept alone in the cells for a few days, or we used straitjackets. But I'm not sure if this was a problem because that was the way things were done, according to what the superiors said. There was discipline, and the patients wanted to be treated well, not hit, but not shouted at either. I don't know. It was another kind of therapy.

Q: In your opinion, this therapy, that is liberating the patient, making them free, allowing the patient to go out, etc. does it benefit the patient? I ask you from your experience, even if you are not a doctor, nor am I.

NUN: There are some cases that have improved a lot, we cannot yet say about some of the others, and perhaps it is also due to the quality of the illness, the tendencies they have. But for some, yes, they have changed for the better.

Q: Therefore, in your opinion, was this a positive experience?

NUN: For the sick, it's a good experiment.

Q: However, do you find that overall this fact — that is, evidently there is more effort to be made, the wards are open, you must follow up, etc. — creates a bit of anguish, anxiety, even a bit of anarchy, some chaos, perhaps?

NUN: You see, now there are three women's wards open.[39] And there is one ward for chronically ill patients, beds, infirmary, and the dangerous patients have been placed

39 This recording took place in the summer of 1967 [note in original].

here, at least those who tended to run away. Now they are being looked at, and they are working to be able to open this ward. Now it's not that we disapprove of this, but this gives us food for thought because knowing the patients and knowing that they are different and can be dangerous due to the consequences of these changes, then it gives us a little food for thought, but ultimately, we are always willing to collaborate.

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

NUN: No, I wasn't saying that.

The nun does not want to record her response. We resume shortly after.

Q: As for entertainment, every now and then they organize a festival. Do you also participate in organizing this?

NUN: Yes, maybe in part if it happens, we will go there, several times a day. In those three days of the festival we went to have a look, even in the evening, and we took part in the shows. We also collaborated in the preparations, in meeting some needs, we helped the staff who were preparing the dinner, we were busy with work for the festival, we help when there is something to be done.

Q: Perhaps you also have the feeling that in a work regime, by creating obligations, a certain discipline can provide more awareness.

NUN: We can't comment on this.

Q: Because you say you see them more as more listless.

NUN: Perhaps it is the very fact that they have more money, that they see themselves as being more rewarded. They have this freedom of openness, they have the bar, they can hang out there, all together, they have more trips, they have more free time, and so this also makes them less willing [to do things]. Once upon a time it was enough to leave the ward and for them it was already a big thing, they went to the workshops

willingly, because they already saw themselves as better off than the others, while now they are all free, they want to be the one who walks down the avenue, while someone else has to sacrifice themselves to work.

Q: This is true, once upon a time those who collaborated, by working, were the ones who left the asylum, and were already in an exceptional situation, and therefore now, since this is no longer an exceptional situation, they are less stimulated, but nevertheless there are still those who work. Did they once also do organized chores?

NUN: No, inside the pavilions, no.

Q: I'm sorry that you, Mother Superior, stopped when you were about to tell me about a particular point of view of yours, but perhaps this would have helped with our understanding, the understanding of everyone, I am of the opinion that sometimes it is better to say things clearly, discuss, speak.

NUN: You see, we nuns are a little older, we are not like the youth, the staff at the beginning, who are just learning their jobs, we have experience.

Q: I understood this, you have been working for many years like all those who do a demanding job and this is exhausting work for everyone and therefore for them too, but do you think that for example this new situation could be more interesting for the youth?

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

Q: Yes, but perhaps in the sense that like everyone else you have had most of your experience with another kind of system.

NUN: Yes, that's it, but we get on well, we have nothing to say, but we also have nothing to disapprove of in the past era. Let's be clear: it is perhaps unfortunate that there was some exaggeration in terms of past methods, because in reality we were punished if we went too far, woe betide anyone who touched a sick person, there was very rigorous discipline. We love our sick patients very, very much, but sometimes due to their illness things went too far, and they claimed that that had been beaten or mistreated. We never wanted

this to be true, because there was such a severe director that it was seen as terrible if a doctor or a nurse hit a patient and not only that, but it was seen as terrible if they were even mistreated, in fact staff were hit with fines. The personnel caught in such an act were changed from one place to another.

Q: In my opinion, in this community the old systems of psychiatry are criticized, and these are systems that are still generally used in many Italian hospitals, but here a new system is being implemented.

NUN: Indeed, all we have to do is adapt willingly, because we can see that things have improved a lot. They have improved in many ways to tell the truth. Once when we gathered in church all the patients had to wear the same uniform, the sick had to have their hair cut and their hair was not cared for like today as we have a hairdresser.

Q: They look like human beings, there is a little more order, yes, perhaps things are modest, because this is a hospital for poor people, it is not a clinic.

NUN: It's not a big province, it does what it can, in a way.

Q: I saw that they too are now taking part in the 8:30 am meeting.

NUN: It's an excellent way to explain our problems, by talking we understand each other, so to speak.

Q: It seems like it to me too, I told you so! Maybe it's the best way to explain things and to understand each other. Thank you.

The problem of "vocational choice" presents itself in very different ways in other cases. It was interesting, in this regard, to interview some people whose work at the hospital has a more specifically voluntary character.

The "external" penetrates the hospital through the work of social workers and the presence of volunteers. The function of this team is to act as a buffer in terms of relationships between the treatment team and patients, and between the outside world and the community. Social workers maintain relation-

ships with families, institutions, and bureaucratic institutions regarding pensions, subsidies, and social security. With five hundred patients, each of whom is a "case" and has a "case" to solve, the work of the assistants is often lost in the pursuit of the paperwork from one office to another, while their presence in the wards would be important in order to promote initiatives and being energy to the environment. The action of volunteers is entrusted to the good will of individuals and the sincerity of their attitude. The following interview was taken from a recording made with the social workers of the hospital and with a group of students (including Sonia Baiss) who are completing their internship here. At the time of recording the men's C ward had not yet been opened (June 1967).

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

BAISS: No, I've never been scared. In contrast perhaps to what others might think. Like my colleagues, I too had never visited a psychiatric hospital before and the idea I had of it and that I had formed through films was something like a nightmare. Instead here it is like being in any other place, like in any other environment where there is a community of people.

Q: Even though you are a student, do you have a specific task here in the hospital?

BAISS: Yes, I was assigned to the men's C ward, initially with a sort of excuse, that of Christmas preparations, to try to reactivate the patients a little, because the nurses couldn't do this due to a lack of time. And then it was decided that I would stay there, and I accepted because the job seemed really exciting to me, especially with the prospect that the ward could open up.

Q: Since department C is the only male ward still closed, what were the reasons that made you choose this department?

BAISS: I don't think I was able to choose because I didn't know the hospital enough. I accepted the job as I am convinced that this particular role in the last men's ward

that is still closed responds to two needs at the same time. First of all, there is the objective need of the institution to address and possibly resolve the painful situation of over seventy patients forced to live in a climate that retains the characteristics of an [old] mental hospital. Secondly, I thought that working with very backward people offered rewards not only for the sick but also for me.

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

BAISS: It's not just what I think about this, they also tell me. We have managed to establish a fairly frank relationship whereby we try to tell each other the things we think. At first, I made them a little uncomfortable, the idea of having a female figure in the ward excited them, then they got used to it and accepted me as a person who was part of the ward to whom they turned to have contact with their family members, to inquire about pensions, subsidies, to ask me to take them out of the hospital, to organize trips. In short, it seems that they understood my role in the ward quite well.

Q: Have you already taken any trips with the patients in ward C?

BAISS: No. Perhaps thanks to the relationship that has been established with the nurses, there is a tendency to delegate these activities (trips, tours around Gorizia, or even going around the hospital) to the nurses. Because they say that since I haven't been in the ward for long, I don't know the patients that well. They trust themselves more because they see me as an intern and are unable to give me enough real responsibility.

Q: In short, they made you feel like a bit of a beginner.

BAISS: A little yes, however the relationships have become quite clear even with the nurses. After a couple of months we managed to clarify them and now we collaborate quite well.

Q: You have spent a lot of your working time in this ward, which is the closed ward, where the seriously or very seriously ill can be found. Some of them do not even speak or bear the signs of a serious illness. What are your thoughts

regarding these sick people, their possibility of recovery, or their assimilation with others?

BAISS: Well, I wouldn't say that the most seriously ill people are found there. Because sick people with the same characteristics are also in the other wards. They just had the bad luck of remaining in the closed ward. As for the fact that they don't speak, I believe that if you find yourself in a ward for twenty years where no one ever speaks to you, you too will lose the habit of speaking. It's not that they don't speak because they have a particular illness or are aggressive for particular reasons. They are as they are precisely because the institution has made them that way and I am convinced that in a short time it will be possible to change them. It certainly won't be a matter of days or months, but if you consider that a patient has been shut away for twenty years in a ward like this or in a traditional hospital, I think that in a year or two we can help them a lot, truly change them as from night to day.

Q: Have you already seen results in this sense?

BAISS: Yes, I have seen notable results because we have managed to organize community meetings in which participation is spontaneous and is always quite strong. On average there are thirty people per meeting, although there are only about ten who speak, no more. The others listen or comment in a whisper because they don't yet have the courage to express themselves. Others comment when the meeting has broken up, come to ask me for information, or talk to the nurses about things. However, they were very active. Then they begin to demand things, they begin to express their need to have money, to be free. So a committee was organized in the ward, again with voluntary participation, and they tried to administer a fund of money given to them by the club.[40] I believe that all this can be considered as important results. If you consider the fact that there are ward meetings, that we have managed to create

40 The patient club.

committees, that people are ready to go when they feel like going out, and complain because they have the worst clothes in the whole hospital and want to go and choose their own clothing, who have taken care to separate out their only decent dress from the others, well, I consider all these things to be notable results, and all in a brief period.

The issue of personal choice, which, in practice, drives the entire hospital community of Gorizia, is particularly clear from this interview with a doctor.

Q: Dr. Schittar, you are also a volunteer, or at least you have been for a fairly long period of time. What prompted you to come to Gorizia Hospital?

SCHITTAR: When I arrived in Gorizia I was completely unfamiliar with psychiatric practice and almost with any theory. Psychiatry had always been a big interest of mine, but I was a general practitioner. I was an assistant in a pulmonology division of a normal hospital and moreover I had started working, but without too much enthusiasm, as a general practitioner .

Q: You had therefore undertaken a career that is that of most young doctors. Why did you interrupt this path, let's say, abruptly?

SCHITTAR: It is a bit difficult to identify the reasons that lead us to make such important choices. Mine was partly an emotional reaction to the type of role I would have had to undertake as a general practitioner. It seems clear to me that, at least in current practice, to which a newly graduated doctor must adapt, the medical profession lives day by day in a kind of situation of bad faith. The role of the doctor is by definition that of a "superior" person; they are by definition cultured, educated, objective, "good," and economically disinterested because their mission is "a mission." Above all they are someone who knows about medicine, who knows about diseases and knows how to cure them. In short, "science and conscience" are always

qualities that are taken for granted. The bad thing is that they end up serving to justify the position of power that the doctor encapsulates, despite everything, in our society. The doctor's relationship with the patient is almost always (and always in mutual practice and in hospital wards) a relationship of authority, a relationship that sometimes covers and hides very serious flaws, from real scientific ignorance to the many abuses to which patients must submit every day. It is a very stressful situation for those looking for a different kind of human relationship.

Q: And did you find this different relationship in Gorizia?

SCHITTAR: I would say yes. In Gorizia at least a relationship other than the authoritarian one is valued, both between members of the medical team and in relations with patients and nurses. There is a tendency to reduce the role of the doctor to that of a technician, it's a bad word but it's clear enough, a health technician, not necessarily in terms of mental health, of which we can all be considered "technicians," doctors, nurses, patients. But it's not just this. The enthusiasm that this type of work arouses also derives from its voluntaristic and "humanitarian" aspects, but above all, it seems to me, to escape from the attitude of the new convert, from its "political" meanings. Here a young doctor feels that in some way, with their work, with participation in numerous group meetings at all levels, they achieve the double aim of a, let's say, professional activity and a daily battle of ideas, with the latter certainly more rewarding than the former!

There are few work opportunities in this community, and they are limited to a laboratory for the manufacture of chairs, another for cardboard boxes and a third where containers for wine are made of straw. All in all these activities employ around thirty people, while a small team of laborers is employed on the farm. Many others work in hospital services: kitchen, laundry, etc. These fields of activity traditionally belong to a small group of long-term patients who are completely integrated into these

modest tasks. Generally speaking, the work reserved for patients is neither hindered, nor is it encouraged, in order to avoid exploitation. They can provide good services as a farmer, worker, or craftsman, [but] there is the absence of a normal salary, because no law protects the work of an inmate in a psychiatric hospital. Therefore, apart from any consideration of the value of occupational therapy, the community, by denying the validity of this work, also brings with it the consideration that the savings made by the public administration through the work of the patients do not benefit the patients themselves and nor do they help their rehabilitation.

The only activity organized by the community until some time ago, which was efficient and popular, was a music therapy class based on the teaching of the simple rhythms of Karl Orff's "Musik für Kinder." The music room has now been closed and music therapy is no longer discussed due to a low-level labor dispute between the administration and the nurse who took care of the section. The latter, having attended a specialization course in Salzburg, with the best of intentions, after a few years of this activity had asked to be recognized officially as a music therapist. However, this was a new demand and was not foreseen within the bureaucratic roles of the provincial administration. Until some time ago the community published a monthly magazine with the title *Il Picchio* (*The Woodpecker*), perhaps because it addressed (like the bird itself) the same problems in a repetitive way, or because the title wanted to be ironically allusive [*Il Picchio* — a play on the name of the local Trieste-based newspaper *Il Piccolo*]. This publication was active for three years and was particularly interesting because it expressed the progress of institutional life over time. Today it is no longer produced because the freeing up of the hospital has made such mediated communication tools useless. The director of *Il Picchio* was Furio, a patient, who remains one of the leaders of the community. Furio is an intelligent and experienced man in his fifties who knows the problems of the psychiatric hospital better than any other patient. The recorded conversation I had with him spontaneously and comprehensively summarizes the brief

history of liberalization of the hospital and the current thinking and position of patients within the community.

Q: I really like those cigarettes there.

FURIO: Actually, when I returned to Italy I didn't know which cigarettes to smoke, when I ran out of Caporal,[41] I couldn't buy any because they were too expensive.

Q: They should fall in price by the end of the year, because the French complain that the Italians sell them too expensively.

FURIO: They are contraband, since few foreign cigarettes are sold in France.

Q: They say that the rest of us here sell these for 80 francs, you in Italy with taxes and everything can sell them for 150 lire, whereas the Italians sell them for 290 lire. In short, it's a lie.

Here, however, let's begin our conversation about yesterday's ways of doing things and try to understand, together with your testimony, the history of the community, therefore when should we start? About six years ago?

FURIO: Yes, six years, because we are already at the end of the year. Practically things started here in July and August 1962.

Q: Did you already start with what they now call the therapeutic community in '62?

FURIO: No, we started by freeing the patients from the constraints that were in force. We started knocking down the metal fences, then the walls, then they stopped for a couple of months, just like that, to see what the reaction was. Because I believe that the director, even if he had the scientific conviction that certain institutional constraints on the hospital needed to be removed, it was a new experience for him as well and he had to try out various methods. And once he saw that the results were positive, then he actually started to free things up.

Q: Therefore the first phase was the liberalization of the hospital and this began in '62. Well, was this liberalization an open process, that is, were the patients made aware of it,

41 A type of US-produced cigarette.

had the medical team already started discussing things with the patients?

FURIO: Yes.

Q: Or maybe it was only done with some of you?

FURIO: With some of us, not all, but it was done with some of us and then it had to be done with the others. Even today we continue to discuss these matters because many think that all this change is only thanks to the good nature of the director and instead many others are aware that if there had not been for the collaboration of the patients and the nurses, the medical team would have been able to do very little.

Q: Well, do you rule out the possibility that a first gesture should be interpreted as an act of humanitarianism?

FURIO: I absolutely exclude it. It's a question of scientific conviction, it is undoubtedly this. It could appear that it was a gesture of humanity, because the living conditions before were not humane.

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

FURIO: It was conducted in the traditional way; the wards were locked, there was practically no participation of the patient in the life of the ward or anything outside of material work. There was the "good patient."[42] There was this type of organization and I believe this still exists in traditionally run hospitals. Doctors create two types of the ill, that is, two roles for the ill: there are good patients and bad patients; the good patient is the patient who helps the nurses with cleaning and ward work; the bad patient would be the one who does not intend to collaborate.

Q: Can a patient be exploited or not?

FURIO: Yes, the sick person on whom you can rely, as in a sense of *telling people to do things,* the sick person as being under the thumb, so to speak.

42 This is a reference to Erving Goffman's description of the "perfect patient" in the asylum in his *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Anchor Books, 1961).

Q: And therefore there were wake-up times, sleeping times.
FURIO: Wake-up times, lunch times, patients spent all day in a room doing practically nothing.
Q: Were there any means of restraint, were any means of restraint used?
FURIO: No, in my department I would say no, at least since I was here, restraints such as straitjackets or beds were not used. The most restless patients who would not stay still and had to stay in bed were tied with sheets.
Q: On this basis, liberalization began. When you talked about this intention to liberalize the hospital in the wards, how were these proposals received?
FURIO: The demolition of the fence was welcomed with enthusiasm. Finally we could go out, now we would have the opportunity to go wherever we wanted, there were often attempts to escape from a closed space, in fact we had more escapes when the hospital was closed, and then they could be considered as escapes. Today if someone leaves it can be considered as more of a breach of rules more than an escape; they are not monitored.
Q: The setting is different.
FURIO: It's different. And then some thought, "get rid of the fences, we can leave."
Q: And were there doubts, fears?
FURIO: Doubts and fears, I think there were more on the part of the nursing staff, because they said, "how can we do this, how do we control these patients?" In practice, in those first days after the fences were taken down there was a nurse in the courtyard with the ill patients, who in some ways prevented them from leaving the perimeter of the courtyard thanks to his mere presence. In practice the fences were still up.
Q: Was there ever a state of anxiety amongst the sick, was there joy?
FURIO: Perhaps in some, yes, in some there was a state of anxiety which I believe was caused by habit, because it was the breaking of a habit that the patients were so used

to. Many times we saw this: after the demolition of the fence, when the nurse who monitored the perimeter of the courtyard was removed, many of the sick people did not leave, the patients had become automatons, they had become machines.

Q: At first the mere presence of the nurse prevented this.

FURIO: It prevented it, and then it was habit that prevented us from moving away, it really put us in an anxious state: what will I find outside? What will I see? It must also be understood that the first wards opened were those wards where a good number of patients already left the hospital during the day, for work, accompanied, etc. So it didn't shock people in itself; the shock occurred for the people who did not leave the ward and who had never left. In these people I was able to see thoughts and phrases such as, "now there are no more walls, there are no more fences, let's go for a walk in the park." "Eh, but you know, who's over there? What's over there?" There was anxiety, we didn't know what to do outside and I would say that this was undoubtedly due to habits acquired over many years of being locked up. We no longer knew what was outside.

Q: Was it possible to notice an improvement in the patient's condition in this initial phase? Did opening immediately bring a visible improvement?

FURIO: It brought an improvement especially in social relationships. The patients became more sociable. In fact, before in the closed ward we sometimes found an enormous buzz in the living room, but sometimes there was total silence, everyone was closed in on themselves. But practically when there was that buzz there was also no type of conversation, no type of contact with each other. Conversations began and ended in the observation ward: "Are you here too?" "What's wrong?" "Here you're ok, who knows when you'll be released, you can't leave anymore, I've been here for a long time." And it ended there. And instead with the opening up everyone felt the need to leave the ward in the company of others, they began to go out in

groups of two, three, four, and these groups also began to chat, to converse with each other, they began to create social relationships.

Q: So at this point community action intervened? That is, this is the liberalization phase.

FURIO: Yes, the liberalization phase had been reached, but for technical, medical, and other reasons two wards were still kept locked, also because I think there were legal difficulties, it would not have been possible to free up everything at once. It was necessary to keep a ward that still had the characteristics of a closed ward, a truly closed ward, and in fact initially those patients who needed assistance or created problems in the open wards were sent to the closed ward.

Q: How about confinement?

FURIO: Yes, if they didn't display the behavior needed to remain in an open ward, they were sent to a closed ward and separated from the rest.

Q: Thus this was a very fragmented phase?

FURIO: It was a very imprecise phase. For a couple of years, the doctors have done everything they can to ensure that a patient is not sent to a closed ward. Even if a patient is in a state of high anxiety they must remain in the open ward.

Q: I mean, at this point the community phase intervened, that is, the one that encouraged contact between patients, the ill and doctors, doctor and staff and everyone else, through meetings, etc. Was this phase, which was marked by many meetings set up in order to get used to contact, etc., accepted by all?

FURIO: I would say it was accepted with enthusiasm. I saw it like this: especially when the community meeting began, which was the second initiative. Because previously there was only one ward, the men's ward B, which was known as the so-called "therapeutic community" and was the first to be opened, that held ward meetings, collective meetings in which the problems of the ward were discussed. These meetings were very heartfelt at the beginning, because ultimately the patients felt that they had to go to these

meetings and that they had to have the floor in order to protest against things that were not working, and around which there had not yet been had any challenging conversations. Then, at a later stage, we began to discuss the resignation of some, or the problems of others, and this was a sign of a maturity amongst the community. And same can be said of the community meeting. In those first meetings there was a high level of participation even though it was almost always the same people who spoke, because many others did not know how to express themselves, or were ashamed, or were shy. There was a good level of participation in the community meeting as it was believed that it was the community meeting that determined the life of the hospital, [but] this is only partly correct because the community meeting should be seen as a form of dialogue, a conversation, that is, an examination of problems, an attempt to study them, and the resolution of problems that are within our reach, that is, within the internal reach of the community, in terms of asking for support to doctors, nurses. But when problems arose that the community was not able to resolve, that is, when the last word belonged either to the administrators or outside [the hospital], then the community felt that it was losing some of the power it believed it had.

Q: Was this misunderstanding initially generated regarding the powers of the meeting?

FURIO: In fact this phrase often recurred: "What are we doing here?" "Here we can never decide, we always argue and we never decide anything." This was a complaint that often occurred. Participation began to decline, people went to the community meeting because they believed that by going there their personal issues could also be resolved, in fact this was the question they first asked the doctors: "Send me home, when will they send me home?" Then they would address this openly in the meeting and the meeting would attempt to discuss this request, but it could not say:

"Well, go home!"[43] Therefore there was a notable effort at education and self-education, in order to understand what the limits and possibilities of power of that meeting were.

Q: Did this phase last a few years?

FURIO: I think it lasted for three years and it still continues in some respects.

Q: We'll talk about this later, so, according to you, the meetings also served to self-educate people, and in some way to provide a type of culture, that is, to give someone the opportunity to learn to express themselves, to use a certain kind of language ... ?

FURIO: More than the educational factor, I believe it encouraged people to converse, beyond any learning.

Q: But is there an educational aspect?

FURIO: Yes, a very slight one, but it is there. I have heard many people express themselves in a different way than they once did.

Q: Did the fact that you immediately created a library, newspaper, etc. also contribute to this?

FURIO: This undoubtedly had its importance.

Q: Is it at this stage that you became the leader of this editorial group, of *Il Picchio,* as was reported to me?

FURIO: This is not quite correct, even if today it might appear that way. It's not that I'm trying to show off and be a leader, but this happened because I was encouraged by everyone and in particular by the director [Basaglia], who told me: "Both for your own good, Furio, and for the good of everyone else, you have some abilities, you need to use them in a practical way, you need to become an active person within the community." Naturally I felt that it was necessary to have someone to lead, in part. And my role was a bit like a buffer between the nursing staff and the patients, it was a role where I tried to mediate and play down things that had a way of becoming important, for example a patient

43 Given the legal restrictions at the time. Reforms in 1968 and 1978 would change this situation considerably.

who was treated by the nurse in an abrupt manner, he automatically turned to me and said: "Look, Furio, that nurse is so-and-so." I couldn't go and tackle that nurse head on, that was obvious, but I spoke up in the department meetings and asked, "don't use these methods, because they irritate certain people."

Q: And in any case *Il Picchio* also emerged from this phase.

FURIO: *Il Picchio* began to appear as early as August 1962, in order to stimulate an acceleration of the liberalization phase and also to make the newspaper team responsible, to form a leading group. Practically the leading group arose from the newspaper, but no matter how much effort I made and how much I spoke up and how much collaboration was sought, the collaboration of the patients was not extensive and the newspaper rested almost entirely on my shoulders and many people had a tendency to identify *Il Picchio* with Furio. In fact they almost made a pair, when they said Furio they meant *Il Picchio.*

Q: This is a confusion that can happen.

FURIO: In fact, I was trying to remedy this identification.

Q: As a personal experience, was this act of being so active within the community good for you, did it do you any good?

FURIO: It undoubtedly helped me, because, I must say, in the past I had had a very tormented existence both in terms of myself and others. The decision to end it all had matured within me, and I no longer expected anything from life, I had wasted my life, I was burned out, I had wasted my life, "come on," I said, "what is the point of it all?" In fact, I was hospitalized after a suicide attempt which I then repeated in the hospital itself.

Q: And did these things that happened afterward help you?

FURIO: They did, at least that thought [of suicide] wasn't as insistent as it was before. I saw that there was still a purpose [to life]. Before I had a somewhat empty head from the apathy that had taken over me, I was apathetic toward everything, this issue, the feeling that if I did something I

could still be useful to others, it helped me enormously even if I had to be constantly stimulated to overcome my apathy; but the fact that at that moment I came to understand that I could be useful to others, obviously if it did not definitively remove that idea [of suicide] which was a strong one, it greatly attenuated it.

Q: And I imagine that the same process happened differently, and in different ways for many others.

FURIO: For everyone else, I would say, also because it seems to me that for many, for certain people, they have problems similar to mine. There were people who had to go to the closed ward and had fled, attempted to escape, and then tried again. When the ward was opened these attempts ceased and I think that those people also thought in the same way as me: "if I do this, this can be a negative thing, not only for me but also for the others." And these people also no longer needed to escape, due to the fact that escaping from an open place makes no sense.

Q: Thus now we have reached a stage where, six years later, practically all the men's wards are open, last July there was the opening of C and soon the opening of the last closed female department will happen, so essentially, we can say we have reached a completely open hospital phase. I think I can detect a notable level of discussion between patients and healthcare workers, etc. You who see this from the inside and know the situation so well, what does it seem like to you?

FURIO: Yes, undoubtedly there is a level of debate even if on the one hand there is always a certain hidden respect for the doctors: "Well, we have to respect them!" In fact people very often uses a very illuminating phrase, "the superiors," that is, when we talk about doctors, nurses, nuns, and the bursar, etc., we say "the superior," that is, the person who commands, the person to whom I must obey, to whom I am subjected. We are certainly subject to them, because a patient cannot do what they want, just as no one can do what they want, not even in the outside world. But here we

try to remove this fear. In my opinion, there is a difference between saying, "don't do this because you go against certain rules of cohabitation, of life in the community," and instead telling people not to do things because of the fear of their superiors. Many still say, "I wouldn't do this so as not to offend the director." It is a concept based on dependence, which I have tried to change. Look, you don't have to do it only to avoid doing the director an injustice as a director, but also because he is a person who belongs to our community.

Q: There is one thing that can be said, that is, in short, many here say this: "Here I am no longer afraid, I am fine." "I am defended, I am sufficiently free, I feel that I have a function, etc., and therefore I can defend myself from the outside by staying inside."

FURIO: Yes, this is in fact a reality, but there is also the other reality, that there is always a desire to leave the hospital, at least amongst a good majority. There will always be a small minority who practically have allowed themselves to be overcome by a kind of resignation; in short, they are resigned to spending the rest of their lives here. In the end, I can also understand this stance, especially for people who have been here for twenty–twenty-five years, and whom society, represented by relatives and in particular by people who are close to them, has forgotten. I believe that someone has reached such a state of resignation when they say, "I'm happy to stay here, it's fine." But I believe that when questioned more closely, their desire to leave was still there.

Q: If the aim of the community is to heal the patients and help them to return to their lives outside the hospital, is there a danger of the community closing in on itself and ending up defending behavior that shouldn't be defended?

FURIO: I think that many people have now reached this kind of resigned state; but I believe that if society reaches out to these people, the aspiration to leave will return to them. Now we are in a phase of intervention from the outside toward the inside, that is, we have obtained internal

freedoms. Now it is necessary that we gain external freedoms and open to the outside world.

Q: External opening up, that is, acceptance of the mentally ill person on the outside. In your opinion, from your experience, is the stance of the outside world toward the mentally ill still a harsh one?

FURIO: Yes, without doubt, prejudices regarding mental illness and the mentally ill are very widespread and very deep-rooted. Many times I challenge certain family members who use specific phrases like this: "I can't take him [the patient] home because I'm scared." And I make this objection: look, in my opinion his fear has no reason to exist, as that person is not dangerous at all; they are not dangerous, because they don't do anything dangerous, I don't think that raising your voice every now and then is dangerous, everyone has done this. I think that people have settled into a comfortable situation and are assuaging their consciences by saying, "I'm scared, it's dangerous, I can't take it," it is easier this way, me on one side and you on the other, so the problem is not one that is faced. Instead, we saw that when this problem was addressed, people who had spent ten, fifteen, twenty years in hospital were discharged, and it was possible to discharge them when it was possible to open up to the outside world. These issues were then brought back into the family, outside the hospital.

Q: And in this way have many people been dismissed from the hospital?

FURIO: They say, "it's good here," etc., but in my opinion, I repeat, they say this because they are resigned to things, and this is a resignation due to the habit of being abandoned by the outside world for so many years, because the outside world does nothing for us, practically, because we also see people who were here. For example, earlier you mentioned Mila who worked for a long time at the bar and has now resigned. This person with whom I spoke before, we were very good friends, even for work reasons. She was an active person, a collaborative person, I asked her, "are you

leaving?" And she said, "eh, yes, if the outside world doesn't come to me, if I don't solve my problem externally, I have no other possibilities." When it was possible to address the problem externally (because the problem no longer existed in the hospital, as the patient was cured and demonstrated this through the activities she carried out), it was possible to resolve things and discharge her, that is, at first this person was resigned, but she was resigned to things because she was distanced from the outside world, when she saw that the outside world was willing to accept her, this person regained her desire to leave.

Q: So, once the liberalization phase has been overcome and the therapeutic community phase has begun, the problem of the therapeutic community becomes one which is entirely external? Is the therapeutic community a transitory phase?

FURIO: Yes, it is a transitory phase. It will clearly have positive aspects as regards the treatment of disease: we see that patients no longer have the social breakdowns that they previously experienced in a traditional hospital. Today a patient entering here is not isolated, they always have the possibility of relationships with other people, with their peers, that is, there is not that clear break that there was before. Then at that point the breakthrough depends a lot on the outside.

Q: Therefore, society has been proven wrong in its sense of a patient as "dangerous to himself and to others"[44] when the acts carried out by the community prove that it is able for people to get better, and this demonstrates that the patient is not dangerous.

FURIO: I think this could happen, but I can't see a patient discharged from our hospital committing an act of violence without a justifiable reason. And in fact, we discussed an incident of violence by a former patient from another city. I expressed an opinion and then I also found other people,

44 Another reference to the terms used in the 1904 law with regards to internment inside asylums.

both nurses and patients, who shared my opinion: if that patient had first been admitted to this hospital, this event had occurred, and a patient had been called to the scene, or a doctor, or a nurse from this hospital, whom they knew well, this would not have happened. We are referring to a recent news story, which demonstrated that the traditional methods used by the psychiatric hospital can kill a police sergeant.[45] Moreover, journalistic reports revealed many truths. There was a phrase that personally struck: the wife phoned the police station saying, "my husband is in a state of agitation." They said, "we cannot intervene just because she is afraid, the person must move on to concrete threats." Then afterwards she called again: "he threatened me with the gun, he is armed and threatened me." Then they sent that sergeant who was killed. It seemed that as soon as this sergeant arrived, the other one shot his gun, but that's not true. This sergeant went to the landing, with the patient's wife and daughter, and entered, spoke to the patient, then managed to leave the door open, and said to the lady, "he's calm now, but we'll take him away with us in any case." He said something like, "we'll take him away with us anyway."

Q: Therefore did this exasperate him?

FURIO: It exasperated him. We thought that if in place of that sergeant there had been a nurse or another patient, or a doctor who had met with the patient during his hospitalization, this event, in my opinion, would not have happened.

Q: Of course, because the level of violence it contained would not have been exasperated, who knows, for family reasons.

FURIO: I don't believe that a policeman has the qualifications, manners, and preparation necessary to deal with a sick person.

Q: But the content of that sentence also comes into play, assuming it was pronounced like that, it certainly would

45 This clearly refers to a contemporary case. I have not been able to identify the incident discussed here.

have been pronounced approximately like that, because there is the idea that the sick person is a thing.

FURIO: In fact, "we're taking him away with us." As if he were a piece of furniture.

Q: Overall, in general, we see an image of the sick person as a violent person, as a person who goes into a rage. In fact, those who come here for the first time, and this was true of myself the first time I came here, the first question people ask is, "but where are the sick people?"

FURIO: There are some sick people who can be defined as nuisances, but I don't see any sick people who are dangerous in here. They could be defined as a nuisance, when they always repeat the same thing, when they beg for a coffee or a cigarette, but I don't think this is true. This is not the same as being dangerous.

Q: Do you attribute this state of absolute nonviolence to the action of the drugs and the action of the community?

FURIO: In my opinion, this nonviolence is approximately eighty percent down to social relationships. Drugs are effective in terms of the general therapy of the patient, but social relationships affect the patient's behavior by a good eighty percent.

Q: No longer feeling like a thing, feeling like a person, being asked to take on these responsibilities, is all this almost essential in terms of progress?

FURIO: Yes, we see that there is a kind of regression when this is done not with conviction, not with sincerity, but with an alarming form of paternalism which at times is offensive. We don't realize it, but many times you can't treat an adult in a paternalistic way like you would treat a child who throws a tantrum.

Q: Do you fear this will happen sometimes?

FURIO: Yes, it certainly happens.

Q: That is, in a certain sense there is this way of approaching the patient paternalistically: "well, poor guy, come here and let's talk."

FURIO: Yes, this sense of pity. Many times I think that deep down we are hurt when we are treated with pity, if there is a sense of pity it means that I am inferior. Many people who are not attuned to this problem think that to benefit the patient it is enough to treat them with paternalism, which in my opinion is not the case.

Q: When do you think this happens?

FURIO: It occurs in cases where the patient for one reason or another takes on an attitude of protest, becomes irritated and says, "but, why?, etc." And then they are told, "you know, I did it for you, but I ask you for forgiveness." If there is an unfair thing that has been done to a sick person, it needs to be discussed, and we should not fall back on phrases like, "you're right, sorry, I made a mistake, I shouldn't have said that." There must be a level playing field, because otherwise the patient undoubtedly suffers, perhaps they don't realize this. Often it is nice to be pitied, but it is often irritating.

Q: Therefore there is a need for external education, in this sense.

FURIO: Education above all, because perhaps understanding can be achieved through mutual understanding, but this is an understanding linked to words, not made concrete by action.

Q: Probably the current development of society in terms of culture etc. also leads to certain forms of understanding that are of a humanitarian nature. For example, as in a phrase like, "well, poor people, lets help them live better, let them have a cinema."

FURIO: At least as far as I'm concerned I always try to argue that forms of entertainment have this meaning, of being able to be together with others. In my opinion it's not about going to see a film or going to a dance, or seeing others dance or dancing, but about being together, because going to a dance doesn't end with dancing, but in dancing-type relationships between people, and between relatives and

patients, groups are formed, discussions are held, and this is what in my opinion is useful.

Q: Has the potential for discussion expressed by the community increased in recent years, that is, are debates, discussions, interventions more frequent?

FURIO: Yes, but in my opinion not by much. I always like to keep in mind the point of view that the sick people who come to these places are from the lowest classes of society and that due to the disease itself they have almost never been able to have, so to speak, a hint of education. Many people have not even attended school, and this matters, not because they have not attended school and do not know how to read or write — they may have learned to read and write — but I believe that school teaches a child to live in society practically as well as to giving them the knowledge they need. Not having lived in groups during childhood, not having formed groups, these people are a bit apathetic toward social relationships, and the way of life [inside the hospital] instead stimulates this social relationship.

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

FURIO: Yes, it is really a hospital for poor people. A person who has means does not come to this hospital; they are treated privately and go to the so-called nursing homes. In part I think perhaps unconsciously people here feel like they are in a minority, and have not received an education, but only in certain cases.

Q: I think we have analyzed this problem fairly well.

FURIO: Yes, I have my personal opinions. I see my experience like this, the continuous relationships that I have with our friends are relationships that I sometimes feel are a little distorted by the fact that I am considered a person in possession of abilities superior to theirs, for example, they say, "let Furio do certain things, let him do it, he is the one who is capable."

Q: Because you have now taken on a function.

FURIO: Yes, I have taken on a role that in my opinion is incompatible with the community, and many times I withdraw consciously from this role.

Q: Because it seems, talking frankly between us, that you see your position as somewhat contradictory, that is, either you are part of the community because you are a leader, because you are a therapist, or because you are someone who does certain things, or you are part of the community because you are a patient. Now you are not really a patient, and you are not a therapist, and thus your situation this is a bit ambiguous.

FURIO: Yes, this situation of mine makes me uncomfortable, continually uncomfortable.

Q: But if they gave you a specific role, would you accept it?

FURIO: Well, if it was a precise role, I would be a little afraid of having some sort of official recognition. For example: Furio is no longer hospitalized and has been given this role. Look, I believe this is impossible, I couldn't accept it as I would feel that my place would always be on the other side.

Q: Because you think that in this sense the community would not. . . .

FURIO: I saw the case of a nurse from Udine who came to me to ask for advice on sociotherapy, because for him he saw me as a sociotherapist, and this nurse confessed this to me very openly. He said: "I feel uncomfortable, because many times I have to take a stand against the management in favor of the patient and often I cannot do so because I am an employee."

Q: This would lead to a contradiction.

FURIO: I also told him this: "I too am aware of this issue because sociotherapy is not only for the sick, but it is necessary on many occasions for the staff as well."

Q: You used an important phrase, which is not a slip of the tongue, that is, you said, "the other side."

FURIO: Yes, on the other side.

Q: Therefore, in your opinion, we have not reached a point of equality, there is one side and there is the other side.

FURIO: This is felt on both sides. A patient feels that the nurse and the doctor are different from them. On the other hand, the nurse and the doctor, even if they good-naturedly try to show that it is not true, sometimes automatically highlight this separation: "I am the nurse, and you are the patient."

Q: And in what way do you think the medical team here failed to overcome this situation?

FURIO: The medical team makes every effort to overcome this but, as I repeat, many decisions cannot be made communally. There are those that can be taken are taken communally, and others that must be taken by the medical team. This naturally validates the diffidence of a patient who says, "even if I have shown you this solution, in the end who decides?" If you participate in our affairs you will have seen that we often find ourselves at an impasse, with great difficulty in making a decision. Now let's say this is the case for the women's C ward, which was the men's C ward. We asked for it to be opened up because we wanted the people in this ward to be like us, that is, for their ward to be opened up. But this was not a decision that we could make, it was a decision that had to be made by the medical management, who had to sort out the problems of the closed ward, and to allow the patients of that ward the same rights as the others. And now, when we talk about the women's ward still being closed, we say, "director, please open it."

Q: But the rest of you, having looked at things, believed that the decision to open up could be made.

FURIO: To our request to open up, the medical management was obliged to respond by saying, "look, there are such and such problems."

Q: And then you say that this decision-making power which is only in the hands of the medical management creates two sides?

FURIO: Yes, it creates two sides. Undoubtedly, many times it makes the patient feel that they are part of the community, but that they are not a part of a community that can determine the life of the community. The community

becomes convinced that it is not possible to do a certain thing for certain reasons, and at the same time it feels a little powerless. So that when a new problem arises, and the participation of the community is requested, naturally people do not participate.

Q: There is some kind of crisis.

FURIO: We must never forget that for the patient, both the doctor and the nurses are always considered as privileged people because once their shift and their work are over they can leave, go home, enter the outside world, because almost always this is the context, and it comes to the surface. This person is here for practically eight hours and then they leave. There is this difference in situation that creates this sense of inferiority.

Q: But isn't the patient aware that they must stay here for a certain period in order to be treated?

FURIO: Yes, but since we have long-term patients who have been living here for several years. This period is already so long in itself, and it becomes even longer if it is also considered as stretching into the future. Many people are aware of this.

Q: And so the possibility of a crisis and some misunderstandings between patients, staff, and healthcare workers on both sides remains. The crisis is always determined from the outside, that is, when the health workers are unable to return to the outside world a long-term patient who has recovered, who is in here and who would like to leave.

FURIO: This is a fact, and it is disputed. Doctors and nurses are external to the sick population. They are people from outside, and this shortcoming is felt by many, and I believe that doctors feel it too. This is the real difficulty in terms of raising awareness in the outside world toward the problems of the mentally ill.

This series of interviews and the facts that connect them would not be complete without adding another testimony that allows

the reader to compare two situations: that of the Scottish[46] therapeutic community of Maxwell Jones and that of Gorizia.

Q: You have been to Dingleton. Can you make a comparison between the two communities.

ONGARO:[47] Compared to Gorizia, in the Scottish situation we can see, in my opinion, less friction between the microsociety of the hospital and external society. This may depend on various factors: a greater Scottish openness toward innovations of a technical–scientific nature and therefore higher levels of tolerance in the external environment; the less political character of the Scottish experience, also in terms of the fight against the hierarchization and structure of roles, which is limited to the institutional reality there. What differentiates, in this case, the experience of Gorizia is the overall crisis — via an institutional crisis — in terms of the structures upon which a coercive and oppressive reality such as the asylum can be preserved. However, a point of identity between the two communities could be identified in the impasse currently common to both, that is, the danger of an involution that limits the original "protest" to a level of technical perfectionism that negates its main significance. This can be felt in Dingleton, where the hospital has been open since 1949, before the establishment of the therapeutic community by Maxwell Jones. The degree of stabilization of the hospital structure is such as to be able to lay out all the possible alternatives for the patient, within the institution,

46 Here I have corrected the used of "England" in the original.

47 In the Italian edition referred to as Franca Basaglia. She did not change her name when the two were married in 1953, as is customary in Italy. However, the editor in this case may have chosen to indicate her name as Basaglia in order to emphasize her link to Franco Basaglia (she had no psychiatric or medical training) — or it may have been her own choice. Her name is often reported in different ways in various publications. For Ongaro see Foot, *The Man Who Closed the Asylums,* and Annacarla Valeriano, *Contro tutti i muri: La vita e il pensiero di Franca Ongaro Basaglia* (Donzelli, 2022).

but in a way that denies any spontaneity and mitigate any internal contradiction. The usefulness of this comparison can also be seen through a danger that also affects Gorizia: that, once the moment of institutional negation has passed (with the opening of all wards, etc.), it struggles to have an impact on the outside world and is reduced to forms of internal perfectionism that are sterile and devoid of a cutting edge.

Q: Are the British aware of this?

ONGARO: I would say that they do not seem to be aiming to impact external structures through anti-institutional practice. Their proposals and attempts at change (e.g., sectoral reforms[48]) remain within the limits of a kind of attempt to create forms of psychiatric care that tend at most to propose an "ideological solution" for social conflicts. In this sense, what for Gorizia would be seen as a failure (the recognition that the political scope of an action would need to be reduced, and the sense of limiting this practice to the institution) in Dingleton is simply a reality created by forms of practice. Ultimately it is the objective that is different.

Q: In short, is the therapeutic community in the UK more static than the Italian one?

ONGARO: Overall yes, because Gorizia is still in a phase of negation and Dingleton could be a symbol of its future, once this phase is overcome. Gorizia's problem will now be to see to what extent its action of negation can be directed outward, given that the objective — this time — is the social structure itself and no longer a particular institution.

Q: To summarize, what are the differences?

ONGARO: On the one hand the political nature of the Gorizia activities, and on the other the greater didactic–therapeutic commitment at a staff level in Dingleton which, however, falls within the sphere of specific institutional interests.

48 A reference to a type of reform which used spatial and geographical features in order to divide up and decentralize the asylum system.

This intervention, which focuses on the relationships between community and society in two different countries and in different political, economic, and social situations, concludes this section on the therapeutic community of the Psychiatric Hospital of Gorizia. From reading the testimonies I hope it is clear that they have not been altered in any way and that, even at the risk of sometimes being incomprehensible, they are transcribed faithfully. Someone listening to the tape recorder or rereading the interviews has already asked me if the sick people interviewed are already better or are among the least sick. In this sense, having been absolutely free to choose, I did not make any discrimination in my choice. Andrea, Margherita, and Carla are long-term patients, that is, they have been hospitalized for many years, literally abandoned by their families. They no longer have anyone in the world to turn to and society has no interest in welcoming them.

It must also be said that a large part of the patients, and I am not talking about those who have physical ailments, have followed an adventurous and sometimes unlikely "career." From the investigations carried out by the *équipe,* it appears that some elderly people, for whom it was possible to trace the remote origins of hospitalization, entered the hospital with mild illnesses, which gradually worsened due to subsequent treatment inside institutions. The continuation of segregation right up to a definitive moment almost always depends on the attitude of families who have not been able to accept the presence of an inactive and boring or annoying relative within their home.

Many others are the result of the war, like Carla, for example, who arrived at the hospital after time in a Nazi concentration camp. It matters little whether Carla was Princess Mafalda's companion or not, perhaps she attributes this bond with the unfortunate daughter of the king to pathetically ennoble her pain, as if the accumulation of her personal hardships were not enough. What is certain is that she has tattooed numbers on her forearm which remove any doubts about her career as an

outcast.[49] In interviews as in all meetings, the attention of those present and participation is determined by the topic discussed. If it interests most participants, the meeting becomes lively; if a passionate topic does not emerge, the discussion drags on like anywhere else, in a feeble manner and without participation. However, it is rare that there is not at least a moment of interest since the patients have understood that their opinion is listened to, requested and equal to that of others.

I deliberately use the phrase "the others" because, as Furio explains in his interview, despite everyone's efforts, class and status divisions exist in the community, as they do in reality. In fact, the mentally ill understand what their exclusion entails when after a day of community life and community commitment they must remain in the hospital while the others are free to leave. This is one of the reasons for the crisis. The other critical phase, in my opinion, can be seen when a patient declares that they can live only if protected by the microsociety of the liberalized hospital, that is, when they voluntarily close themselves inside the citadel where a movement of facts and ideas has developed, and was intended to make this patient free, responsible and no longer the subject of "public scandal."[50]

49 Nardini had a number tattooed on her arm, an indication she had been in Auschwitz.

50 Another reference to the wording of the 1904 law.

The Institutions of Violence

Franco Basaglia

In psychiatric hospitals, patients are often crowded together in large rooms from which they are not allowed to leave, even to use the toilet. If they have to relieve themselves, the nurse on duty rings for another nurse, who comes to accompany the patient. This ritual usually takes so long that patients end up soiling themselves on the spot. This natural response to inhuman regulation is interpreted by the hospital staff as the patient "acting out" in spite toward them, or as "incontinence," a symptom of regression due to their illness.

In a psychiatric hospital, two people lie without moving on the same bed. Under the pressures of overcrowding, the hospital staff takes advantage of the fact that catatonic patients will not bother each other and assigns two to a bed.

In a junior school an art teacher rips up a child's drawing of a swan with paws, telling the child that she only likes "swans on water."

In a nursery school, the children are forced to sit silently while the teacher works at her knitting. She threatens them that if they move or talk to each other or do anything that will disturb her work, they will have to spend the rest of the day with their arms — painfully — raised in the air.

A patient being treated in a public hospital ward, if they have not paid for a private room, is at the mercy of the doctor and his

moods and may be subject to outbursts of anger that have nothing do to with them.

In a psychiatric hospital an "overexcited" patient is given the "mask," a common method of knocking a patient out by suffocation.[1] This is something which is only known about by those who have seen the asylum system. It is a primitive technique which is used everywhere. A damp cloth or towel is thrown over the patient's head so they cannot breathe and then tightened around their neck until they lose consciousness.

Parents often work out their frustration by constant violence against their own children, especially if they do not measure up to their competitive aspirations. If a son or daughter is not better than someone else's, this *difference* is experienced as a failure. A child may be punished for poor grades as if physical punishment could resolve the school problems.

In the psychiatric hospital where I work, some years ago an ingenious system was developed by nurses on the night shift to make sure that a patient would wake them every half-hour so they could punch their timecard, which was a hospital regulation. The method consisted of having a patient (who had to remain awake) sort out strands of cigarette tobacco which had been mixed together with breadcrumbs. The task was designed to take approximately half an hour, after which the patient roused the nurse and won the tobacco as a prize. The nurse punched her timecard, indicating she was awake, and then she could resume her nap, giving the same, alienating task to another human clock.

The following was published in *Il Giorno*[2] some time ago:

> An end to gloom! San Vittore prison will finally lose its dark, dismal appearance. Several painters have been working for days and one wing which looks out over Viale Papiniano has been painted a bright uplifting yellow. When the whole job is finished, San Vittore will have a more dignified demeanor,

1 Similar to what we would now call *waterboarding*.

2 An Italian daily newspaper published in Milan.

lighter and less distressing than in the past. As for inside the prison? The cells will still be dark, but in the meantime, the bright yellow exterior walls will "lift our hearts."

The examples could go on *ad infinitum,* touching every institution around which we organize our society. The common thread in all these situations *is violence carried out by those who hold the weapons, against those who are hopelessly dominated.* Family, school, factory, hospital — all are institutions based on the rigid division of roles, the division of labor: slave and boss, teacher and student, employer and worker, doctor and patient, organizer and the organized. The main characteristic of these institutions is the clear division between those with power and those who do not have it. The division of roles involves a *relationship of abuse and violence between the powerful and the powerless, which turns into an exclusion of the powerless from power.* Violence and exclusion underpin all social relations in our society.

The ways in which this violence is managed varies depending on the need of those in power to hide and conceal it. This has led to the creation of institutions ranging from the family and schools to prisons and asylums. Violence and exclusion are justified as necessary, for example as the consequence of legitimate educational goals (the family and schools) or as a result of "guilt" or "illness" (prisons and asylums). These institutions can be defined as *institutions of violence.*

This is the recent and ongoing history of a society organized around the clear division between the haves and the have-nots, which leads to deceptive dichotomies between the good and the bad, the heathy and the sick, and the respectable and the disreputable. The situation is quite transparent: paternal authority is oppressive and arbitrary; schools are based on threats and blackmail; the employer exploits the worker; asylums destroy mental patients.

However, our so-called affluent society has now realized that open displays of violence can create internal contradictions that could damage it. Advanced capitalist society has found a new system in the delegation of power to technicians, who adminis-

ter that power in its name and who contribute, through different forms of technical violence, to the creation of a series of new excluded groups.

The task of these middlemen is to mystify violence through techniques, without altering its real nature. They ensure that those subjected to violence will adjust to it and not develop an understanding that might allow them to turn that violence against their dominators. Their task is to discover new forms of deviance that have up to now been considered normal, and thus to expand the grounds for exclusion.

The new social psychiatrist, psychotherapist, social worker, industrial psychologist, and industrial sociologist, to name but a few, are little more than new administrators of violence on behalf of the powerful. By easing friction, by decreasing resistance, and by resolving the conflicts caused by the institutions they represent, the new technicians and their supposedly healing, benevolent, and nonviolent activities, actually allow global violence to continue. Their task, which is defined *as therapeutic guidance,* is to adapt individuals to an acceptance of their condition as the "objects of violence." Adaptations may vary but violence remains the only reality that is allowed.

Nothing has changed. Technicians promote consensus regarding the social inferiority of the excluded, just as, in a less subtle way, they created definitions of biological diversity that sanctioned the moral and social inferiority of those who were different. Both systems try to reduce the conflict between the excluder and the excluded by marshaling scientific evidence of the basic inferiority of the *excluded*. Therapy, in this context, is a revised, updated version of previous scientific distinctions which created the "norm," with sanctions for those who transgressed.

The only possibility for the psychiatrist is to reject any false solutions and to increase awareness of the situation in which both the excluders and the excluded coexist. The therapist's ambiguous position will continue until we realize what kind of game we are being asked to play. If therapy consists in preventing the patient from becoming conscious of their status as excluded and moving from a narrow sphere of persecution by

family, friends, and hospital to a more global level, where they become aware their status as excluded within a society in which they are superfluous, the only response possible is to reject the *therapeutic* act whenever it acts to play down the reaction of the *excluded* toward those that exclude them. To do this, we ourselves — the contractors of power and violence — must begin to understand that in the very moment that we are objectified by our role, we too are excluded.

Whenever we compete for power — in exams in order to become a professor, a chief physician, or to acquire a well-paying private set of patients — we give ourselves up to the *establishment* that wants us to fulfill our duties, without deviating from the norm. It wants us to guarantee our support and our skill in order to defend and protect *it*. By accepting our social mandate, we guarantee that a therapeutic act is an act of violence against those excluded from power. They are entrusted to us so that we can scientifically control their reactions toward the powerful. If we work inside of a violent institution, we must reject this social mandate and translate the rejection into practical activity in a dialectical way. We have to *disavow the therapeutic act as an act of concealed violence and combine our own consciousness of being mediators of violence with the understanding that we need to stimulate those in our care who are excluded.* We must not contribute in any way to their adaptation to their exclusion from society.

A system's negation is due to an *overturning,* an act which throws into crisis a specific field in which we work. This is the case with the present crisis of the psychiatric system, as an institutional and scientific system, which has been *overturned* and called into question by a growing understanding of the specific field, psychiatry, in which we operate. The encounter with institutional reality reveals a sharp contrast with technical and scientific theories and is connected to processes which have little to do with illnesses and their treatment. This necessarily brings about a crisis in scientific theories of mental illness, as well as in the institutions based on these theories, forcing us to try to

understand "external processes" rooted in the social, political, and economic system.

The incorporation of the mental patient into the body of medical knowledge has been a slow and laborious process for science. In the medical field, the meeting point between the doctor and the patient is the patient's body, which is considered to be an object of medical investigation. But when the discourse is shifted to the level of psychiatric encounter, the result is neither simple nor without consequences. The meeting point between the psychiatrist and the mental patient remains the patient's body, but here it is a body that is *presumed* to be ill and that is objectified *a priori,* in order to determine what approach to take. In this case, the patient will be assigned an objective role which becomes the basis for the institution that will protect them. This type of objectifying approach ends up influencing the patient's idea of themselves, so that they can only experience themselves as an ill person, exactly as they are viewed by psychiatrists and by the institutions treating them.

On the one hand, *science* has told us that mental illness is caused by an ill-defined biological issue, in the face of which we must passively accept deviations from the norm. Psychiatric institutions became exclusively custodial as the direct expression of the impotence of a discipline which, when confronted with mental illness, could only define, categorize, and manage it. On the other hand, psychodynamic theories that have attempted to find meaning in symptoms through investigations into the unconscious have also objectified the patient in a different way, not as a *body* but as a *person*. In similar fashion, phenomenological thought, notwithstanding its desperate search for human subjectivity, failed to rescue people from processes of objectification which are *forced* upon them; human beings and their objectivization are still considered as facts which cannot be changed, but only *understood*.

These, then, are the scientific interpretations of the problem of mental illness. What actually happened to the mentally ill, however, can only be understood from within our asylums, where neither analyses of oedipal complexes, nor theories about

our being-in-the-world have saved patients from lethal passivity and alienation. If these "techniques" had really been integrated into the hospital organization, if they had been confronted and challenged by the reality as experienced by mental patients, they would have been forced to expand and penetrate every aspect of institutional life. This would have necessarily threatened the coercive authoritarian structure and hierarchy on which the psychiatric institution is based. But these approaches and their subversive potentials are contained within a system of psychopathology, which instead of questioning the fact that patients are objectified, continues merely to analyze various forms of their objectification. They are thus contained in a system that sees its own contradictions as inescapable facts. The only possibility [historically] would have been to superimpose individual and group therapy on biomedical and pharmacological treatments, but the effect of this would have been negated by the custodial environment of traditional hospitals or the paternalistic nature of the more humanistically oriented hospitals. Since psychiatric institutions are impervious to any intervention that goes beyond a custodial approach, a real therapeutic relationship is only possible for a noninstitutionalized mental patient. In their relationship with the psychiatrist, voluntary community patients retain a margin of freedom related to their contractual power. Here, however, the integrating and accommodating character of the therapeutic act is obvious insofar as it sees a reshaping of structures and roles that are in crisis but which were not destroyed by a spell in an asylum.

The possibility of a therapeutic approach to mental illness is closely related to the larger social system, where each relationship is determined by economic laws. *It is not medical ideology which establishes any kind of [therapeutic] approach, but rather the socioeconomic system.* If we examine it closely, mental illness means concretely different things, depending on the social standing of the sick person. This does not mean to imply that mental illness does not exist, but it points to an important fact about mental patients in psychiatric institutions: the consequences of mental illness change according to the treatment the

patients receive. These consequences, the level of institutionalization and destruction of the patient in state asylums, are not the direct result of the disease, but rather of the type of relationship the psychiatrist and society establish with the patient. These include:

1. An *aristocratic* type of relationship, in which the patient has a contractual power to counter the doctor's technical power. Here the relationship is reciprocal only in terms of the roles: a medica*l role,* kept alive by the myth of technical power; and the private patient's *social role,* which constitutes his only guarantee of control over the therapeutic act of which he is an object. The free "client"-type patient imagines the doctor as a repository of technomedical power while the doctor imagines the patient as a source of economic power. Since this is an encounter between different forms of *power,* more than between persons, the patient does not necessarily succumb passively to the power of the doctor, as long as he maintains a real economic value. But when that value is diminished and their contractual power vanishes, they then begins the true "career of the mental patient" as a person whose social position has neither influence nor value.
2. A social security or *health insurance type of relationship,* in which there is a reduction in the psychiatrist's technical power but an increase in his arbitrary power in the face of someone whose care is paid for by the state but doesn't realize what negotiating power they have. In such encounters the patient is not always aware of their rights or their actual position in the relationship. Here, reciprocity only exists insofar as the patient can demonstrate considerable maturity and social, especially class, consciousness. The doctor, meanwhile, retains an ability to determine the nature of the relationship, reserving for themselves the possibility of calling forth their *technical power* any time they feel their arbitrary power to be under challenge.
3. An *institutional* relationship, in which the doctor–patient relationship is imbalanced and the institutionalized patient

> is in so vulnerable a position that the power of the psychiatrist is virtually unassailable. The patient is left with no choice but to submit to institutional rules and arrangements. He becomes a citizen without rights, entrusted to the whims of the doctors and nurses who may toy with him as they wish. In the institutional context there is no reciprocity, nor is its absence in any way concealed. It is in this encounter that we can see laid bare and without hypocrisy what psychiatric "science," as a projection of society, has in mind for the mental patient. The real issue is not mental illness but rather powerlessness. In the complete absence of any form of contractual power, the mental patient has no other way of resisting except through a display of "abnormal" behavior.

This sketch-like analysis of different ways of approaching and experiencing mental illness — and we can only know *which* aspect it presents in a *particular* context — shows that the problem is not the type, causes, and prognosis of illness itself, but rather *the form of relationship that is established with the patient.* The illness as a morbid entity plays a secondary role, even though it is the common denominator of the three situations described above. Uniformly in the last case, and often in the second, the stigma that becomes attached to the illness confirms the individual's loss of social value, which is something already implicit in how the illness has been experienced.

If, contrary to the appearances of our psychiatric hospitals, illness itself is not the determining element of the mental patient's condition, then we must examine the other factors which play such an important role.

Patients in psychiatric hospitals represent *the only category of patients whose stigma goes beyond the illness itself.* These patients are people without rights, subject to institutional power, at the mercy of the representatives of society, the doctors, distanced and excluded. We have already seen that the patient's exclusion or expulsion from society is closely tied to the lack of contractual power, to their social and economic condition, and not to the illness itself. On what basis, thanks to which technical, scientific,

clinical diagnosis was the patient admitted? Can we speak of an objective clinical diagnosis, tied to concrete scientific facts? Or isn't a diagnosis simply a label which hides, under the veil of a specialist's judgment, a more profound discrimination? A wealthy individual with psychotic symptoms treated in a private clinic will be diagnosed differently from a poor person with the same symptoms committed to a psychiatric hospital. The first patient will not automatically be labeled a mental patient who is "dangerous to themselves and to others and a public disgrace,"[3] nor will their treatment strip them of a sense of their history or forcibly separate them from their own reality. Private treatment need not interrupt the continuum of the patient's existence, nor does it reduce or irreversibly destroy their social role. Therefore once the crisis is over, the patient can be reintegrated into society. The destructive, institutionalizing power present at all levels of the asylum organization only affects those who have no choice *but* the asylum.

Can we continue to delude ourselves that the patients in psychiatric institutions include the mentally ill from all strata of society? Can we really claim that it is only the illness that reduces them to so miserable an objectified state? Would it not be fairer to argue that these patients are first of all the objects of a prior violence, the violence of a social system that pushes them out of productive life, onto the margins of society, and finally all the way to the hospital door? Are they not the waste, the disruptive elements, in a society unwilling to recognize its own contradictions? Are they not simply people starting off from a difficult position who have already lost before they have even begun? How can we continue to justify our exclusion of these people, and our definition of all their actions and reactions only in terms of an illness?

Diagnosis has become a labelling process that classifies the patient's *passivity* as irreversible. But perhaps this *passivity* is not only and always a sign of sickness. In considering the patient's passivity only in terms of their illness, psychiatry confirms the

3 This is a reference to the law on psychiatric hospitals from 1904.

need to separate and exclude them without recognizing that a diagnosis might be discriminatory. So the patient is excluded from the world of the sane, society is freed from the *critical* elements they represent, and society's concept of what is the norm is confirmed and validated. Given these conditions, the relationship between doctor and patient can only be objectified, since communication between them occurs through the filter of a definition and label which allows no possible appeal.

This approach can be changed by looking at an *overturned* reality in which the problem is no longer illness itself, but rather the *relationship* that is established with the illness. The doctor, the patient, and the society by which they are defined and judged are all involved in this relationship. *The objectification does not lie in the patient's objective condition, but in the relationship between the patient and the therapist, in the relationship between patients and a society which entrusts their care and protection to doctors.* A doctor requires objective definitions that permit them to assert their own control, just as society needs to discard some people and reward others in order to conceal and escape from its own contradictions. The rejection of the inhuman condition of mental patients, the rejection of their objectification, is closely connected to the current crisis of psychiatry and of the society that it represents. Psychiatry, science, and society have defended themselves from the mental patient and from the problem of their presence among us. When as psychiatrists we exercised our power over those who have already been violated by their families and in their workplaces, our defense inevitably turned into a crime without end, and we concealed the violence we used with the hypocritical mask of necessity and therapy.

What kind of relationship can we have with patients, now that we have identified what Erving Goffman defined as the "series of career contingencies"[4] that lie outside the illness? Does not the therapeutic relationship act as a *new form of violence,* as

4 Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Anchor Books, 1961).

a political relationship directed at integration, since the psychiatrist as a representative of society has a mandate to cure patients by *therapeutic acts* which merely help them to adjust to being "objects of violence"? Does psychiatry convey to the patient that this is the only choice they have?

If we passively accept our role, aren't we psychiatrists ourselves the objects of violence by a technical power which determines how we will act? This is why our present work must be a form of *negation,* an institutional and scientific overturning that leads to the rejection of the therapeutic act as a way of resolving social conflict. The first steps toward this reversal have been achieved by proposing a set of institutional reforms that have been defined as a therapeutic community, according to the British model.

The first experiences with a therapeutic community model date back to 1942 in England.[5] British pragmatism, free of the very ideological thought of German-influenced countries, moved away from the hardened view of the mental patient as incurable and pointed to *institutionalization* itself as the primary cause for the failure of psychiatric asylums to restore patients to health. Thomas Main's experiences, and later those of Maxwell Jones, were the beginning of what was to become a new from institutional community psychiatry, based largely on sociological assumptions.[6]

At the same time, in France, a large psychiatric movement, led by Francesc Tosquelles, was beginning. An anti-Franco exile since the Spanish Civil War, Tosquelles began his career as a nurse at the psychiatric ospital in St. Albans, a small town in

5 Italians often use "England" to mean the UK, or even Scotland. I have corrected these in some cases where they are clearly errors.

6 Thomas Main (1911–1990) was a psychiatrist and psychoanalyst who came up with the term "therapeutic community" and worked in the Irish UK system before and after 1945. Born, like Main, in South Africa, Maxwell Jones (1907–1990) was a key figure in therapeutic community theory and practice and an important influence on Basaglia.

France's Massif Centrale.[7] There he received his second medical degree and eventually became the head of the institute. Here as well, it was in a small hospital, and not in a psychiatric research institute or a study center, that a new language and a new kind of institutional psychiatry institution arose, *based on practice and necessity,* and with psychoanalytic premises.

These two examples, which had different theoretical origins, showed in practical terms how effectively they could overturn an ideology that understood mental illness as an abstract entity, clearly separated from the patients and their experiences in psychiatric institutions.

German-speaking countries, however, tied to a rigid Teutonic ideology, are still trying to resolve the problem of psychiatric asylums by building ever more perfect structures in which the custodial mentality still dominates. We need only cite the example of Gütersloh, Hermann Simon's hospital, now headed by Walter Winkler, devoted solely to technically perfecting Simon's ideology of ergotherapy.[8] Social psychiatry is now also fashionable in Germany, but there it does not include an understanding that psychiatric asylums have failed or that they violate and objectify patients. The German interest in social psychiatry is superficial and ephemeral, based on a perceived necessity to keep German psychiatry *abreast intellectually*. One unfortunate consequence is the construction of new institutions of social psychiatry, such as the one that will be built at Mainz, the new Brasília of German psychiatry, under Heinz Häfner's leadership.[9]

7 Francesc Tosquelles (1912–1994), a Catalan radical psychiatrist who practiced in France and was an important influence on Basaglia and, for example, Frantz Fanon.

8 References to psychiatrists Walter Winkler (1914–1984) and Hermann Simon (1867–1947). For Basaglia and German psychiatry, see Chantal Marazia, "'Visions of Another World': Franco Basaglia and German Reform," in *Basaglia's International Legacy: From Asylum to Community,* ed. Tom Burns and John Foot (Oxford University Press, 2020).

9 Presumably a reference to the German psychiatrist Heinz Häfner (1926–2022), but his name here is misspelled, as Marazia has pointed out.

In Italy as well, where mainstream psychiatry has been influenced by German thought, institutions have changed very slowly, lagging years behind England and France. Although there were precedents to refer to with the French experience of community mental health[10] (or "sectoral" reforms) and British therapeutic communities, we also felt an urgent need for contributions that would be relevant to our own social and cultural reality, and not just as adaptations of other models. Because of this, we chose the community therapy model only as a general reference point to help us to begin *negating* the reality of the asylum. Inevitably, this was preceded by the negation of any formal classification of mental illness, since those categories were considered ideological in terms of the patient's real condition. The British model provided a good reference point at the beginning until the asylum began to change and our work was necessarily transformed.

Later, the definition of our institution [at Gorizia] as a *therapeutic community* was confusing since it might be misunderstood as a model for the definitive resolution of a negation. If the therapeutic community model is absorbed and incorpo-

10 So-called sectoral reforms, which are mainly oriented and projected outward, have the advantage of soliciting more widespread and timely medical action. However, if this is not accompanied by the simultaneous destruction of the psychiatric hospital as a closed, forced, and institutionalizing space, these actions are undermined by the existence of the asylum, which continues to act as a threat from which the patient can only flee to save himself. The healing-type acts of an efficient mental hygiene service would certainly be able to prevent the admission to hospital of a large number of patients, thus avoiding the dangers of hospitalization, with the risks this entails in the current state of our psychiatric hospitals. But it cannot be denied that the principle of external psychiatric care remains within an institutionalizing logic around a fear of hospitalization: hospitalization will be the extreme step to which one will be forced if other means have not been able to resolve a case. Nor would the creation of structures such as the so-called "open wards" in psychiatric hospitals solve this problem, in the sense that it would underline the privilege of those fortunate patients admitted there with a mutual agreement, as opposed to the "closed wards" where the "regularly admitted" would continue to be admitted and labeled [note in original].

rated into the system, it loses its oppositional function. When we trace the steps in our transformation of the institution, what emerges is the need to continually question and to change our course of action, as each effort becomes part of the system and is in turn negated or destroyed.

Our therapeutic community arose as the denial of a situation that was proposed as a *fact* rather than a *product*. Our first contact with the asylum showed us what forces were really at play. The patient, rather than perceived as a sick person, was the object of institutional violence that acted on all levels, because any opposition was defined as a symptom of the illness. The degradation, objectification, and annihilation of the patient does not derive from the illness but is produced by the institution's destructiveness in its attempts to protect the sane from madness. But even if we strip patients of this superstructural and institutional overlay, they are still the object of society's violence. In addition to being a mental patient, they are entirely lacking in economic, social, or contractual power — a simple negative presence, reduced to being nonproblematic, noncontradictory, in order to mask the contradictions of our society.

In this situation, how can we treat illness as a *fact?* How can we recognize and locate illness, except as an *unknown* that we cannot yet define? Can we ignore the distance that separates us from the patient and blame it on the sickness itself? Mustn't we first remove all the layers of objectification to discover what lies beneath?

If the first step in this subversive activity is an emotional one, a refusal to see the patient as a nonperson, the second must be a realization of the political nature of this activity. Every approach to the patient continues to fluctuate between a passive acceptance or a rejection of the violence on which our social and political system is based. *A therapeutic act is a political one, aimed at integration. It tries to resolve an ongoing crisis by turning the negation that provoked the crisis into a form of acceptance.*

This is how our process of liberation began, faced with a violent and highly repressive reality, there was an attempt to *overturn the institution.* Going back over the gradual stages in this

process, we will here present a series of excerpts,[11] in chronological order, from our understandings of the work we were engaged in. Perhaps in this way it will then be easier to understand our work, which we refuse to see in terms of being a *model* for resolving conflicts, which might actually have been a way to preserve the system.

August 1964

In 1925, a manifesto signed by a group of French artists calling themselves "the surrealist revolution" was sent to the directors of *mental asylums.* It ended by saying: "Tomorrow, when the time comes to visit your patients and you try to communicate with them… remember that you have only one advantage over them: the use of force."

Forty years later, the situation has barely changed; most European countries are still ruled by the old ways of doing things that move uncertainly between welfare and safety, pity and fear. Coercive limits, bureaucracy, and authoritarianism still govern mental patients' lives — those same patients for whom Philippe Pinel had vociferously demanded the right of freedom.…[12] It seems psychiatrists have finally, today, rediscovered that the first step in curing the patient is to restore the *freedom* that had been stripped away. In the closed asylum, where the mental patient had been isolated for centuries, the need for a system of administration for the complex hospital organization meant that doctors were only required to guard, protect, and curb the excesses that mental illness could produce. The value of the system overrode the value of those it was supposed to

11 The first excerpt is taken from Franco Basaglia, "La distruzione dell'ospedale psichiatrico come luogo di istituzionalizzazione. Mortificazioni e libertà dello 'spazio chiuso': Considerazioni sul sistema 'open door,'" in *Franco Basaglia: L'utopia della realtà,* ed. Franca Ongaro Basaglia (Einaudi, 2005), originally published in 1965. Other references are from internal documents.

12 A reference to the French doctor Philippe Pinel (1745–1826), who famously pioneered "moral treatment" for mental health patients.

cure. But today, psychiatrists realize that attempts to "open" the asylum produce a gradual change in the patient's presentation of self, their relationship to their illness and the world, and a change in their outlook, which had been restricted and diminished by both the illness and a long hospitalization. From the moment that the patient enters the asylum, they enter a new emotional vacuum.... They enter a place originally intended to cure them and render them harmless, but which now seems created in order to completely destroy their individuality and *objectify* them....

When the first steps are taken, however, to transform the asylum, the patient... no longer appears resigned and ready to submit to our will, intimidated by the force and authority of his keepers.... They now appear as sick people who, although once *objectified* by their illness, now refuse to be further reduced and objectified by the doctor's gaze that tries to keep them at a distance. The aggressivity that would occasionally break through patient apathy and indifference in the past was an expression of illness and even more of forms of institutionalization. In many patients this was now replaced by a new aggressivity born of the dawning recognition that they had been "unjustly" stripped of their humanity and freedom, merely because they were in an asylum.

It is at this point that the patient, with an anger that transcends their own illness, discovers their right to live a truly human life....

Once the asylum's alienating aspects are gradually dismantled, it is then necessary to prevent the institution from deteriorating into a cheerful haven for grateful slaves by using the only possible leverage that we psychiatrists have at our disposal in order to have an authentic relationship with our patients: the individual's *aggressivity*. This can be the basis for a relationship of reciprocal tension that alone is capable of breaking the bonds of paternalism and authority which up until now have maintained their institutionalization....

March 1965

Our hospital is extremely institutionalized in all its aspects: patients, doctors, and nurses.... Therefore we have tried to provoke a situation in which all three groups can break from their rigid roles, creating tensions and countertensions involving everyone. This has meant taking a risk, which was the only way to put patients and doctors, and patients and staff on the same level, united in a common cause. The new structure we would create had to be based on this tension, and if this had to be maintained at a high level, otherwise everything would have reverted to the previous levels of institutionalization. The new organization of the asylum had to emerge from the bottom up, instead of from the top down. Rather than presenting a plan as a *fait accompli* that the community was asked to support, the patient community itself would create a structure born of its needs and necessities. Likewise the organization of this structure would not be based on rules imposed from above but would itself become a therapeutic act....

But illness is almost always tied to social and environmental factors, and to the degree of opposition to a society that ignores human beings and their needs. The solution to illness must therefore also be social and economic, so that those who for whatever reason have not succeeded, and who could not resist the pressure, can be reintegrated into society. Any attempt to address mental illness that does not include basic structural changes will prove meaningless. Any real solutions must deal with what happens to mental patients when they are released, their difficulty in finding work, the social environment which rejects them, and all the circumstances that force them back into the psychiatric hospital. Reforming current psychiatric laws means not just new systems and rules that establish a new institution, but confronting the basic social problems linked to that reform.

June 1965

If we examine what social forces were able to cancel the mental patient so totally, we realize that only one is capable of such power: authority. An institution based exclusively on authority, whose primary goal is efficiency and order, has to choose between the patient's freedom, with its potential for resistance, and the smooth running of the asylum. The choice almost inevitably fell on efficiency and the patient has always been sacrificed in its name.… Now that drugs and their effects have made it obvious to psychiatrists that they are not dealing with a sickness but with vulnerable people, they should no longer consider the mental patient as a threat to society. Nonetheless, this society will always defend itself against whatever frightens it and will always impose its restrictions and limits through institutions designed to treat mental patients. Psychiatrists should not participate in the destruction of their patients, who have been transformed into objects, and reduced to mere things by an institution that communicates with itself instead of reaching out to the patients.…

For their rehabilitation, the patients stuck in our asylums need new forms of nurture and a welcoming environment. But, more importantly, they need to exercise a reawakened feeling of resistance to the power that has defined and institutionalized them. Once this returns, the emotional vacuum in which they have lived for years will become filled with personal strength, reaction, conflict, and the aggressivity which constitutes the only leverage for their rehabilitation.

We are faced with both the need for an institution and the impossibility of creating it. There is a need to sketch out a system we can refer to, only in order to immediately transcend it. Faced with an impatient desire to initiate change from above, and the necessity to wait until it develops from below, and in the search for a new kind of relationship between patients, doctors, staff, and society in which the protective role of the hospital will be equally shared… the level of conflict must remain high so that every individual patient's anger is stimulated and not repressed.

The creation of a hospital run by the community and based on nonauthoritarian principles puts us in a position that is different from the rest of society. This tension can only be maintained if psychiatrists take a radical position aimed at demolishing the values underlying traditional psychiatry. We must free ourselves from our roles and try to create something which may contain the germ of future errors, but which will help us to break out of the frozen present situation. We cannot wait for laws alone to sanction our actions. . . .

A true therapeutic community stands in opposition to the social reality in which we live. It aims to destroy the principle of authority, and it is antithetical to all the principles of a society that identifies completely with rules that relentlessly carry it toward anonymity, impersonality, and conformity. . . .

October 1966

In Italy, however, we are still unjustifiably lazy and sceptical. The only socioeconomic explanation that can be given is that our social system, far from offering full employment, is not really interested in rehabilitating mental patients. How can they be assimilated into a society that has not yet resolved the problem of work for its healthy members? The demands that psychiatrists make will lose their most important social meaning if their work inside a disintegrating hospital system is not linked to broader structural changes that consider all the social problems connected to psychiatric services. A therapeutic community is a necessary first step in the progress of the psychiatric hospital, necessary above all for its function of revealing how the mental patient was traditionally perceived, and for identifying new roles that did not exist in the authoritarian hospital. Yet a therapeutic community is not a final goal, but only a transitional stage, while we wait for the situation to develop further and provide us with new meanings. . . .

All the members of a therapeutic community — doctors, staff, and patients — are united in their total commitment, and the contradictions of reality supply a fertile ground from which

a reciprocal, therapeutic activity will arise. It is in the interplay of contradictions — between doctors and patients, between nurses and patients, and between doctors and nurses — that the therapeutic aspect of our work emerges as a dialectical experience linked to contradictions.

When these contradictions are dialectically understood instead of ignored or covered up, and when the technique of finding scapegoats is dialectically discussed instead of accepted as inevitable, the community may be called therapeutic. But a dialectic exists only when there is more than one possibility, when there exists an alternative. If the patient has no alternative, if their life is predetermined, and their only participation consists of obedience, then they will find themselves imprisoned by psychiatry, just as they found themselves imprisoned by the outside world, unable to confront dialectically its contradictions. Just as they could not challenge that reality, they cannot challenge the institution, which leaves them only one escape: refuge in psychosis and delirium, where there are neither contradictions *nor* a dialectic. . . .

Changing the interpersonal relationships inside the institution is the first step, and it is both a cause and an effect of moving from the custodial ideology to a more therapeutic one. This change tends toward the creation of new roles that are entirely different to the old ones. In this uncharted land, which is the starting point for a new therapeutic institutional life, each individual will create their own role.

In the therapeutic community, the doctor is constantly challenged by a patient whom they can neither ignore nor remove. The patient is always there, expressing their needs, and the doctor cannot withdraw to some detached position where they can ignore the problem of the illness. Nor can they resolve it by simply giving generously of themselves. In fact, their transformation into an apostle with a mission would create another kind of distance and difference, no less serious and destructive than the previous kind. The psychiatrist's only possibility is a new role, created and then destroyed by the patient's need to fantasize about them. The patient first sees them as protective, and then

negates that, so they can experience themselves as strong. While the medical aspect of their relationship would remain the same, this new role would allow the psychiatrist to better understand patterns that emerged, and they would be able to represent, in this relationship, the dialectical pole which both controls and challenges, and is controlled and challenged in turn.

The ambiguity of the psychiatrist's role will continue, as long as society does not clarify their mission. They have a precise role bestowed on them by society: to control the hospital organization in which mental patients are protected and treated. We have seen how the concept of protection, and the security measures needed to contain the dangerous patients, stands in sharp contrast to the concept of treatment aimed at the patient's personal growth. How can the doctor reconcile these two contradictory needs, while society does not clarify whether it wants psychiatric assistance to be directed toward custody or cure?

December 1966

Every society based on cultural and class distinctions and on competition creates spaces where it compensates for its own contradictions, and where it fulfills its need to objectify a part of its own subjectivity. . . .

Racism in all its forms is an expression of this need for compensation, just as the asylum, as a symbol of what we might call "psychiatric ghettoes," expresses the desire to exclude whatever is frightening and incomprehensible. This desire is justified and scientifically rationalized by psychiatry, which considers those that it studies impossible to understand, to be relegated to the ranks of the excluded. . . .

The mental patient is an outcast, but in our present society, they can never oppose those who exclude them, since all their actions are circumscribed, defined, and finally, dismissed, by their illness. Yet psychiatry, in its dual medical and social role, can help a patient understand their illness and how society has excluded them in response to that illness. The mental patient

can rehabilitate themselves out of their institutionalization only if they becomes aware of being rejected and excluded.…

In asylums, traditional psychiatry has demonstrated its failure. Faced with the problem of the mental patient, it has resolved it negatively, excluding them from a social context and therefore from their humanity.… Any human being, regardless of their mental state, placed in a coercive environment where humiliation and despotism are the rule, will begin to gradually identify with the laws of their captors and will begin to objectify themselves. They construct a facade of apathy, disinterest, and insensitivity which is an extreme defence against a social world that first excludes, then humiliates them. It is the last personal resource that the mental patient, like the inmate, uses to protect themselves from the unbearable experience of consciously living as an outcast.

If an awareness of this exclusion exists, and society's responsibility for it, then the emotional vacuum the patient has lived in for years can be gradually replaced by a surge of self-righteous anger. This will turn into an open opposition to their reality, which they now reject not because they are sick, but because that reality really cannot be endured by any human being. Theyr will win their own freedom; it will not be a gift from someone else.

March 1967

Originally, the patient suffered a loss of identity, but then the institution and psychiatry gave him a new one, through objectifying him and surrounding him with cultural stereotypes of mental illness. The patient in an institution that insists on relating to him as a sick body adopts the institution itself as his own body and assimilates the self-image that the institution imposes.… A patient, who already suffers a loss of liberty by being sick, has to obey a new body which is the institution, negating any autonomous desires, actions, and aspirations that would make them feel alive and still themselves. They become merely a body lived through the institution and for the institu-

tion, so much so that they can be considered a part of its physical structure.

"Before going out, all locks and patients were checked." These are the words found in a note left by one shift of nurses for the next shift to show that the ward was in perfect order. Keys, locks, bars, and patients are all part of the hospital furnishings, without even a minimal differentiation among them.... The patient is merely an institutionalized body. Sometimes, until they are completely tamed, the patient "acts out" and tries to reacquire the characteristics of an actual, lived body, refusing to identify with the institution.

An anthropological approach to institutional life gives us different interpretations of the behaviors traditionally associated with mental patients. *The patient is "indecent" and "disorderly"; they behave in an unseemly manner.* These can be interpreted as aggressive symptoms that show that the patient is still trying to escape the objectifications which they feels confine them, to show that they are still alive. Within the institution, there is a pathological reason for each action and a scientific explanation for all behavior. Therefore the patient who is not successfully objectified when they enter the asylum is finally tamed and labeled with all the blessings of *official science*....

The patient finds themselves in an institution that systematically envelops their personal space, which is already invaded by the illness itself. The passivity that the institution forces on them does not let them experience events according to their own internal dialectic, it does not allow them to live and to be with others so that they can all protect and defend themselves. The patient becomes an undefended body, moved around, like an object, from ward to ward, concretely prevented from creating a body of their own, and prevented from making their reality dialectical.... This is a community that can only be described as antitherapeutic, an enormous empty space filled with bodies that cannot experience themselves and who sit there, waiting for someone to seize them and make them live as they see fit, that is, as "schizophrenics," "manic-depressives," "hysterics"—finally turned into things.

April 1967

We have seen how pathogenic the asylum is. Any transformation that is not accompanied by an inner struggle and a calling into question of the entire structure will only be superficial and illusory. It is not a particular tool or a technique that is destructive and antitherapeutic, but rather the entire hospital organization which focuses on efficiency, and which inevitably objectifies the patient, who should have been its *raison d'être*. The introduction of a new *therapeutic technique* into an old institutional context would be both destructive and self-defeating. The institution, understood as a problem to be solved, could be quickly covered up again so the problem appears less dramatic. Even the so-called psychosocial therapies used by psychiatrists as a "path to social integration" run the risk of simply obscuring problems. Like the emperor's new clothes in Hans Christian Andersen's fairy tale, they provide no cover at all, since the underlying structure will only negate or destroy them.

January 1967

The problem of the mental patient can no longer be denied … so now they try to keep them within a society that still fears and scorns them, through a series of institutions that protect society from the human diversity that they continue to represent.…

The choice is clear. There are two paths. We can decide to confront the mental patient without projecting onto them the evil we fear will contaminate us, and we can start to see their problems as an unavoidable part of our present social reality. In this case the problem of "mental illness" can no longer be contained within the restricted definitions of "science" like psychiatry. Rather it becomes a more general problem of a political nature, involving the kind of relationship our society desires or does not want to establish with some of its members. Or we can continue to pursue the current path: we can *sedate* our anxieties by creating newer and better barriers to increase the distance

between *us* and *them*. We can construct a beautiful new “model” psychiatric hospital.

June 1967

Traditional psychiatry, which treated its categories as universal, has shown itself not to be up to the task. But once we call it into question, we run the risk of falling into a similar impasse, unless we maintain a critical stance in our practice.… If we want to begin from the “mental patient” as a primary reality, there is a danger of approaching the problem in an exclusively emotional way. A simple reversal of the negative image of the coercive, authoritarian system into a positive image through humanitarian-type gestures might relieve our sense of guilt toward the patient but would only confuse the issue.… We need a psychiatry that constantly checks itself against reality and finds in that reality elements by which it can challenge itself.

Asylum psychiatry knows that it has failed in its encounter with reality. Once it lost contact with reality, it did nothing more than write “literature” and develop ideological theories, while mental patients suffered the consequences of this split–segregation.… To fight the effects of an ideological science, we also have to struggle to change the social system that sustains it.

Psychiatry has played its role in excluding mental patients by confirming that their symptoms are organic, random, or incomprehensible. But it also is the expression of a system that believes it can negate or erase its own contradictions by ignoring them, rejecting any sense of dialectic, and trying to portray itself as a science without contradictions.… The patient is our only reference point, and we must consider both aspects of their reality. A patient has a dialectical series of psychopathological problems, and they are also socially stigmatized outcasts. For a community to be therapeutic, it must take this dual reality into account — illness and stigmatization — in order to gradually reconstruct a patient as they were before society acted against them with all its negative force.

In actual practice, the so-called therapeutic relationship unleashes a dynamic that has nothing to do with the illness, but which nonetheless serves an important function. In the power relationship that is established between doctors and patients, the diagnosis of illness is fortuitous, an opportunity to create a power strategy that will be crucial to the development and life history of the illness itself. Whether it is the almost absolute "institutional power" granted to the psychiatrist in an asylum, or "therapeutic," "technical," "fantasized," or "charismatic" power, the psychiatrist has advantages over the patient that inhibit any reciprocity with their interaction and the possibility of real relationship. The patient, precisely because he is a mental patient, adapts all the more easily to this object-like relationship, as he tries to escape from a problematic reality he does not understand how to confront. In the relationship with the psychiatrist, he will be objectified and relieved of responsibility for himself, through an approach which fosters his regression....

The psychiatrist has a power that has not served to increase their understanding of mental patients and their illness. Instead they have used this power to defend themselves from their patients, with one of their key weapons: the classification of syndromes and pathologies.... Because of this, psychiatric diagnosis has inevitably become a value judgment and a label. Faced with the incomprehensible contradictions of our reality, there is nothing to do but unleash forms of accumulated aggression on the incomprehensible objects that it produces. The patient has been isolated and ignored by psychiatrists so that they can devote themselves to abstract definitions of illness and to the classification of symptoms, unafraid of being contradicted by those who were ignored.... Through diagnosis, psychiatry avails itself of a power, a technical terminology that sanctions society's exclusion of those who are not integrated into the system. This sanction has no therapeutic value, however. It is limited to a classification of who is normal and who is not, and the norm, once scientifically established, is not a flexible and debatable concept, but something rigid and tightly connected to the values of both doctor and society....

The present problem in psychiatry is therefore what choice to make. Psychiatrists could once again use their tools to defend themselves from patients and from the problems they raise. There is a constant temptation to calm the anxiety provoked by their relationship with the patient, yet even this is a sign of the reciprocity of the relationship. . . .

Psychiatry is plunged into a real crisis. Looking beyond the divisions that this crisis has produced, it should be possible to begin to see mental patients, stripped of the labels that have until now masked them and classified them into fixed roles. But psychiatric reformers are already preparing to attack us with new solutions, which usually mean new labels for old psychological structures. Learning the language is easy but the words do not necessarily correspond to the work that has been done or that remains to be done. . . .

Psychiatric crisis, or institutional crisis? The two are so tightly interconnected that we cannot separate cause and effect. Both have a common denominator: the type of objectifying relationship established with the patient. Science sees the patient as an object of study, to be dismantled according to series of classifications by the institution, and, in the name of efficiency, or in the name of scientific labeling, as an object of the hospital structures. . . . At this point shouldn't we just dismantle what has been done? Otherwise, we will remain entangled in the pathology of this science, which has invented patients in the image of its own definitions. Reality cannot be defined *a priori.* The moment we define it, it vanishes and becomes an abstract concept.

The current danger is that psychiatrists want to resolve the problem of the mental patient through technical tweaks.

This would mean that the psychiatrist, through modern, well-equipped institutions, or via perfectly logical but destructive conceptualizations, would perpetuate a relationship between objects — something I would define as *metallic* — where reciprocity would still be systematically withheld.

Psychiatry has no understanding of the nature of mental illness, which requires a relationship diametrically opposed to the present one. At all levels — the psychiatrist, the family, the insti-

tution, the society—the present relationship is characterized by violence, as the mentally ill are first attacked and then marginalized.... Only exclusion and violence makes the so-called healthy members of a family take out their accumulated frustrations on the weakest member. Only *violence* motivates a society to exclude those who refuse to play the game according to its rules. Nothing but violence and exclusion underpin institutions that, for efficiency and self-protection, establish rules to destroy the individual's remaining personal dimension....

Let us confront the *world of terror, the world of violence,* the world of exclusion. We do not want to recognize that we constitute that world, because we are the institutions, the rules, the principles, the standards, the codes, and the organizations. Unless we realize that we are part of a *world of threats and lies* that overwhelm the patient, we will never be able to understand that the patient's crisis is also our crisis.... Above all, it is the patient who suffers. His only possible path is to live unproblematically and undialectically because the contradictions and the violence of our society surpass endurance. Psychiatry has reinforced this choice by showing the mental patient that they are allowed into only one place: the one-dimensional institution created for them.

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It is not the therapeutic community as a new fixed, unchanging institution that guarantees the therapeutic nature of our activity. It is rather the type of relationship that is initiated in this community that will make it therapeutic, to the extent that it succeeds in focusing on the institutional dynamics of violence and exclusion and creates the basis for a gradual awareness of this violence. This will then allow patients, doctors, and nurses to confront and combat those dynamics and to see them as closely tied to a specific social structure and not as unchangeable facts. Scientific research on mental illness will only be possible after we have eliminated all the superstructures connected to vio-

lence in the asylum, and in the family, to violence in society and within all its institutions.

This documentation concerning the radical changes going on in our institution [Gorizia], was not intended as a description of a particular *technique* or of a *system* that is more efficient or more *positive* than any other. The reality of today will differ from the reality of tomorrow, and in trying to stop it in time it either becomes distorted or irrelevant. The excerpts are merely conceptualizations of our practice, which gradually developed as the original concentration camp-like environment gave way to more human relationships. The problems and the approaches have changed gradually as our work has become clearer and broader.

However, since we are working in a therapeutic institution, we are usually asked whether community control is the answer for psychiatric institutions, what the statistics tell us about our results, and whether more patients are cured. This is difficult to answer in quantitative terms, and I am not sure in any case that this is the right way to frame the questions.

If we look at psychiatric hospitals, we find, for example, that antipsychotic drug therapy has produced both surprising and disconcerting results. Drugs have an undeniable effect, and we have seen their results in our asylums with the reduction in the number of patients "associated" with a hospital. But with hindsight we can also begin to see a negative effect, both in terms of the doctor and the patient, since drugs affect the anxieties of both, producing a paradoxical situation. The doctor, through the drugs that they administer, soothes their own anxiety about a patient with whom they cannot communicate or find a shared language. They compensate for this inability to handle an "incomprehensible" situation with a new form of violence, while still continuing to objectify the patient. The "sedative" effect of the drug ensures that the patient will remain in their passive patient role. The only positive aspect of the situation is that it creates the possibility of a relationship, even if that possibility is dependent on the doctor's subjective judgement. On the other hand, drugs affect the patient by making them perceive others

as less distant, so they assume the possibility of a relationship otherwise denied to them.

Ultimately, what is changed by the drugs is not the illness, but the doctor's apparent attitude toward it. This confirms what we said before, that mental illness is not an objective condition, but one whose nature is created by the doctor who classifies it and the society which negates it.

This is supported by the fact that in 1839, before the age of psychopharmacology, John Conolly[13] succeeded in creating a free and open psychiatric community. The effect of drugs has made clear what doctors were not able to understand; they were more concerned with the abstract concept of illness than with real patients. Looking at the issue closely, antipsychotic drug therapy presents a challenge to doctors and their scepticism. Once that challenge is met, perhaps we can initiate an approach which may or may not include the use of drugs.

At a time when our work is being examined and judged by the public, we are faced with a fundamental choice. We could underline our methods of work, which, after a first destructive phase, was able to create a new *institutional reality,* and we could propose our model as a way of resolving the problem of psychiatric institutions. Or we could propose *negation as the only possible approach to a political and economic system that co-opts every victory and uses it to strengthen itself.*

With the first choice, we would only end up with another aspect of the same reality we have destroyed. The therapeutic community as a new institutional model would be a technical improvement, but would remain within the traditional psychiatric system, and a part of the general sociopolitical system.[14] In

13 John Conolly (1794–1866), British psychiatrist and pioneer of non-restraint treatment for the mentally ill.

14 The UK example seems to us to be the most representative in terms of clarifying the terms of the problem. Within the National Health Service, psychiatry no longer occupies a secondary place, and the mentally ill, like all other patients, are considered as "informal people" and are therefore integrated into the general medical system. But, while it is difficult not to agree with this general approach, there still remains a key issue, as integration

our work, we have tried to show that mental patients are excluded and are scapegoats within a society riddled with internal contradictions. Now society itself has begun to show an understanding of this obvious form of exclusion. The therapeutic community, when it resolves conflicts and adjusts its members to society's violence, can make society's task of integration operative and can play into the hands of those it originally fought. In its first and clandestine stage, which was supposed to be an initial step in a long process of radical change, the therapeutic community managed to avoid being controlled, classified, and fossilized. But now the therapeutic community has been discovered, it cures patients better just as OMO[15] washes clothes cleaner. Doctors, nurses, and patients, all those who have contributed to creating this new, improved, *good* institution, may find themselves locked in a prison of their own making, excluded from the reality they had thought to influence, waiting to be reintegrated into a system that plugs up its most obvious leaks and ends up caus-

into the system can conceal an avoidance of the issue of mental illness and therefore provide an illusion in eliminating one of the major contradictions linked to reality. The risk is that the problem of contradictions linked to mental illness will be suffocated by a soft form of community regression within some psychiatric organizations. For example, the concept of a "living–learning situation" or of "sensitivity training" as outlined by Maxwell Jones turns out, if not controlled by real community practice, to simply be an attempt at unproblematic integration. A "living–learning situation" and "sensitivity training" could be a conflict resolution technique, adaptable even to communities of non-ill people, and would thus be an attempt at an ideological solution that does not consider the contradictions of reality (placing itself on the same level as Lewin's concept of "resolving social conflict"). If the UK approach is, therefore, interesting because it gives the patient an active role in their *self-making* [in English in the original], it does not seem acceptable when this *self-making* highlights a tendency toward integration, and thus a reformist meaning can be applied to the psychiatric system. Although the organization of the hospital in which we operate is based on similar assumptions to those in the UK, we are well aware of this danger: the sense of the patient's role and *self-making* must be sought in protest and not in integration. See Franca Ongaro Basaglia, Franco Basaglia, and Gian-Franco Minguzzi, "Exclusion, programmation et intégration," *Recerches* 5 (1967): 75–84 [note in original].

15 A washing powder.

ing even bigger ones. The only possibility we have is to maintain the patients' link to their own history, which is always a history of abuse and violence, and to remain clear on the sources of that abuse and violence.

We refuse to propose the therapeutic community as an *institutional model,* a new technique for resolving conflicts. The meaning of our work must continue as a *negation* that entails both a destruction and an overcoming of the coercive prison system of psychiatric institutions and psychiatric ideology, so that we can move on to the violence and exclusion of the whole sociopolitical system, and not let ourselves be exploited by that which we want to negate.

We are perfectly aware of the risks we are running, of being overwhelmed by a social structure based on rigid norms and social sanctions. We can allow ourselves to be co-opted and integrated, so that the therapeutic community would be limited to a struggle inside the political and psychiatric system, without attacking its fundamental values and assumptions. Or we can continue to undermine, today through the therapeutic community, tomorrow through new forms of struggle, the dynamics of power as a source of regression, illness, exclusion, and institutionalization.

Our position as psychiatrists means we must make a direct choice. Either we accept our *mandate of power and violence,* in which case any act of renewal that stays within the limits of the *norm* will be enthusiastically accepted as the new *solution* to the problem. Or we can refuse this ambiguous position, trying as much as possible to confront the problem in a radical way, positing it as part of a global approach that rejects partial and deceptive solutions.

By calling into question the present reality, we have made our choice to stay connected to the mental patient. We must force ourselves to constantly evaluate our work and push it forward, even though this is often interpreted as a sign of scepticism or inconsistency on our part. But only by checking our work against the contradictions of our reality can we avoid falling into

the *ideology of the therapeutic community* and avoid schematic, categorical work.

In the meantime the psychiatric *establishment* defines our work as lacking seriousness and scientific respectability. We embrace this criticism. Finally we can share in the lack of seriousness and respectability that has always been the mark of the mental patient and of all those *excluded* from society.

An Asian parable[16] tells of a serpent that crawled into the mouth of a sleeping man. It slid down into his stomach and settled there, imposing its will on him and depriving him of his freedom. The man now lived at the mercy of the serpent and he no longer belonged to himself. One day the serpent finally left, but the man no longer knew what to do with his own freedom. During the long period of domination the man had become so used to submitting his will to the serpent, all his wishes and impulses to the creature, that he had lost the capacity to wish, to strive, or to act autonomously. Instead of freedom he found only the emptiness of the void, for the serpent had taken with it the man's new essence which was acquired during the period of his captivity. The man was left with the terrible task of reclaiming, little by little, the former human content of his life.

The analogy of this fable with the mental patient's compromised condition is obvious. It presents itself as a parable about the patient's assimilation of an enemy that destroys him with the same lies and violence that the serpent presumably used to dominate and destroy the man in the story. But our encounter with the mental patient has shown us that *we are all slaves of the serpent* and that unless we attempt to destroy him, or expel him, we will never be able to reclaim the humanity of our lives.

16 Reported by Jurij Davydov, *Il lavoro e la libertà: Una teoria della società comunista,* trans. V. Strada (Einaudi, 1966) [note in original].

The Ideology of the Therapeutic Community

Lucio Schittar

A discussion around the issue of the "therapeutic community"[1] requires not just the adoption of a historiographical perspective or, more simply and with less commitment, the consultation of a number of texts, but also an attempt at a critical analysis of the origins and of development of this new approach to therapy. This type of study appears even more necessary today, because the therapeutic community tends to be viewed as a solution to the problems of psychiatric institutions, while it might seem (if it is not seen as a "situation" which can also lead to disintegration and rebirth, or as a transitional phase, and perhaps a necessary one, in terms of the process of institutional renewal) that it is merely a new "scientific" means of controlling deviance.

1 This chapter refers mainly to the experiments of therapeutic communities carried out in the UK and North America. Therapeutic community experiments are underway all over the world. In Italy, therapeutic communities have been set up in private settings [note in original].

This is a reference to the psychiatrist and psychoanalyst Diego Napolitani (1927–2013), who set up a small therapeutic community in Milan in the public sector in the early 1960s, another in the private sector in the same decade, and another in the public sector in the province of Milan in 1967. Napolitani had also worked with Maxwell Jones in Scotland and others in some "open wards" of traditional psychiatric hospitals.

Today, the idea of a therapeutic community often appears as a kind of fashionable solution within psychiatry, as a structure within which problems can be resolved, as well as the contradictions within institutional psychiatry between therapeutic aims and a need for the social exclusion and the control of individuals who behave in a certain way.

Many people seem to believe or simply wish that a therapeutic community can resolve these contradictions, but if we study the origins and developments of this kind of system it becomes clear that there are numerous doubts about the possibilities of such an outcome.

The therapeutic community is a typically Anglo-Saxon "invention," or rather a English one, because the UK is the country with the longest tradition of attempts to renew a psychiatric institution[2] — since the times of William Tuke, John Conolly and the "moral cure" of the mentally ill.[3]

Conolly himself, through his astonishing tendency to stress the therapeutic necessity to free up psychiatric hospitals (*in 1839* he completely abolished restraints for eight hundred Hanwell patients) can be considered[4] as the first stage of a trend that from the first half of the nineteenth century led to Maxwell Jones and contemporary therapeutic communities.

But other factors, in addition to those of the reformist tradition, can be seen in the importance of religious origins (the

2 And not only in terms of psychiatry. For example, Borstal-type institutions were attempts, carried out at the end of the nineteenth century, to humanize juvenile detention centers. They have many points of contact with those therapeutic communities established in some UK and American prisons in recent years [note in original].

3 William Tuke (1732–1822), a Quaker who set up a private mental hospital in York in the UK, whose methods were highly influential in terms of so-called "moral treatment"; John Conolly (1794–1866), British psychiatrist and pioneer of no-restraint for mental health patients.

4 See Richard Hunter, "One Hundred Years after John Conolly," *Proceedings of the Royal Society of Medicine* 60, no. 1 (1967): 85–89. See also Agostino Pirella and Domenico Casagrande, "John Conolly, dalla filantropia alla psichiatria sociale," in *Che cos'è la psichiatria?,* ed. Franco Basaglia (Amministrazione provinciale di Parma, 1967).

Tukes were Quakers), which have contributed to the emergence in the UK of social methods for treating patients. The influence of war also seems to have been important (World War II), with an enormous number of cases and a relative shortage of psychiatrists and nurses, and therefore the need, requirement on the part psychiatric institutions to operate with fewer staff.

We might add that the war "tore psychiatrists out of the closed world of their mental hospitals and the cosiness of their psychotherapeutic consulting rooms and plunged them into the turmoil of army training camps, tented hospitals and combatant units and made them forcibly aware of the tremendous power of social factors for affecting men's thinking and feeling,"[5] thus confirming the theories and practice of a new kind of Sullivanian psychiatry.[6]

The reasons for the rise of sociotherapeutic methods were also broadly "political."

During the war and immediately afterward there was a decisive change in the political–cultural patterns of English society with the community's assumption of social responsibilities which had previously been ignored. Labour Party administrations and subsequent governments led to the approval of important social security measures, such as the formation of the National Health Service, and laws such as the Disabled Persons (Employment) Act of 1944, which marked a turning point in society's attitude toward the mentally ill, who were moved to rehabilitation programs outside of hospitals and therefore away from a situation of social exclusion.

5 David H. Clark, "The Therapeutic Community: Concept, Practice and Future," *The British Journal of Psychiatry* 111, no. 479 (1965): 947. All citations in this chapter lacked page references. Whenever possible, these have been provided.

6 Harry Stack Sullivan (1892–1949), a US psychiatrist whose work on social and group psychiatry was highly influential at the time and in the 1960s. For his importance in Italy see Marco Conci, "Harry Stack Sullivan and Stephen Mitchell in Italy: A Historical and a Personal Account," *International Forum of Psychoanalysis* 32, no. 3 (2023): 180–91.

The reasons that pushed Maxwell Jones, for example, to try to unpack the real power that psychiatrists exert on patients entrusted to their care, in some ways by getting rid of specific external features (white coats etc.), were also political in a broader sense.

In terms of medical practice the attempts to challenge authority and the role of medical power as a social role with its residue of magical witchcraft and anthropological features took the form of discussion groups, which raised problems that arose within community life, discussions in which patients, doctors, nurses, and social workers should have all been able to participate with the same rights, with the same sense of authority, and with the same decision-making ability.

These were, in short, the "theoretical" origins of these developments; in fact, the notion of "therapeutic community" arose in 1946 with Thomas Forrest Main's article in a special issue of the *Bulletin of the Menninger Clinic,*[7] a review of the progress of post-war British psychiatry, when discussing the work of the English psychiatrists of the "Northfield group" (Wilfred Bion and John Rickman, and later S.H. Foulkes), and he described the Northfield hospital using the term "therapeutic community."

Bion and Rickman had organized a group of patients in 1943 in Northfield hospital, including soldiers suffering from neurosis, as a community, with discussion groups and patient participation in the running of the ward

Jones did the same thing in Mill Hill in 1941–1944, and then in a hospital for former prisoners of war in Dartford in 1945, and in the Industrial Rehabilitation Division in 1947 (which later changed its name to Social Division) of Belmont, which became a hospital for psychopaths where Jones worked until 1959. (HJe is now director of Dingleton Hospital in Melrose, Scotland).

Jones himself quickly became the most well-known representative of those psychiatrists interested in therapeutic com-

7 See Thomas Forrest Main, "The Hospital as a Therapeutic Institution," *Bulletin of the Menninger Clinic* 10, no. 3 (1946): 66–70.

munities, and this approach to institutional issues was soon implemented and imitated by many Western psychiatrists.

To cite some key figures: Alfred Stanton and Morris Schwartz, Erving Goffman, Russell Barton, John and Elaine Cumming, William Caudill, Ivan Belknap, and all the other scholars who looked at the microsociology of psychiatric hospitals and investigated the effects of the formal and informal organizational structures of institutions on the life and conditions of patientsand contributed in a decisive way to institutional psychiatric reform, which was often implemented as a form of "community therapy."[8]

In 1953, in the conclusion of a study on psychiatric organizations of the states adhering to the World Health Organization, a committee of experts stated that the psychiatric hospital should be seen as a therapeutic community, based around principles such as the preservation of a patient's individuality, the idea that patients can be trusted and have the ability to take on responsibilities and make initiatives, that there be regular patient engagement with some kind of employment, and so on.[9]

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8 See also Alfred Stanton and Morris Schwartz, *The Mental Hospital: A Study of Institutional Participation in Psychiatric Illness and Treatment* (Basic Books, 1954); Milton Greenblatt, Richard H. York, and Esther Lucile Brown, *From Custodial to Therapeutic Care in Mental Hospitals* (Russell Sage Foundation, 1955); J.A.R. Bickford, "The Forgotten Patient," *The Lancet* 266, no. 6896 (1955): 917–19; Denis V. Martin, "Institutionalisation," *The Lancet* 266, no. 6901 (1955): 1188–90; Ivan Belknap, *Human Problems in a State Mental Hospital* (McGraw-Hill, 1956); Milton Greenblatt, Daniel J. Levinson, and Richard H. Williams, *The Patient and the Mental Hospital* (The Free Press, 1957); William A. Caudill, *The Psychiatric Hospital as a Small Society* (Harvard University Press, 1958); Russell Barton, *Institutional Neurosis* (Wright, 1959); Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Anchor Books, 1961); John Cumming and Elaine Cumming, *Ego and Milieu: Theory and Practice of Environmental Therapy* (Tavistock, 1962); J.K. Wing, "Institutionalism in Mental Hospitals," *British Journal of Social and Clinical Psychology* 1, no. 1 (1962): 38–51; and Albert F. Wessen, ed., *The Psychiatric Hospital as a Social System* (Charles C. Thomas, 1964)

9 See WHO Expert Committee on Mental Health and World Health Organization, "Expert Committee on Mental Health: Third Report [of a Meeting

These "fundamental principles," if implemented in practice, would have led to a new form of psychiatric hospital, but they would not necessarily have led to the formation of a therapeutic community as understood by many today and as has been developed by British practitioners, such as Jones.

This more recent form of therapeutic community — a "real" therapeutic community — is based around principles that have been defined as revolutionary and which subvert traditional doctor–patient relationships. Although it cannot be reduced to rigid formulas, this type of community is centered around the use, for therapeutic purposes, of all the resources of the institution, conceived as the nonhierarchical "staff" of doctors, patients, and others.

As Denis V. Martin states: "A Therapeutic Community is where a deliberate effort has been made, and to the greatest extent possible, with a wide-ranging therapeutic project, to value everyone's contributions — from the personnel to the patients."[10]

But we should stress that there is no one model for a therapeutic community, beyond general characteristics which allow for a multiple-level therapeutic approach within the institution, and the implied rejection of an exclusively binary doctor–patient relationship. Rather we should think of continually evolving structures which should not be seen in a schematic way.

According to David Clark, however, we can lay down some sets of ideas with common characteristics:

1. *Freedom of communication.* Every effort is made to ensure that communication is possible at all levels and all ways, and not only through a hierarchical system as in traditional institutions.

Held in Geneva, November 24–29, 1952]" (World Health Organization, 1953), https://iris.who.int/handle/10665/37984.

10 See Denis V. Martin, *Adventure in Psychiatry: Social Change in a Mental Hospital* (Bruno Cassirer, 1962), vii.

2. *An analysis of everything that happens within the community in terms of individual and, above all, interpersonal dynamics.* This no longer takes place only through group meetings but also thanks to the increasing psychodynamic role of the psychiatrists. At most, community meetings can slowly transform into group psychotherapy sessions (see John Mack).
3. *A tendency to undermine traditional authority relationships* with a flattening of the hierarchical pyramid, where the patient is traditionally at the bottom and subject to the release of the tensions of the entire hospital. This horizontal movement, with its necessary division of decision-making power, is undoubtedly the most significant innovation within therapeutic communities.
4. *The possibility of social re-education*[11] which can be both spontaneous and structured within the institution (through events such as dances, films, theater, parties, individual or group trips, etc.).

11 Jones has argued in his most recent writings for a process of *social learning* as the most important tool of community technique. 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, are lost due to morbid regression. The therapeutic community, by somewhat attenuating (as in with tolerance of delirium, interpretation instead of repression of acting out, etc.) the tensions in encounters between the sick individual and others, allows for a process of relearning, of reacculturation whose ultimate goal is rehabilitation and the reintegration into the external community. The use of a term like "acculturation" (which historically has been seen as a form of acceptance of the culture of the "master" by the "servant," and can therefore be considered equivalent to "colonization") with the insistence on the difference between a "healthy" culture and a "sick" culture, seems to repropose in a sociopsychiatric way a kind of fundamental bourgeois distinction between "good" and "bad" that finds in the forms of alienation that separate the sick from the healthy the justification for relegating the "mad" outside of processes of social interaction. Instead, exclusion from social interaction is the cause, and not the effect, of deculturation: the subhuman culture of "long-term patients," relegated for years to the asylum is its natural outcome, but, thanks to various studies on institutionalization, we now know that this has very little to do with mental illness [note in original].

5. *Meetings* (usually on a daily basis) of the whole community and frequent and regular smaller meetings, at all levels, which are the obvious place where all the processes mentioned above converge.

In the study of the structural characteristics of the ideology and practice of the community, other features can also be identified. The sociologist Robert Rapoport in *Community as Doctor* has identified four fundamental themes through research into the ideological foundations of therapeutic community in Henderson Hospital.[12] First, *democratization:* everyone's opinion was considered in the same way. Second, *permissiveness:* community members showed a high degree of tolerance for the acting-out of the even most disturbed patients. Third, a *community* was created in terms of intent and purpose. Fourth, the *importance of reality.* All members of the therapeutic community were constantly engaged in this sense.

Rapoport pointed out that these features of community ideology connected in a dialectical way with practical aspects of the hospital, which sometimes required, *in response to a threat of possible break-up of the community,* a suspension of the atmosphere of permissiveness and the reemergence of the "latent authority" of the staff, the return of rules, and the repression of deviance.

So for example, democratization itself also went through a kind of "stop-and-go process" from an initial phase (phase A) of "everyone's participation," to mounting anxiety amongst staff, and concluded (phase D) with the imposition of leadership by the healthcare staff.[13]

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12 Robert N. Rapoport, *Community as Doctor: New Perspectives on a Therapeutic Community* (Charles C. Thomas, 1961).

13 It was therefore clear from Rapoport's study that the obstacles that community ideology came up against in its attempts at concrete practice were above all created by a need to maintain the organization on a basis of functional efficiency. Ultimately, community ideology had to yield to organizational ideology [note in original].

In addition to the Henderson hospital study by Rapoport, other important communities in the UK, all or almost all of which arose in psychiatric hospitals, can be found in Martin's Claybury hospital (which was outlined in *Adventure in Psychiatry)*, Clark's Fulbourn hospital, and Dingleton hospital (Jones, etc.).[14]

Numerous therapeutic communities have also sprung up in North America, some in private clinics, others as part of psychiatric facilities in universities, others still in psychiatric wards of general hospitals, and finally there are intermediate structures which cover community psychiatry, day hospitals, hospitals open at night, hostels for recently discharged patients, etc.[15]

The problems that arose during the application of a community method to the psychiatric field have been the subject of numerous studies.

For example, the issue of the therapeutic effectiveness of the community has been the subject of much debate. Does the therapeutic community truly "heal"?[16] Does it really want to heal individuals in a traditional sense ?[17] Is a community more suitable for "neurotics," "psychopaths," or "schizophrenics," or "depressed" and "manic" people (Christian Kole and Robert Daniels), is it really required for all (Jones): patients, doctors, and nurses?

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14 See David H. Clark, "Administrative Psychiatry 1942–1962," *The British Journal of Psychiatry* 109, no. 459 (1963): 178–201, for a detailed history of psychiatric institutional changes that have taken place in English-speaking countries in recent years [note in original].

15 One of the first therapeutic communities in America is the Wilmer therapeutic community, in the Psychodiagnostic Center of the Oakland Navy in California, which has been given so much publicity (a film has also been made about it) that many consider it a kind of model community. It is just worth noting that it was a military unit (in which military hierarchies were respected) with very strict rules, inscribed in tables on the walls of all the rooms. Moreover, it was a locked unit [note in original].

16 F.J.J. Letemendia, A.D. Harris, and P.J.A. Willems, "The Clinical Effects on a Population of Chronic Schizophrenic Patients of Administrative Changes in Hospital," *The British Journal of Psychiatry* 113, no. 502 (1967): 959–71.

17 Rapoport, *Community as Doctor*.

There were also discussions around the possibility of reducing or abolishing the tools linked to traditional forms of therapy: insulin therapy, electroshock therapy, and pharmacological therapy.[18] Tensions between members of the therapeutic team are also highlighted by some."[19]

But rarely has there been an attempt to move beyond a "community" ideology to look at the sources of real decision-making power and any sense of real participation on the part of patients.

Those who did attempt this, such as Robert Rubenstein and Harold D. Lasswell, concluded: "the patient continues [in the Therapeutic Community] to be deprived of certain freedoms, and hospital staff members remain the expert agents delegated by the society to exercise extraordinary power over patients entrusted to them. The director continues to be authorized to deprive patients of rights and privileges usually considered their prerogative as citizens of democracy."[20]

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18 G.L. Klerman, "Staff Attitudes, Decision-making and the Use of Drug Therapy in the Mental Hospital," in *Research Conference on Therapeutic Community,* ed. H.V.B. Denser (Charles C. Thomas, 1960); Robert Rubenstein and Harold D. Lasswell, *The Sharing of Power in a Psychiatric Hospital* (Yale University Press, 1966); and Harry A. Wilmer, *Social Psychiatry in Action: A Therapeutic Community* (Charles C. Thomas, 1958).

19 Raymond I. Band and Eugene B. Brody, "Human Elements of the Therapeutic Community: A Study of the Attitudes of People upon Whom Patients Must Be Dependent," *Archives of General Psychiatry* 6, no. 4 (1962): 307–14; Maxwell Jones, "Group Work in Mental Hospitals," *The British Journal of Psychiatry* 112, no. 491 (1966): 1007–11; Maxwell Jones, "Social Learning: Crisis and Confrontation-Staff Training," Presentation at the Convegno nazionale di socioterapia, Vercelli, April 8–9, 1967; Maxwell Jones, *Social Psychiatry: A Study of Therapeutic Communities* (Tavistock, 1952); Maxwell Jones, *Social Psychiatry: In the Community, in Hospitals, and in Prisons* (Charles C. Thomas, 1962); Maxwell Jones, "The Concept of a Therapeutic Community," *American Journal of Psychiatry* 112, no. 8 (1956): 647–50; Maxwell Jones, "Therapeutic Community Practice," *American Journal of Psychiatry* 122, no. 11 (1966): 1275–79; and B.B. Zeitlyn, "The Therapeutic Community – Fact or Fantasy?" *The British Journal of Psychiatry* 113, no. 503 (1967): 1083–86.

20 See Robert Rubenstein and Harold D. Lasswell, *The Sharing of Power in a Psychiatric Hospital* (Yale University Press, 1966), 249.

Beyond this, patterns of social exclusion characteristic of mental hospitals can be reproduced in the therapeutic community with the presence of closed wards (which deprive patients of freedom of movement and remove the possibility of making basic choices around their lives)[21] or through a selection of the most "suitable" patients and the dispatch of those seen as more "disturbed" and "difficult to integrate" than others to different institutions.[22]

The response of other British and North American psychiatrists in the face of the issue of authority and real power in therapeutic communities has often been dogmatic, with the affirmation of a need for power, in an imaginary way, but also in reality, of the doctor.[23] In other cases the solution to this problem has been resolved using forms of false consciousness, both through a justification of the patient's subjection through references to their illness and by stating that the patient's participation in community power was a reality, even if this took place in line with "consensus techniques" and if this "participation" occurred in closed wards.

To illustrate the attitude that some psychiatrists have taken in this regard, a few citations are useful:

For H.C. Denber and P. Rajotte: "We need to reduce hierarchical distances but maintain them: the fragility of the schizo-

21 See Wilmer, *Social Psychiatry in Action;* William Cone, "The Therapeutic Community in Action: A St. Louis Experience," in *The Psychiatric Hospital as a Social System,* ed. Albert F. Wessen (Charles C. Thomas, 1964), and many others.

22 Zeitlyn, "The Therapeutic Community."

23 Jones himself, who in his early contributions had been very critical of medical power, resolved the problem of power conflicts within the psychiatric hospital through the theory of "latent authority" ("When certain limits are reached, the latent authority [of the leader] must emerge and take all the necessary steps to ensure that the community's trust in its own control capabilities is not undermined"), and in hospital practice with a position of authoritarian leadership that connects the activity of the community to his role as a leader [note in original].

phrenic's inner world must be able to rely on a structure external to him."[24]

According to J.D. Patton, "the doctor is the leader [of the therapeutic community]";[25] for Alexander Gralnick, "there is one person, the Medical Director, responsible for overall control [of the therapeutic community], in whom is vested almost sole authority."[26]

For Stubblebine, "[a]nother principle [of the therapeutic community] is that authority relationships must be opely recognized and accepted. The therapeutic community is essentially an expression of faith and confidence in the ability of persons to examine their immediate social situation, with all of its authority complexes. In order for the group to openly discuss authority problems and to profit from such discussion, it is fundamental for *the professional group leader* to be comfortable with his exercise of authority. *He must have the greatest possible freedom from feeling threatened when his statements or contributions are studied, criticized, or altered, He must be so secure that he can be relatively nondefensive — acting as a model of objectivity.*"[27]

Let us try to understand at this point the reasons why the therapeutic community does not appear to have kept its promise to make a clear change to institutional situations. With the cultural assumptions on which it was founded and devel-

24 See H.C. Denber and P. Rajotte, "La communauté thérapeutique: Une forme systématisée de sociothérapie et son application à un groupe de schizophrènes," *Annales Médico-psychologiques, revue psychiatrique* 119 (1961): 115–28.

25 See J.D. Patton, "The Therapeutic Community," *Medical Times* 86, no. 2 (1958).

26 Alexander Gralnick, "On Behavioral Determinants in a Therapeutic Milieu," in *The Dynamics of Psychiatric Drug Therapy: A Conference on Psychodynamic, Psychoanalytic, and Sociologic Aspects of the Neuroleptic Drugs in Psychiatry Held under the Aegis of the Departments of Psychiatry of McGill University Faculty of Medicine and Queen Mary Veterans Hospital, Montreal, P. Q., Canada,* ed. G.J. Sarwer-Foner (Charles C. Thomas, 1960), 235. Schittar incorrectly attributes this quotation to the editor, Gerald J. Sarwer-Foner.

27 J.M. Stubblebine, "The Therapeutic Community: A Further Formulation," *Psychiatric Services* 11, no. 1 (1960): 18. Emphases by Schittar.

oped (social psychology, mainly in Lewinian terms) it could not maintain these premises and has therefore often ended up becoming a new "therapeutic" tool in the hands of doctors, on a par with drugs, electroshock treatment, and Hermann Simon's occupational therapy.[28] It has been smuggled in as a revolutionary instrument under the guise of sociopsychological techniques linked to "problem solving," seen as crucial to teamwork in a series of fields: be they industry, bureaucracy, or psychotherapy.[29]

These are techniques linked to group social psychology, which have been strongly influenced, especially in North America, by Kurt Lewin's theory of the "social field." The Lewinian mode of resolving social conflicts[30] has been applied in therapeutic communities as it was in order to introduce greater efficiencies in bureaucracy and industry.[31] In this way, it is argued, conflicts

28 A reference to Hermann Simon (1867–1947), psychiatrist.

29 A good example of the application of socio-psychological democratization techniques to the therapeutic community is provided by Christian Kole and Robert S. Daniels, "An Operational Model for a Therapeutic Community," *International Journal of Group Psychotherapy* 16, no. 3 (1966): 281: "Decisions [in the therapeutic community] are made by a process called 'reaching a consensus.' The word consensus is interpreted as meaning that no decision is final until it is supported by a general feeling in the group that a given action is necessary or acceptable. 'Reaching a consensus' avoids the suppression of minority opinion that might occur if decision-making were by a simple majority vote. Consensus is often signaled by a change in group atmosphere. Usually someone with prestige makes a statement which joins seemingly different opinions and clarifies the underlying feelings. Tension then drops and people relax, oftentimes laughing and talking."

30 See Kurt Lewin, *Resolving Social Conflicts: Selected Papers on Group Dynamics* (Harper & Bros, 1948). For an intelligent critique of Lewinian theories, see Henry S. Kariel, "Democracy Unlimited: Kurt Lewin's Field Theory," *American Journal of Sociology* 62, no. 3 (1956): 280–89.

31 See, for example, regarding the application of group techniques to industry, Morris S. Viteles, *Motivation and Morale in Industry* (W.W. Norton & Co., 1953), 188: "[T]he use of group participation permits smoother 'locomotion' to the same 'goal' without the creation of 'tensions' which may lead to industrial strife. Participation in decision-making in industry is generally viewed as an experience wherein attitudes favorable to change are taken on by the workers. [...] The possibility of industrial

can be resolved through the "participation" of all and through discussion, while conflicts can be smoothed out by means of the "manipulation" of a group, by means of a tolerant and understanding attitude. The endgame for group discussions tends to be the integration of everyone into the group itself. Participants, under the guidance of a wise and enlightened leader, attempt to reach a common and "good" outcome, which can be recognized in the orderly practice of bureaucracy, or regular production, or as a form of healing, and the rehabilitation and integration of the mentally ill.

It is thus clear how important organizational efficiency is and the ways in which it is seen as something which on its own will be able to achieve a "good" outcome.

If the "good" outcome is the care of the mentally ill, then the organization, in order to be efficient, will have to have the psychiatrist at the helm, who in this new form of organization, the therapeutic community, will be called an "administrative psychiatrist"[32] or, in the more coherent formulation of Levinson and Klerman, a "clinician-executive,"[33] that is, a clinician and a manager at the same time, thus realizing on the one hand the

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strife is lowered, since the change in group perception associated with group participation tends to bring the production 'goal' closer to the standard desired by management. Furthermore, 'emotionality' is lowered, since workers playing the 'role' of planners tend to keep discussion at a relatively depersonalized level." See also Michael S. Olmsted, *The Small Group* (Random House, 1959), 86: "It is perhaps the business world which stands to gain most prominently from learning more about the creative potentials of group problem-solving. The plans and decisions which guide large-scale enterprise in this country are in good part made by committees and conferences. Rightly or wrongly, businessmen and others have come to consider the conference the best means for seeing that the managerial work of this world gets carried on. In short, billions of dollars rest on the assumption that group decisions are in some sense better than indvidual decisions."

32 David H. Clark, "Administrative Psychiatry 1942–1962," *The British Journal of Psychiatry* 109, no. 459 (1963): 178–201.

33 Daniel J. Levinson and Gerald L. Klerman, "The Clinician-Executive: Some Problematic Issues for the Psychiatrist in Mental Health Organizations," *Psychiatry: Interpersonal and Biological Processes* 30 (1967): 3–15.

panorganizational ideals proposed by neocapitalist society, and on the other the desire for psychopathology which can often be found amongst psychiatrists themselves.

Clearly the exercise of activity and power by the psychiatrist at this point is no longer contested — it is no longer seen as a problem:

> The clinician must deal with his patients' behavior as well as with their private fantasies and feelings. He must be able to set and maintain limits and to take decisive action at crucial points in clinical management. The joke about the therapist who offers an interpretation as the patient jumps out of the window is funny as a caricature of therapeutic passivity and permissiveness; but it is not what a good therapist would do. Firmness and initiative are less emphasized by nonetheless essential virtues of the clinician.
>
> Conversely, the clinical identity retains its relevance for the psychiatrist–executive. An appopriate concern for the feelings and personal needs of organization members will facilitate, not hinder, his efforts to build the organization. His clinical ability to listen will stand him in good stead in his efforts to increase communication and the negotiate disagreements.[34]

A phase seems to have ended. What began as a need for a deep renewal of psychiatric institutions in terms of practice and theory turned out to be a new type of institution, which is more modern, more efficient, but in which power relationships seem to remain the same.

The "third psychiatric revolution" would seem to be nothing more than an adaptation of methods of social control of pathological behavior to the needs of [capitalist] production, which has been refined over the last forty years through the intervention of sociologists and experts in mass communication. It also seems that sociologists and psychologists who study organi-

34 Ibid., 14–15.

zations have also found a way to apply certain techniques in the psychiatric field (above all group techniques), which have proven to be effective in the management the neocapitalist economy, with the pretext of overcoming dehumanizing structures in the asylum, while leaving the oppressive power of social structures intact.

This conclusion would appear to confirm arguments made by Marcuse:

> Insofar as operational sociology and psychology have contributed to alleviating subhuman conditions, they are parts of progress, intellectual and material.
>
> But they also testify to the ambivalent rationality of progress, which is satisfying in its repressive power, and repressive in its satisfactions.[35]

However, the balance sheet for a therapeutic community cannot be seen as entirely negative. The problem of the transformation of psychiatric institutions and their patients has found a form of resolution in the therapeutic community, which can lead to positive developments, and it certainly cannot be denied that this system laid bare several contradictions as problems for the first time and as clear elements of institutional reality.

The merit of the therapeutic community is that it continues to highlight these contradictions daily, removing them from the unproblematic and good/bad classifications of the traditional psychiatric hospital. Even if, as we have argued, there is always a serious risk that things will go backward, it is to the credit of the community that it allows this risk to continue to exist, and can provoke constant protest by patients in order to avoid this happening. These protests are not "democratic" and do not take place in the various assemblies and meetings, but can be seen, for example, in the control (which the free movement of patients allows) of the use that doctors make of their power.

35 Herbert Marcuse, *One-Dimensional Man: Studies on the Ideology of Advanced Industrial Society* (Beacon Press, 1964), 70.

These contradictions remain, but the important thing is to become aware of them. The discussion that we outline below, which arose from the considerations that emerged in this study, can provide an idea of how this awareness takes place.

Team Meeting of November 27, 1967

JERVIS: I think we need to be aware that there is a danger in Schittar's criticism about the false nature of the therapeutic community, that is, a danger in concluding that since this is all "false" and that we might as well go back to how we were before.

SLAVICH: This is basically what many people say in Italy: we can talk about the power of the patient, but in the end the power of the doctor constantly reaffirms itself within the institution and nothing more can be done. Everything is postponed to a distant future, when and if a move to out-of-hospital care will ever be implemented.

JERVIS: It is interesting to look at the interpretation of some of the positions that I have adopted. I have also criticized on more than one occasion the mythical aspect of the therapeutic community, and I was told that my political analysis was also merely postponing everything to the revolution. Since external society imposes this role on you and manipulates your reformist practice so that it becomes distorted or falsified, you try to change your practice, but in the end this just postpones everything to a future in which a new society exists. This seems like a problem that needs to be addressed with some care. We need to be severe in our self-criticism, that is, not just through a critique of the Anglo-Saxon therapeutic community, but also in criticism of our own work. However, we should do this in a way that indicates a possibility of overcoming this situation, without using psychiatric and backward-looking arguments.

SCHITTAR: As regards our self-criticism, I would say that, it is one thing to block any discussion of medical power (as we have seen with many Anglo-Saxon psychiatrists), but by

discussing this power that is entrusted to us we continually participate, in practice, in the contradictory aspects of this power, even if it can be said that it remains in the hands of doctors.

SLAVICH: It is understandable that someone who is aware of these problems in terms of our critique of the problems with the therapeutic community at some point takes the situation into their own hands and says: "We need to lead things, we must have the courage to state that the community must be led." If everyone, they argue, even the pseudo-advanced patients, are subject to the power of the doctors, we might as well state clearly that the therapeutic community is being led.

JERVIS: This ends up in being a call for "reality confrontation" [in English in the original]: given that the therapeutic community must continually confront reality, and if that reality is oppressive, and not just outside of the hospital, but also, despite everything, within the therapeutic community, this oppression must be recognized as real and is therefore institutionalized in some way.

PIRELLA: How can we resist our own situation and unmask the nature of forms of oppression? I would like to ask a provocative question, that is, I would like to know about the resistance to our situation and ask that oppressive behaviors be both exposed and noted. At a certain point the transformation of a traditional situation into a top-down and paternalistic one, according to some, both from the right and from the left, both from the right and from those who they are very careful not to mystify their work, is seen as a shift of the context of power from that which is oppressive and clear to one that is more bland and soft and in some sense hidden. Hence power in a traditional situation is obvious and oppressive and power and authority in a therapeutic community is more hidden and more subtle, more nuanced. In my opinion a provocative question might be this: while we know what prevents the denunciation of this oppressive power in the old context

(the structure of oppression itself), in a new situation what prevents those who work in the field (patient, nurse, doctor, social worker, etc.) from open criticism in all space, and at all times, of this hidden form of power, which is always oppressive, but masked? That is, if it is true that the criticism that we make of Jones is that he has transformed the psychiatric hospital into a place where the techniques of social psychology are applied as ways of creating consensus. If this is true, in our situation, or in Jones's situation, what is it that prevents everyone from denouncing, unmasking, or demystifying this power? Is there something preventing it? Is it such a perfect system that consensus is reached in any case, without contradictions?

SLAVICH: It seems that it was truly perfect. After all, the ideals of these communities are made up of many Giovannas, where "Giovanna" is seen as an example of an integrated leadership consensus position that is detached from the community (whether this leader is Jones or someone else) and for which the needs of the therapeutic community are satisfied without raising too many issues. I have the impression that a therapeutic community functions well in this way on its own terms. Once the principle of reform of an authoritarian situation has been established, I think that a system emerges which is already complete and without cracks in it — one which does not allow for any understanding of the "latent authority" that lies underneath the system.

JERVIS: I think your pessimism is worth discussing, but I don't know if I can accept it completely. It seems to me that even a revisionist–integrative therapeutic community of a well-articulated psychosociological type, with this consensus functioning perfectly, still creates contradictions. And I also have the impression that, however, there are still elements of dissatisfaction, nonintegration, of rebellion, or even elements of open authoritarianism. I feel that the existence of an integrated paternalistic therapeutic community, in which everything happens within a sense of well-ordered

consensus, is not possible, that is, it always leaves areas outside of the system. In short, a therapeutic community of a neocapitalist type must always oppress someone in order to function, it needs to crush any margins of nonintegration.

SLAVICH: I completely agree. I forgot to mention the need for a small, partial, "enlightened" form of closure within the therapeutic community. Certainly, for example, an integrated therapeutic community cannot do without measures that in crisis situations safeguard their integration. For example, they require a closed ward. Here the integrated therapeutic community proves to be a hybrid system that still holds onto, in order to exist, the residues of explicit authoritarianism beyond those that are hidden. Integrated therapeutic communities need to allow for the possibility of repression. Only if there is no material possibility for exclusion can a discussion take on a dialectical form.

PIRELLA: In terms of my previous question, "what stops people from clearly denouncing forms of oppressive power which are still there?," we could give this answer that it is the possibility that a repressive mechanism commanded from above can be triggered at any moment, and that this is a real possibility, not a hypothetical one. It is possible that, for example in the Jones's context, that those who commit serious acts of disruption will be sent to a closed hospital in Edinburgh, or that there is a closed ward in an open hospital, or again, that there is the possibility that at a certain point forms of "latent authority" are used in cases where there is deviant behavior. At this point I would try to deepen our investigation and return to the key question asked by Schittar: are *we* a therapeutic community in this sense?

SLAVICH: We could also turn things around: what prevents a community from becoming a case of integration? I believe that is a threat resulting from the irreversibility of the situation that has been created. For example, the nonexistence of a closed ward certainly preserves the

dynamism of our situation and prevents it from becoming frozen as a "perfect" model. The pressure from patient protest created by their freedom of movement (which was given to them but which is now firmly in their hands) is a true guarantee of the power and control of the patient toward us and in the face of the institution. The patient controls the doctor and avoids a backward step in terms of community formation, authoritarian attitudes, or artificial community-type situations.

PIRELLA: Is there such patient control?

SLAVICH: I think so. I don't think it is expressed that way either verbally and "politically" in meetings, nor with votes by the majority, but it is expressed as a form of pressure and control within the "fluidity" of the overall situation.

JERVIS: I think that in theory one could even imagine a therapeutic community in which all power is controlled or even exercised from below, that is, through committees in which everything is "democratized," but I don't think that this is an ideal solution, because when the base introduces the need to maintain the community as a functioning community, in practice it ends up introducing a need for power. In my opinion, the only way to guarantee that we do not move toward a new form of mystification is not a question of delegating power to the base, but of taking risks that allow for the possibility that a community might fall apart. Because if we delegate power to the base when the base sees us as a guarantee in terms of management, in reality we are merely handing over this mystification to someone else.

PIRELLA: I don't agree. I don't agree for the reason that this statement does not consider that by definition a patient in a psychiatric hospital cannot manage the hospital. In a phase in which the patients manage the hospital their contestation of power is at its peak, because they contradict a fact that power itself justifies, namely their exclusion and a state of dependence. So it seems to me that there was some confusion in your statement … between the power

within the hospital and power on the outside. If we are the contractors of external power, we are so to the extent that we keep the situation under control. If the situation escapes our control (partly or completely; there are some situations that can escape our control completely, as we have seen), at that moment there is a serious challenge to external power. The difference lies in the dynamics of protest which distinguishes our type of community from classic [therapeutic] communities. The new fact is that our community is marked by protest at all levels. So there is reciprocal control and also reciprocal forms of protest, between doctors and patients, or doctors and nurses and then between doctors and nurses and patients, and all this leads, in a contradictory and disorderly way, to a protest against external power in a global sense, against those forms of power that would instead force us to maintain a situation which is completely under control within a managed community, which is something we don't do.

JERVIS: I fully agree. It is truly a revolutionary fact that power is no longer managed by those who are its official representatives but is controlled and undermined by those who are the official outcasts.

BASAGLIA: It seems to me — even if I haven't followed the entire discussion — that the problem of the therapeutic community and its future lies in the awareness of the dangers of a simple form of psychiatric reformism. If we want to recognize in this situation a dialectical dimension, we must also identify a second possibility which may consist in the highly contradictory nature of a situation: that the institution is simultaneously denied and managed, a disease is simultaneously bracketed and cured, a therapeutic act is simultaneously rejected and acted upon. In this sense negation takes place at the same time as management and vice versa. The presence of supposed "accepted rules" within a psychiatric institution could be, to a certain extent, a kind of contradiction, given that the explicit function of the institution is to contain

what goes beyond these rules. Until the system establishes that the psychiatric institution itself is a new structure within a set of acceptable rules, a therapeutic community could play a disruptive role, [but only] if it takes on an attitude of denying the functionality of the psychiatric institutional system as a place of the abnormal within the framework of "acceptability." Which also means that the presence within other institutions (family, school, factory, etc.) of disruptive elements discharged from a psychiatric institution that no longer wants to be a place for the dumping of its external contradictions, could serve (in the same way that acceptable rules are contradictory in a place of abnormality) to highlight real contradictions in the field of the so-called "norm." The "dismissed" could play this role as people integrated into the society, through the role of a reintegrating institution, but they could also fulfill a disruptive function. Their mere presence in the external world would clearly deny the sense of that world as made up of that single dimension as desired by the system and, at the same time, underline the action of an institution that refuses to exist only as a noncontradictory place for the dumping of contradictions.

Myth and Reality of Self-Government

Antonio Slavich

"Self-management," "self-government," and "community decisions" are terms that increasingly turn up in the reframed language of new psychiatry, to the point that one might think that these aims are being achieved in places which until yesterday were institutions of care and coercion, and that a new way of doing things is being created: more free and more "democratic" in terms of the management of power, and in which a mentally ill person can participate. This is certainly a seductive idea. It magically erases the fundamental contradictions that place the institution in contrast with the patient in a nondialectical relationship which revolves around objectification and subordination, the only relationship that is compatible with the goals of that institution, which are social exclusion or, in a different way, their rapid social reintegration as a productive being, and to ensure the preservation of that same set of institutional mechanisms. This seductive idea is above all one that manages to place violence in its various forms in brackets, a violence that is the only way to manage such a set of contradictory relationships. It is, above all, a seductive idea that removes from those who officially manage power in these institution an embarrassing set of contradictions in which they find themselves — and despite themselves — immersed.

If we ignore these deep-rooted contradictions, any sense of a "community self-government" on the part of the patient can only lead to abstract and vague models. Despite their different origins in terms of their ideological roots, forms of "self-government" always work in a nondialectical way. We can identify, in this regard, the following three positions:

a) A perspective that argues that a simple reversal of the situation can lead to the resolution of all contradictions inside institutions and patients assuming high-level and rational decision-making capacities, in a sort of "psychiatric republic" limited to one microsocietal area, arbitrarily detached from specific social realities, which are the main sources of each institution's makeup.
b) A second perspective represents the possibility of "self-government" of the mentally ill as a threatening and antagonistic contradiction. This "sick power" is marked by dark aspects of irrationality and chaos. And this kind of hypothesis is therefore useful in order to justify, as a counterpart, the authoritative preservation of institutional power, in official hands, according to a classic asylum tradition.
c) A third way of envisaging self-government, which is currently quite common, sees a kind of spontaneous composition of internal contradictions by means of an enlightened *external* intervention, a *technical guide* (be it medical or sociological) that serves as support to the orderly and rational management of some aspects of institutional power by patients who have "become cooperative."

These three positions, which have been separated here in a somewhat arbitrary way (they tend to overlap, thanks to changing forms of false consciousness), end up creating a kind of false community. However, if these positions do not seem acceptable to us, in part because they are so vague, this does not mean that, when rethinking the possible meanings connected to the negation of an asylum institution, these problems should not be posed — albeit in a different way.

In fact, one cannot speak of self-government on the part of the patient without posing at least two clear questions: one about the actual nature of power the patient has, and the other about the historical means for the transfer of this power from a traditional setting to the patients themselves, in the context of an attempt at the overturning of the institution of the asylum. This possible transfer of power cannot be merely looked at in theory, but must be verified in a concrete way, before it is possible to talk about "self-government." Therefore by abandoning any temptation to remain in the realm of philosophy, and by attempting to analyze contradictions as they manifest themselves in an institutional and concrete situation — the experience in Gorizia over the last six years — we can try to analyze the attempts to redistribute institutional power, and see if, and in which ways, the powers acquired by patients had real weight in terms of a crisis of the structures of an asylum institution, and if these were different to those of what might be called "community democracy" or "self-government."

In the typical context of a traditional psychiatric hospital — as in Gorizia in 1961, at the beginning of our experiences there — patients were not in a place in the hierarchy that allowed them to exercise any institutional power in a positive way. They were clearly "outside of the game." The logic of the institution did not allow for any deviation from the norm, and any idea of self-government by the sick, therefore, was not even an object of discussion. However, the physical presence of the mentally ill still has an impact to some extent, and it is not negligible. First of all, they still constitute the very reason for existence of the institution and are therefore a key reference point for everyone involved in any kind of organizational activity and for anyone who finds themselves within the hierarchy of power with some margin of control. Secondly the weight of this presence, even if only in the form of numbers, is also measured reflexively by the harshness of the coercive and repetitive practice that the institution must use to marginalize, schematize, and simplify a problem that derives from a mass of objects of care: the patients. The total disempowerment of the patient is not, however, negated by

concessions to some individuals in terms of personalized power, in the form of privileges that can be exercised exclusively within the narrow limits allowed by the system.

The deep contradictions between the institution as a mechanism and the sick as an object of care therefore ensures that power is entirely located in the first of these two camps. The characteristics of its distribution are, however — and they were in Gorizia — quite complex, and they are themselves contradictory. First of all, there is the hierarchy of internal authority which, while both complicated and stratified, exists and works in *coherent solidarity* across various levels, based on an objective agreement over institutional purpose. Doctors and care personnel all receive the same kind of social mandate relating to care and the use of custodial practice and are an integral part of the same functional mechanism. As such they act in ways which are both supportive and compliant — each with their own technical models — for the achievement and maintenance of an institutional outcome. Their common connection to the same subject of the exercise of power — the mass of the sick — facilitates the distribution of hierarchical roles between different professional categories and within each of them. The patient develops into the only, and entirely passive, means of operational communication between these different categories: doctors, nurses, religious and administrative staff, etc. Yet they also remain within the circles of their respective corporatist interests and identify with the sociocultural constraints of the respective caste.

This formal solidarity between different hierarchical levels is facilitated by a social demand that is constantly renewed in a process that is resolved only via direct contact with the object of that demand (the patient). The delegation of the management of power for institutional purposes arrives at a hierarchical peak from outside of the institution itself, after a long series of steps that involve the basic structures in external society and its sources of power (the family, the social environment, the patient's workplace; then the judiciary, the forces of law and order, etc.). The role of managing the hospital, for example, develops into a form of embarrassment for doctors who,

inside the hospital, soon hand this power over in a hierarchical way to care personnel, in ways which formally follow legal rules, while the "scientific" needs of treatment are satisfied in terms of the "general rules" of care. Support and administrative staff are told to exercise direct power on patients. This is a broad form of their role, assigned with a wide margin of discretion, and which allows for the exercise of direct and personal authority on the patient. It follows that, in a traditional asylum, a doctor holds only formal and abstract power, while this power is actually exercised by the nurses in a substantial and concrete way: they decide on, concede, deny, and create the image of the patients — be they "good" or "bad" — in ways which are then communicated to others (including the doctors).

This mechanism of the passing on of power in a closed hospital can also help to explain how the doctor always manages to maintain a kind of respectability in the eyes of the patient. Their absence from the hospital, justified by the impossible nature of the doctor's various professional commitments, when the doctor is substituted by the broad delegation of roles they hand over in terms of the practical details of care, saves the doctor from the embarrassment of decisions that concern the patient in a face-to-face setting. The doctor can then present themselves to their patients with a strict and distant "mask" that is institutionally correct and lacking in any form of compromise, and they then act as a kind of technical "ghost" who has knowledge and can act, and who is the only real counter-power (within the hierarchy) in terms of the nurses, who instead are an uncomfortable presence who really decide and act in terms of the patients. For the patient, it is the doctor who keeps them in the hospital, and this fact also becomes connected to roles given to them by the system. Thus, the patient ends up accepting, in most cases, a long period in the hospital which is always linked — in the end — to the doctor.

The nurses invariably and diligently perform their duties, even though they are compromised by the physician's disproportionate authority over the patient. Regardless of the personal reasons each nurse may have for working under the institution-

alized and frustrating conditions typical of psychiatric hospitals, it is clear that this is not due to an inherent aptitude for institutional violence among nurses, but rather their violent function as defined by organizational limits. Contradictions stemming from a more mature form of class consciousness, especially among nurses, remain dormant or highly controlled. The contradiction related to the disparity between formal power and actual responsibility among nurses is internal and secondary to their functional solidarity with other professional categories, which is constrained by a rigid hierarchy of roles.

Within the power structures that manage the institution, the religious personnel who are usually at the top of a closed subsystem (a ward or hospital service), between the physician and the nurse, occupy a specific position. The nun fully accepts, like other categories, her functional solidarity with the institution's goals based on a social role which is consistent with the rules of a religious order. However, she tends not to further delegate personal power over the patient, preferring instead to manage it herself through a constant presence in the ward. Thus, she becomes the most reliable figure to whom the physician can delegate authority, imprinting a personal style on each subsystem. She effectively aligns institutional goals with those of religious rule, but to achieve this, she must marginalize not only the patient but also the rest of the nursing staff, managing antagonistic structures that are continuously subdued and controlled with some skill.

This, very schematically, outlines the ways that power was distributed in terms of the "governance" of the institution, at the moment when we started working in Gorizia some six years ago. This was a situation which can probably be found in many other psychiatric hospitals, as total institutions tend to replicate themselves. Of course, the decision-making power of the patient was utterly nonexistent.

At the end of 1961, a new director [Basaglia], followed shortly by another physician [Slavich], began their work in the hospital. Their rejection of a mere preservation of the institution and a formal-style management of the social exclusion of the mentally

ill led to a *sharp break in the functional solidarity* between some doctors (including with the hierarchical leadership represented by the director) and the remaining caregiving and auxiliary staff. This rupture in solidarity caused a disruption in the chain of institutional power delegation. A group of doctors assumed and managed power themselves, forming a vanguard that negated the asylum structure, its conditioning rules and norms, and associated forms of institutionalization.

During this initial period, our work often broke with established norms. We were a constant and ubiquitous presence on the wards; we used a renewed medical and psychopathological approach to the patients, in an attempt to see them beyond the barriers of diagnosis; there was swift abolition of all physical restraint methods and active vigilance in order to avoid violent and coercive acts against patients; numerous institutional rituals that had lost any therapeutic sense were identified and denounced; some traditional methods of rehabilitation were reintroduced; there was a broad and nondiscriminatory distribution of those privileges which were previously limited to a few particularly "useful" patients; and a rethinking of a series of external socioenvironmental situations relating to the patients, leading to numerous discharges of long-term patients and numerous administrative measures aimed at improving the living conditions of the patients. Even if by 1962 the vanguard or leadership in the hospital had expanded with the arrival of new doctors and an increased consensus amongst some staff, there is no doubt that those initial acts, which took in the entire institutional structure, were only possible thanks to the unmediated exercise of power from above, in a hierarchical structure which was forced to keep itself in place in order to negate itself. Such an extensive attempt to overturn asylum structures inevitably led to a profound crisis in preestablished positions of power at various levels, amongst different professional categories, and in various subsystems. In particular the nurses, who lost their roles as a harmonized and autonomous group exercising personal power over patients and deprived of a mandate from the doctors, were abruptly removed from their institutionalized

condition and faced a fundamental choice in terms of understanding the meaning and value of their individual presence at work. This choice was lacking in new norms and predetermined values as reference points (except for the rejection of pure forms of prison guard-like behavior and some subjective provision for a vague therapeutic sense in their work). Every collaborative choice contributed to a broadening of the leadership base, and every refusal reinforced a tendency to preserve the asylum, fueling strong antagonistic tensions and anxieties between the old power structures (which rediscovered forms of solidarity among themselves) and the emerging new power group.

Within these dynamics, patients still played a marginal and repressed role, remaining as the objects of the leadership's decisions and actions. Far from expressing any decision-making capability, they risked exposure to new, subtler but no less insidious forms of power. A temptation toward paternalism was inherent in the acts of the leadership. Formally, this voluntary "passing on of a therapeutic meaning" could indeed appear as paternalism, but was distant from this tendency only insofar as its practice, in a rapid series of organizational phases, was both formulated and immediately negated in a dialectical way, and this prevented any sense of a preservation of the institution by carrying out a stable form of reform, which aimed to constantly subvert its premises. Certainly, the vanguard's decisions and actions worked in favor of the patient and not the institution per se. But they were still decisions-in favor-of, resulting in gifts from above or the granting of privileges, and were initially perceived as such by most patients.

A decision qualitatively different from those that had gone before regarding possible redistribution of decision-making power was the opening up of the first long-term patient ward in November 1962. This was a litmus test in terms of the vanguard's determination to restructure the therapeutic institution on new foundations. Considering that the main form of power as exercised over the patient in terms of a custodial-type ideology was represented by restrictions on freedom of movement and the visual control of a limited space, an irreversible break

with this form of ideology was achieved with the opening up of wards and the introduction of unmonitored movement within the hospital. Despite many reservations and forms of resistance, with temporary and at times compromising measures taken as a precaution, four more wards were opened in 1963.

Initially, as an increasing number of patients gained more freedom of movement with less conditions attached, most remained on the margins of the active processes of institutional renewal; they were united in possessing a freedom granted from above but were still unsure of how to use this freedom except in response to predetermined sociotherapeutic stimuli; others remained confined within numerous asylum-like pockets of closed subsystems. A slow and contradictory process of reindividualization helped some patient leaders to emerge who, through genuine forms of collaboration, began to support the leadership/vanguard. This period (1963–64) saw some patient-managed initiatives facilitated by the care team, which were formally "autonomous" in terms of their management and used internal communication and means of propaganda (such as the patient hospital magazine *Il Picchio*), and were in contrast with the traditional framework in which they were produced, creating "revolutionary" if partial forms of patient self-governance. Some of these initiatives also enjoyed some visibility outside of the hospital — above all through the changes in public opinion created around *Il Picchio* — but were created thanks to an open but limited group (in terms of the hospital as a whole) of long-stay patients — at most 15–20 people — with a clear leader: Furio.[1] Nonetheless, these initiatives, though small in number and run by a few recognized leaders, aligned perfectly with the goals of the vanguard who were aiming at renewal. These patient contributions were significant in this period, particularly in forming organized patient groups from different hospital sectors and organizing and animating leisure activities with traditional

1 A reference to a patient called Mario "Furio" Furlan; see John Foot, *The Man Who Closed the Asylums: Franco Basaglia and the Revolution in Mental Health Care* (Verso, 2024), 120, 127, 173–74.

means (parties, trips, an internal library). However, this contribution was perhaps not as indicative of any redistribution of actual decision-making power as it appeared. This is evidenced by the minimal resistance from conservative forces against these patient initiatives, compared to the significant resistance caused by the free movement of some patients who disrupted the "calm" of the institution. Even as the idea of "the collaboration of all" and the use of group dynamics to overcome specific institutional or interpersonal contradictions developed, and the hospital's primary goal officially returned to being a "therapeutic" one with structures like a "patient club" and various "committees," etc., representing a "democratization" of institutional life, patients still experienced their stay as either a collaborator in decisions and suggestions from the leadership group or as the object of therapeutic initiatives and sociotherapeutic initiatives. Any margin of freedom, though real, was slowly built through an ability to manage their own space and opportunities independently within the institution.

In this phase (autumn 1964), marked by a progressive internal opening and liberalization, with the irreversible granting of physical freedom to patients and the slow reappropriation of psychological freedom *within* the hospital, the formation of the first "therapeutic community" in a long-term ward took place. Initiated thanks to a medical decision (the opening of a sixth ward, the transfer of many patients between wards, the selection of staff and 54 patients for this community experiment), this initiative was significant as it called for active collaboration of a large number of patients from all the male wards. In ward meetings, which began to spread throughout the hospital at this time, and daily interactions with the *équipe,* patients played a determining role in organizing and managing the ward's daily life, establishing rules, shaping its culture, and criticizing residual institutional mechanisms. Although the organizational "decisions" and the solutions to problems, without having to defer to those further up the hierarchies, represented the most striking aspect of the experiment, given its context, the value for the entire hospital actually lay elsewhere: in the possibility

of achieving real and direct communication among all ward members; the concrete subversion of hierarchical verticalization through a continuous effort to establish a precarious form of equality; the collaboration of everyone toward the same therapeutic outcomes; and the discussion of interpersonal issues and tensions without the exclusive and decisive intervention of forms of medical authority.

This first community experiment created a kind of ideology, formulated slogans, and tried to spread certain formal principles of therapeutic organization throughout the hospital. The role of the 54 patients in this initiative was significant, as they actively argued for the opportunities and benefits of the "new" community management in other wards. Spontaneously, groups formed in opposition to ongoing forms of life on wards. And at the same time as the therapeutic community in 1964 a bar was opened, managed by the patients. This group quickly developed its own consciousness and culture, though their expectations were still conditioned by medical decision-making power. The experiment was seen by these patients as a collective effort that would lead with time to their discharge from the hospital. This promise of future freedom helped to maintain cohesion and activate dynamics that appeared externally as a model of "democratic" and community management.

During 1965 and 1966, this "community culture" gradually extended to most of the ward subsystems. Each ward started holding meetings, *équipes* met weekly, and organizational meetings and "committees" were formed and dissolved constantly, often negating themselves. It was not by chance that with the arrival of new doctors in this period there was more progressive movement in all the subsystems on the wards and their complete opening up, and an increase in the number of meetings. In November 1965 there was a spontaneous call for a general meeting, which allowed for all those who wanted to participate from across the hospital, in all kinds of roles, to do so. Decisions relative to these initiatives were still the preserve of the leadership, but many of them were seen in a hostile way by patients, who didn't see any relevance for them in these plans and ideas.

The intensification of communications and broader participation from the base in the alternative opportunities within the institution led to certain services, especially for activities during "leisure time," being freed spontaneously from the control and organization of the *équipe*.

This process of widening collaboration among doctors, patients, and nurses, suggesting a hospital-wide "community" base with a sense of real and active patient participation, could be seen as misleading if some of the most glaring internal contradictions that seem to partly work against this community process are not also considered. So, for example, the relative mismatch in the timing of the process in terms of opening of the female wards compared to the male ones is important. The presence, in each of these wards, of the usual "decision-making" bodies (meetings and discussion groups) did not prevent a relative persistence in terms of hierarchical structures, which in many cases heavily influenced the margins of freedom enjoyed by patients. The reasons for this are many, the last and most negligible of which seems to be the often invoked "passivity" of women, which, it was argued, could also be seen among female *patients*. But there are probably other reasons for the lack of deeper penetration of the overturning action of the asylum institution into these wards. First and foremost, a less active role on the part of the vanguard and also the resistance of the hierarchical sectors of these wards, represented by the nuns, to any loss of control over the personal power over the patient.

Another important contradiction was represented until very recently by the presence of the last two closed wards. Even though these had not been used for some time as places of punishment or for the control of deviance, the possibility of punishment still existed in some people's minds, which acted as an internal counterweight to the progressive concession of freedom of movement to patients. Recently, these last two wards have been opened. With two further "rupture" actions that exceeded the power of internal "decision-making" bodies (which were largely controlled, in these two closed wards, by subgroups of the nursing staff), currently *all* patients have the *theoretical pos-*

sibility to disengage from the custodial system and manage their own personal freedom of movement, availing themselves — or not — of the alternatives that institutional life can offer.

This historical outline has only considered the possibilities that the patient has had and has to position and oppose themselves in relation to old and new positions of institutional power. Our initial conclusion might seem entirely negative: in the progressive formation of an increasingly broad vanguard aiming to overturn of a traditional asylum condition, the patients "officially" seem to have played little part. The doctors seem to have succeeded in imposing their power, even though they intentionally tried to negate their traditional roles, thus showing a persistent and contradictory commitment to their social role. Other professional categories have had the opportunity to give new meaning to their work in the institution, largely by active participation in common forms of action, which still appear to be affected by internal contradictions in terms of the doctor and the patient. Patients have also benefited, *within the institution,* from a *possibility* of rediscovering themselves, within the boundaries of *personal* freedom beyond their condition of exclusion. They have regained some forms of freedom from coercion (though not, for example, from need), and they have been able to enjoy interpersonal contacts, manage their day individually or in spontaneous groups, choose among certain alternatives, etc.: all this within a system with limits that are not only spatial, but are also predetermined by the mechanisms of the institution. In two distinct periods, over these six years, the activities of the patients have shown a tendency to formalize themselves in an apparently orderly, calm, reassuring manner. During a first period (1962–63) this happened around the passive enjoyment of "sociotherapeutic" privileges distributed *en masse* from above; a second period, more recently, saw a conformist acceptance of "democratic" formal rules, in "committees," in activity groups, or sometimes in meetings. Some of these activities, as has been argued, have fallen into disuse, negated by the patients themselves as their artificiality and functionality within a new system of institutional control became clear.

The patient now has the power to negate some of the proposals of the *équipe,* yet they do not do so through a majority form of "decision-making" but by individually denying cooperation. Here we can see the contradictory functions that coexist in meetings, where discussion groups emerge, as they do generally in all those occasions for encounters where active participation seems to signify the achievement of a high level of "community maturity."

On such occasions, in fact, the encounter and confrontation with the minor and major problems of institutional life allow real communication among all participants, even if they remain in silence, and they allow for informal discussion in which everybody's position, thoughts, and externalized images are engaged. They also make possible a kind of awareness that, at most, can concern any of these issues and contradictions, including those of the limits imposed by the condition of exclusion, and the objective impossibility, on the part of the patient, of making a decision that would rupture these limits.

The orderly and formal appearances of discussions in meetings can resemble parliamentary-type models, and once again, in the face of the complex system of meetings, the image of "self-government" of the patient within the institution reappears. However, together with this image, another aspect of the contradictions concerning assemblies also emerges. "Self-government," as mentioned earlier, presupposes power, and this must be capable of translating into decisions that confirm the power of those who make them. Looking beyond the formal parliamentary-type appearance of these meetings, it is legitimate to ask this question, "what are the real decisions made in a psychiatric institution, and how much does the patient have a say in each of them?" An answer perfectly in line with a communitarian ideology could be something like this: "*Everyone* decides, *all* decisions are important." But in reality, in an institution that continues to base its legal foundation on a fundamental contradiction between itself and the patient as the object of care and custodial power, decisions cannot all be equally important, as some touch upon, and others do not touch upon, this funda-

mental contradiction. Similarly, these decisions cannot be made by everyone indiscriminately, as long as such a fundamental contradiction remains, there will always be different participants with different roles.

What are, for example, in concrete terms, the different types of decisions that can be addressed in meetings? The following types can be identified:

1. In a closed institution, where the doctor has the power to coercively detain the patient and therefore continues to act in solidarity with the institution in terms of its fundamental contradictions, the key decisions are those concerning the patient's discharge to the outside world, their transfer elsewhere, and their possibility of leaving the hospital environment while maintaining ties with the institution (family visits, walks, etc.). With these decisions, the patient has no power and group or individual pressure in this regard can only be effective if it expresses a position that the doctor has already decided to endorse.
2. With "therapeutic" decisions, which are the prerogative of the doctor, the patient may have some margin of choice or the possibility of protest. However, they can usually exercise any opposition only through an overall denial of a certain type of therapy because they lack any technical power that can validate questions around the details of the therapy.
3. With internal administrative decisions (individual and group benefits, improvement measures, etc.), the patient may play a part, although this will be limited by participating in meetings with certain highly contentious opinions, when these truly could embarrass the official decision-making bodies. However, this happens very rarely, around facts and arguments that are able to mobilize mass forms of participation. It is undeniable, moreover, that the patient lacks any control over the timing and methods of implementation of these decisions, and, in any case, this type of decision tends rather to strengthen a "new" institutional system, to consolidate

the integration of the patient into the hospital microsociety, rather than to put its contradictory pacts into crisis.

4. Decisions concerning coexistence within the hospital, the organization of certain activities, and free time. Here there are real possibilities available to the patients, especially since the *équipe* seems to have relinquished its sociotherapeutic power, and its "long-run" organizational interventions. It is this latter type of decision that predominantly emerges in the meetings. However, it cannot be asserted that this reflects the power of the patient. They contribute, in a clear manner, to the formation of *community superstructures* that only make sense once they are negated, and do not impact upon the fundamental contradictions we have discussed in this chapter. Any of these decisions can indeed be made outside of forms of technical guidance, but this fact alone should make one suspicious of them and reveal the subtle forms of mystification constituted by labeling all this as "self-government."

If one overlooks the fundamental antagonistic contradiction between the institution, entrusted with a form of mandate which leads to the absence of care and to prison-like activities, and the patient, who is the object of this care and exclusion; if one would like to effectively make this exclusion acceptable to the patient by suggesting to them they could reclaim, within the institution, their "civil rights" by collaborating in the formal, orderly management of the internal contradictions of the institution, one ends up creating a strange kind of dysfunctional situation — as in a game. Every game, however, has its own rules, predetermined norms that do not allow for variations or "excesses." Every mistake within the rules of the game is penalized. It follows that any institution that decides to engage in formalistic community play must also provide, in contrast, strong and valid mechanisms for controlling forms of deviance. It has at least two paths ahead of it: the first, to become a "guided" therapeutic community, which explicitly accepts sanctions within the rules of the game, and consequently is based on the persistence within it of closed institution-like pockets capable of ensuring

these sanctions, with the risk of the negation and ridicule of the leadership or the guidance; a second pathway is to allow the tensions inherent in terms of institutional contradictions to grow to a limit beyond which a noncoercive, persuasive, and interpretative authority would intervene, and which otherwise does not reveal itself. At the heart of this second path is a sharp form of medical–technical power that trusts only in itself, and in its own abilities to interpret and resolve things. Even if this security appears antithetical to the insecurity of those who, following the first "community" model, still find it necessary to admit forms of violence as a counterbalance to permissiveness, from the perspective of the patient's power the result appears identical.

We have seen how even the hospital in Gorizia could not avoid the rules of this institutional game. Indeed, upon closer examination, there would be all the formal premises for it to have refined itself over the years to the point where the treatment team could always and in any case find itself in possession of the upper hand. But in the course of the process of overturning the asylum institution, the action of the vanguard, parallel to the (intermittent) rediscovery of the community-type game, intentionally laid the groundwork for its negation at the same time. In fact, at the moment when, even by virtue of a "gift" from above, the patient has reclaimed their freedom of movement, at a time when the opening of the wards has been pushed to its logical extreme and the opening of the entire hospital, the traditional mechanisms of custodial control are effectively sidelined, at this moment, the call for community collaboration from the mass of patients still demonstrates objective limits and is called into question. Perhaps this can constitute the real limits to the individual power of patients. Faced with the possibility of protest, even the individual and regressive protest of an individual patient, when multiplied by the numerical mass of the hospitalized and added to the logic created by the fundamental antagonistic contradiction between institution and patient plus all the mechanisms with which the institution can attempt to reform itself, can enter into crisis. The limits of permissiveness can no longer be predetermined once and for all, and above all, the

rules ensuring rigid observance of these limits can no longer be dictated. The real decision-making power remains, as we have seen, even in such an open situation, in the hands of the institution, as represented by the leadership of the hospital. But it is no longer possible for it to pass it on to a patient-led "self-government" that conforms to its own decisions and aims, and it is instead controlled in terms of the management of the "government" of the institution. Certainly, everything remains within a context of dialectical possibility. The protests by the patients are almost always unorganized, individualistic, and sometimes regressive, and occasionally even "ill." but it is through the *sum* of these possibilities that mass pressure arises, and can have an echo even outside the institution, in order to force the fundamental contradiction into crisis. Only when *all* possibilities are open does community management of the margins of freedom and personal power acquired by the patient within the institution begin to make sense. In this case, it is not surprising if the patient, while accepting some conventional rules of community coexistence, does not use these forms of power to underline the threatening hypothesis of a kind of "sick power" that can peter out in forms of sterile regressive-type protest and dementia.

As the patient moves away from their institutional conditioning, they can also grasp the meaning and goals of the leadership's overturning of the institution and can therefore use their forms of power to try, in alliance with the vanguard, to act in a common way (aspects which are discussed elsewhere in this volume). The reality of this common purpose can succeed, also thanks to a contribution in terms of power from the patient, in shifting the terms of this deep contradiction. This, thus, no longer arises between the institution and its object of care, but between the institution (which internally, in a precarious situation, rediscovers a common purpose in the overturning of its asylum-like characteristics) and a social context (which would tend instead to create a reformed institution with unchanged aims). The main contradiction shifts in this direction at the moment when the institution, also due to the participation of the "threatening" role linked to patient-driven dissent, begins

to become a problem for the society that expresses it. From this perspective, the internal contradictions that can be seen within the institution are relegated to a secondary role compared to a new dominant contradiction. Within the institutional field, dynamics between different roles and power positions that tend to dialectically resolve such contradictions can now be played out. The patient has a real part in it all, even if they do not actually "self-govern." It is also likely that from this participation they can derive benefits that the doctor would call "therapeutic." But faced with this possibility of mass participation and dissent of patients in terms institutional dynamics, it will now be very difficult for the medical–technical power to feel reassured to the point of believing that it has found in the "self-government" of the mentally ill patient a new, more modern, and definitive resolution.

The Negation of the Traditional Psychiatric Hospital

Agostino Pirella

At a recent conference organized by a foundation in the USA that gathers together graduates from universities across the West Coast, some confidential psychiatric profiles of current Chinese political leaders were provided, which described them as paranoid. In this way, it was demonstrated, using "scientific" evidence, that we can only expect fear and threats from a paranoid person. Some people observed that the presence of US armed forces around China was not a demonstration of a friendly attitude of the Americans toward that country. This was rejected as propaganda.

This is an episode (whose source is serious and reliable[1]) that is useful both as an example of the circular self-justification of science and of its sensationalist use for political ends. 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 as "propaganda." A problem is reduced to an undeniable fact.

1 Saul David Alinsky, "The Poor and the Powerful," *International Journal of Psychiatry* 4, no. 4 (1967): 304–9.

On the other hand, the "scientific" management of problems only appears credible as long as the contradictions between scientific power and society, that is, between the possibility of truly serving a citizen and their needs and the concrete outcomes that are provided as a response to these needs, become acute and explode in a dramatic way.

At this point, there are two possible positions available for "scientific operators." They can continue to ignore the new problems opened by these contradictions, carrying on in their usual ways of managing things and trying, perhaps, to cover up the cracks that continue to open up. Others, instead, may begin to see a need to intervene in a more decisive way because they realize that all the usual knowledge and all accepted practices are at risk of collapsing after entering into crisis. In both of these possibilities, there is a response to a crisis and an attempt to overcome it, but in ways which maintain at all costs the old structures (in the first case) and through a sense of renewal that presents itself as positive and able to resolve contradictions (in the second).

Psychiatry has become simultaneously, in the course of its short history, a branch of medicine (and as such a presumed site of diagnostic and therapeutic acts), a theoretical–practical science connected to the study and identification of specific forms of deviant behavior in individuals, and a form of management of these individuals inside those institutions called psychiatric hospitals or mental hygiene centers. This fact has contributed to the gradual rise in contradictions that have been hidden and silenced for some time in Italy thanks to various forms of disengagement and in connection with the lack of development of a postfascist society. There is no doubt, for example, that the possibility of avoiding confinement in a mental asylum for those who can afford treatment in a private nursing home has contributed to an almost absolute silence about the dramatic failure of psychiatry. A mentally ill person has been for many years, and still is, someone who can be treated brutally, a citizen deprived of their rights. They can have their personal freedom taken away, as well as their possessions, and be denied human rela-

tionships for an indefinite time, and they respond in a pitying way: 'what have I done wrong?" They are those who have broken rules. They are "deviants." Psychiatry has for years delighted in building a fortress of criteria and labels around itself, and has, in turn, constituted itself as a kind of norm or set of rules. The functionality of social rules and scientific rules in terms of the stabilization of a political system is clearly something that can be demonstrated. Need we refer back to the previous example concerning the psychiatric profiles of Chinese leaders?

One of the most tenacious and self-defensive rules of all is that which is connected to the fate of the mentally ill in our society. The mentally ill cannot be tolerated. Their way of appearing and living must be concealed and repressed. Even though the generous distribution of new kinds of sedatives may have contributed to suppressing the most obvious manifestations of "madness," social attitudes toward the mentally ill have not changed. The infraction of norms around "civilized living" must be punished with a specific form of confinement and through terrifying or unpleasant therapies. The reality of the asylum constituted and still constitutes, to a large extent, a very efficient punitive structure with horrific aspects that are often forgotten. We might argue that this is the first major contradiction in terms of scientific optimism and practical reality. Naked violence, the blatant oppression inside psychiatric institutions, cannot be reconciled with scientific aims of therapy and rehabilitation. Since the places where the mentally ill are hospitalized are called "hospitals," the medical evidence around interventions aimed at the "treatment" of deviant behaviors is contradicted by these openly oppressive situations. The harsh and dramatic limits of this attitude, which passes off as medical what is often vulgarly terrorist, is mainly found in the punitive use of certain "therapies." It is known that punitive intent can be seen in the transition between who is active and who is passive in terms of treatment. The fact that in psychiatric hospitals it is often said, for example, that "if you don't behave, I'll give you an injection" (or an electroshock, or something similar) implies the presence of an oppressive dynamic that is hidden behind a naive form

of medical ideology that claims to be legitimate. The fact that certain "therapies," such as pyrotherapy, cardiazol shock, etc., are no longer used, shows that their openly punitive meaning is no longer acceptable for those who intend to replace them with another attitude whereby violence is more subtly and crassly hidden.[2]

Medical ideology continues to falsify. An Italian psychiatrist explicitly testified at a conference about the effectiveness and worth of a drug that, due to its lack of taste, can be secretly administered inside food. This drug solves "the problem of persuasion, an occasional necessary enticement for hospitalization with those who resist or protest … the rebel becomes docile, like a lamb! And in the best cases, if he suffers from spastic torticollis because of the drug, it is he himself who asks for the intervention of the neuropsychiatrist! So, in some cases, even neurodisleptic syndromes seem welcome!" We can also see, moreover, in this case, a sort of racism that tends to use unpleasant side effects for purposes linked to oppressive power. The need to consider contradictions leads to increasingly pronounced forms of mystification. The hospitalized, after being "enticed," deceived, and oppressed, are now entertained with performances, dances, activities, work, which are all passed off as therapy. This prepares them for the two solutions prepared for them by the institution: forced rehabilitation or a habitual attachment to a place that will now be their home, and both cases involve the loss of their personality and the emergence of a deep dependence on others. The breach of norms around "civilized living," an inability to "play along," the anguish of living in a world that rejects and oppresses, all this is paid for with a journey to the total institution.

The doctor who tends to reject an entrapment through a false form of ideology discovers this contradiction after their first contact with the world of institutional violence. They enter this world with tools that immediately prove to be useless and

2 A method of "treatment" involving the raising the body temperature or sustaining an elevated body temperature using a fever.

poisonous. They are not faced with patients, but an institution of violence. However, to discover and make evident this violence, the doctor must begin to negate it. They must, that is, reclaim the power they have delegated to the institution and no longer wield in order to "keep their hands clean." There are nurses, after all, who can restrain, immobilize, and lock people in isolated rooms. This division of labor, the separation between intellectual and manual work, is a form of privilege. The doctor who negates this ideology negates violence in its practical forms. In reality, they also want to highlight hidden forms of oppression. The doctor begins to wield their power in order to reject physical force and confinement in restricted spaces like rooms, dining halls, and wards. Their movement of negation thus begins.

The denial of confinement implies an immediate refusal of a social mandate. This is a mandate that society hands over so that the hospitalized are "guarded" in a way that they cannot do harm and therefore lose any possibility of making autonomous and responsible choices. A psychiatrist who refuses this role assigned to them is a person who is aware of a permanent contradiction which is concealed by medical ideology, whereby a person reduced to an object against their will should be considered "ill like all others." The psychiatrist tends to repudiate both this social mandate and the medical ideology that masks its more degrading aspects. This rejection, developed in close contact with the reality of the institution, is constructed both against ideology and against the concentration camp-type reality that this form of ideology tends to conceal or justify.

The rejection of ideology and the denial of the reality of violence thus combine to favor an awareness of what should not be done, of what must be negated in concrete terms. It is evident that initial stances and the subsequent "transformation" of the hospital were essentially born as forms of negation and refusal, and not as definitive and tested proposals. The reference to British models was experienced as a simple point of support and not as an exercise in guided restructuring. Denial does not imply a "positive" to which to refer as a model, but simply a refusal to perpetuate the institution and an attempt to constantly force it

into crisis. This act of systematic denial involves not only the traditional role of the doctor (who thus appropriates power first-hand) but also the roles of nurses and patients. The role of the "good patient," that is, of a kind of obedient and docile servant, the regressed patient, the authoritarian head nurse, are also negated and contested. This denial then also affects relationships and institutional rituals. Why must every initiative come from above? Why must the patient be "given" what they receive? Starting from the denial of violence, which is thus unmasked, one reaches the radical denial of the institution itself as a place where no one ever decides for themselves.

The First Contradiction: Authority

Within the context of the negation of the use of violence, manipulation, and objectifying and distancing forms of relationship, a sense of the negation of authority progressively takes root. A refusal to accept dependency and a sense of the value of protest, both in relation to patients and among members of the *équipe*, opened up relationships that required continuous verification and full and constant participation in the choices of various collectives (wards, groups, etc.). Within this context, traditional forms of the hierarchical development of power lost meaning — they had already been widely negated — as did straightforward authority-type relationships, even if purged of some of their more oppressive aspects.

The hospital thus found itself in an initial contradiction which could be understood historically, since the negation of authority had initially been accomplished with an act of powerful authority on the part of the director and the doctors. Everything, that is, began with an act of power, with what in another section of this book is defined as the retaking of power that was initially delegated to the staff and the institution by the doctors. The doctor began to negate aspects of the hospital via a powerful authoritarian act, and the contradiction arises from the fact that negation tends to also invest authority relations. While the oppressive meaning of a whole series of pseudomedi-

cal behaviors was being unmasked, and those forms of oppression were brought to the fore, it was also made clear that violence and blind forms of authoritarianism are a kind of "evil." But in practice, it seemed that the authoritarian use of power for the purposes of negation could still be something "good." This rule, born from negation, was both affirmed and denied at the same time. The denial of violence appeared as a "deviation" from a previous institutionalized norm and the expectations of a "healthy" society. This deviation expressed all the real possibilities of protest possible within the institution and escaped automatic sanctions, but did not take shape as a new norm. While this type of protest avoids institutional condemnation (to which the patients, by contrast, have been subjected), the institution continues to survive, positioning itself at every moment as a place of both rules and sanctions. This is a contradictory rule or norm and therefore open to discussion and protest, but also to punishments, at least insofar as it continues to separate people. This contradiction affects all institutional relationships and occurs with equal intensity in all three significant parts of the hospital: amongst patients, doctors, and nurses. We will discuss some specific examples of this later.

The Second Contradiction: The Norm

The negation of violence has radically undermined the hospital and therefore could not become a norm. The norm of negation has neither power nor meaning. Constantly it is said that a gesture, a movement, or a choice is "good" or "bad" or that it is "therapeutic." But in the end, there is a realization that the institution is a norm in itself, and that if one begins to negate, one must arrive at a global negation of the institution. Between negating the institution and negating the possibility of protest, there is often an acute contradiction. Indeed, what appears as the possibility of protest, of crisis, is "good," but what appears as a major inconvenience, as an obstacle for all, as a kind of paralysis of associative life, is "bad." A typical institutional example can be seen when some patients break the rules, such as leav-

ing the hospital without permission, getting drunk, or behaving in a way that destabilizes. The discussion that opens up at this point often demonstrates that these attitudes express a critical response — a kind of protest — in the face of an institutional system, forcing everyone to take a position, to redefine relationships, roles, and to discuss the very meaning of being in the hospital. On the other hand, this crisis also means, in reality, a risk of "death" for the life of the institution, an example of "evil" that everyone tries to conceal, to reject, to push away. The critical ownership of these destructive gestures is not merely a theoretical fact but a practical way of choosing and giving oneself an identity in reality. Good and evil are constantly reproposed as models, not in terms of ethical norms, but as social and "scientific" facts. On the other hand, the real conflicts between the various members of the community cannot open up a discussion on what is to be understood as a norm, except for the very general one of the negation of violence, physical oppression, and exclusion. It is instead precisely those real conflicts that guide the situation toward new choices, such as protests against nurses by some patients and criticism of doctors by some nurses. In the negation of "scientific" decision-making powers, a traditional aspect of culture is denied: the knowledge in the minds of a privileged few. What has been called "thought" is negated within the crisis of decision-making power. What is at stake is not just the rejection of an oppressive institution but also the rejection of the possibility of its automatic reproduction, which is linked to the rejection of a society that produces and maintains this type of institution.

That which is sometimes called "medical knowledge" (following Francesc Tosquelles[3]) presupposes a process by which everything that takes place in the field can and must be critically evaluated and arranged into value-linked models. The negation of this process starts with a phase of intense disorder, but it can become practically verified if everyone present contributes to its development. Criticism does not remain the privilege of those

3 Francesc Tosquelles Llauradó (1912–1944), Catalan psychiatrist.

who carry the "knowledge" of science. The possibility of collective verification of those who create the rules (be they social or scientific) and see the possibility of new norms, which are still to be invented, in the rejection of "technicism" and the straightforward defense of one's own beliefs. The contradictions here are both those linked to the division between intellectual work and manual labor and to a clash between the real need, for a hospital, to respond to the duties imposed upon it by society and a negative way of responding from within, a practical reinvention that tries to reject false and medicalized ideology.

The Third Contradiction: Patients as Inmates

The very role of the patients has been called into question both by the reappropriation of hospital space and by the contrast between this "internal" reappropriation and external exclusions. The mentally ill, who are seen as irresponsible and dangerous to themselves and to others, can regain some possibility of control in the community. They take part in debates, move around within the hospital, lose their traditional forms of labeling as the institution transforms, and as patients, along with doctors and nurses, try to effect change. All this seems to many like a sort of technical solution aimed at rehabilitation. The decisive fact here, however, is that this new freedom gained within the institution, while demolishing the myth of the mentally ill as dangerous, clashes with the barriers that society itself maintains, be they psychological, social, or economic. An awareness begins to emerge around the fact that society produces the mentally ill not in a simple causal sense but as products of exclusion, and that internal freedoms can become alibis for subtler and quieter forms of exclusion. When a patient can only leave the hospital with permission and accompanied by someone, they are forced to realize that they are "no longer human" and not considered responsible for their actions, and this opens up a contradiction between internal freedom and external oppression. By using current legislation we only underline the excuse of considering the subject of exclusion as someone who is "ill." The "patients"

are therefore inmates, hospitalized individuals, capable of practically understanding and checking, together with doctors and nurses, the contradictions within which they are forced to live.

The Fourth Contradiction: Doctors and Nurses

As has been argued elsewhere in this volume, the choices of the medical team are those that arose at the start of the decision to negate and were laid out in terms of a form of institutionally legitimate leadership, albeit one which is open to protest and criticism. The sociopolitical, scientific, and "humanitarian" motivations underlying all of this could also be the object of discussion. What is most evident, however, is the role of nurses, as opposed to the *équipe,* as a group or caste with specific interests, who share a common fate, and have similar problems. This fact is obvious in an institutional situation such as a psychiatric hospital. But the clear nature of this separateness implies a whole series of complications that place the staff in a difficult position, caught between participating in the choices of the *équipe* (with the sociocultural implications this entails) and protest about and toward that *équipe* (with partial mimicking of the patient's role and a demand for autonomy). The debates published in this volume about the opening of wards very clearly pose the problem of the relationship between a leadership or vanguard that opens things up and the staff that may or may not be involved. It would be easy to assert that the staff recognize themselves — collectively — as a defense mechanism in terms of the anxieties created by a new situation. In reality, things are not so simple, because this author is a doctor and cannot help but see the risk of positioning himself as a kind of external judge. This contradictory aspect seems to be part of a broader set of contradictions between autonomy and dependence, protest and freedom, which seeks partial "solutions" in the creation of a homogeneous group, and, ultimately, a class. A discussion of one case study, about a staff strike, may help clarify this point.

Contradictions and Institutional Reality

The end of the closed institution, which was able to hide its contradictions and suppress all protest in order to maintain a clear conscience for the establishment, has "produced" the contradictions which we have outlined in a schematic way in the four preceding sections. In them, we framed the conceptual aspects that refer to the daily experience of reality in the hospital, as discussed in various meetings and interpreted on a number of occasions, and not only by members of the *équipe,* and seen as crises, contradictions, and sometimes as defeats, but never judged via a sense of detached and scientific "serenity." They have been experienced from within and acted upon as situations in which negating the institution means negating ourselves as representatives of oppressive power and the ideology that justifies this power. We will therefore examine some significant institutional issues, those that are closest to these crises and most affected by them.

The Transfer of Patients between Wards

Usually, in traditional hospitals, ward transfers are arranged by a doctor or nurse based on organizational (the availability of beds), technical (the need for special "treatments"), medical (the type of illness), and punitive or "safety"' (decisions about an agitated ward, a disturbed ward, etc.) needs. The desire of a patient to be transferred to another ward is rarely considered, but even more rarely is it expressed, as the patient soon becomes accustomed to the idea that their wishes don't matter.

The negation of the agitated ward in the psychiatric hospital in Gorizia led for a while to the attention of everyone[4] being focused on the two remaining closed wards, one male and one

4 It is significant that while there is a word to indicate those who "inhabit" the hospital (patients), there is no word that includes all those who interact with the hospital field, even though they are important people (patients, doctors, nurses) [note in original].

female. Seriously institutionalized patients were on those wards, along with a certain number of those who had expressed behavioral problems in the past. During meetings, in terms of the life of the hospital itself, "going to ward C" sometimes implied a form of punishment, a sense of being "mad," or that of being unwelcome. Ward C, the only closed ward, became a place of exclusion within the hospital. At this point, it was clear that the hospital had to commit to no longer transferring anyone to these wards, and to instead transfer people from these wards to other open wards, in order to finally open the last two closed wards. It became obvious to everyone that no "medical" attitude could mask this violence of being locked up, and that no infraction of rules could justify the exclusion of people in a degraded ward.

This type of commitment did not unfold without problems, and there was also an episode that represented a glaring contradiction. The crisis was linked to the tension within each individual in order to ensure that the problems created by living in a ward are addressed within the ward itself and not hidden by a patient's removal, and to the point that now nurses, doctors, and patients often decide to discuss the problem of disruptive behavior without resorting to the regressive measure of a transfer. If a patient disturbs some of the others, it now seems obvious to ask why they are doing this and to look into the issue, not so much as an attempt to "solve" it at the outset but in order to "understand" it, to move closer to it, and not distance oneself from it. The main argument that seems to have made headway is that it is absurd to make another ward tolerate a disruptive person; it is much easier for the original ward to address the problem than the receiving one, even assuming that the patient in question wants to be transferred there. A discussion about a patient who had committed some impulsive violent acts against objects, and who seemed to be facing a fairly clear process of exclusion, is typical in this regard. The ward suddenly realized that they knew nothing about this patient, who had in fact already been excluded from the ward before even committing these acts. If the violence itself had contributed to a crisis on the ward, the absurdity of a transfer was obvious. Only by also dealing with

this person could a real (and not false or fantasized) judgment about them be reached. In this case, the level of tension on the ward could be considered useful for those forms of practical verification mentioned above.

It is clear that when tension rises beyond a certain limit, there is a risk of panic. This happened only once, in the male acceptance ward (after the decision not to transfer anyone to ward C), with a patient whose seriously anxious situation was punctuated by destructive outbursts against people and things. The possibilities of confrontation and participation were seriously compromised by this way of relating to the institution. A clear plan to destroy community relations and seriously disrupt coexistence was expressed by this patient. The absolute necessity of obtaining a brief period of respite from this chaotic and regressive type of protest suggested a need for a transfer to the closed ward, something which was provocatively and loudly requested by this patient. This sparked a long debate, in a variety of settings. A partial account of this can be found in the report from a community meeting published in this volume.

This problem is contradictory because it involves, among other things, the self-image that patients possess. For many years, and according to stereotypes common to so-called "normal" people, they have had an image of themselves as "mad," as people who cannot live like other people, who destroy every relationship, and who respond destructively to anxieties they cannot tolerate. In a conversation with the doctor, the above-mentioned patient reported a sense of nostalgia for the good old days when, after a transfer to the agitated ward, they could walk around naked, masturbate in front of others, and regress into unfettered forms of protest. And furthermore, they denounced the continuing closure of a ward (at that time, ward C was still closed) as evidence of the doctors' belief that a closed ward was still required, that cases like theirs had to be dealt with, that the mechanism of exclusion, of punishment, still had to be used.

The patient in question has now been discharged, having overcome their crisis in about two months. The opening of the last ward has now made a "solution" of this type — a transfer to

a closed ward — impossible. The institution needs to invent new ways of acting, or does the opening of all wards also imply the decline of backward forms of protest?

The existence of a highly specialized ward for alcoholics has repeatedly raised the issue of the criteria for transfers. A chapter in this volume is dedicated to this question.[5] It remains to be said that only a personal choice by the patient could have cut the ties of medical authority that overlap with the institution. In reality, it has emerged with clarity that a specialized ward within our hospital is inherently contradictory. The negation of criteria for transfer has become a denial of transfer. The transfers carried out in the last year have all been transfers requested by patients and discussed at length by all parties involved (the original ward, the destination ward). It is clear that this can lead to deadlock, such as in an admission ward, where the temporary and exceptional overcrowding of patients led to some relocation (at least for the night) to another ward. After long discussions, it was decided to choose a certain number of people according to nonmedical criteria (age, for example) to be selected by drawing lots. Obviously, this does not mean that a convenient way has been found for solving this problem if it should arise again. Problems exist and are addressed to the extent that there are no preformed institutional solutions that become (or run the risk of turning into) oppressive ones.

Thus, the hospital wards are different from each other today in two fundamental ways. The first is the distinguishing factor of whether or not they accept first-admission patients. The difference between short-term patients and long-term patients, which will be discussed later, is one of the key features of the current situation within the institution. The second is determined by the internal features of the ward: greater or lesser levels of comfort, the number of patients, forms of "social respectability." The two C wards, which were recently opened, are less "respectable," for example, and less comfortable. Internal exclusion also connects to these issues.

5 See the chapter by Domenico Casagrande in this volume.

Short-Term Patients and Long-Term Patients

Another element of internal exclusion is the presence, in a hospital setting, of patients who know they will remain in the hospital (and indeed do) for just a few weeks. Some of them have been admitted with insurance coverage, others, a few, pay directly for their stay.[6] The contrast between these patients, in various communal situations, with others who have been in the hospital for years initially created a state of conflict, of opposition, rooted in aspects of institutional "diversity." The presence of two closed wards until recently was a justification in itself for divisions. "Let's hope they don't have to go to C" was a joke which was often made, as when someone from the outside says, "you're like someone from the asylum."[7] The sense of ward C as "asylum" was negated by its opening up. But other oppositions remain, one of which is socioeconomic, while another is mainly cultural. The short-term patient, with their insurance coverage, with their intimate and close ties to the outside world, underlines the state of abandonment and loneliness of the long-term patient. The availability of money is clear for a short-term patient, while it is scarce for others. The clothing of the former is neat, almost elegant, while that of the latter is less attractive and less similar to that of the "outside world," particularly for women. Exceptions in this sense among long-term patients have gradually allowed a rapprochement that today appears to be intensifying. But this moment of coming together seems to be more linked to a feeling of common social exclusion than that of any sense of illness.

Here are some extracts from a community meeting:

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6 In the hospital of Gorizia, paying and insured patients are hospitalized in the same ward as "psychiatric" patients, subject to mental health legislation. The so-called neurological or open wards in psychiatric hospitals are to be considered one of the last mystifications of psychiatry in terms of underlining the differences between the "registered" and the "unregistered" [note in original].

7 *Sei uno del manicomio* is a phrase still used, similar to "mad" in English use.

SHORT-TERM PATIENT A: Look, now I'll say something you might not agree with. Last night someone said: you see, the rich people who are here, they come for a holiday, it's not like the old mental asylum, they come for a holiday and so on and so forth, and they feel good here.

SHORT-TERM PATIENT B: Something has been done, something that couldn't be done twenty years ago has been done.

SHORT-TERM PATIENT A: Look, I come from Venice, I don't know if I'm a difficult patient or not, I don't know, the doctors have to decide, but they told me… we can't just run away, because it's ridiculous, they bring us back immediately. But there are so many people who don't want to leave, some don't want to leave precisely because society rejects them, society rejects them, why? Who trusts a patient who has been here for ten years, even fifteen years? He's always been in a mental hospital. Yet mental illness is like any other illness, of the heart, of the lungs.

SHORT-TERM PATIENT B: And do you find this understandable or not? Do you find it understandable that Mr. X might want to take someone under his care tomorrow.…

SHORT-TERM PATIENT A: You have to take it with a grain of salt, but I know it's like that, it will be like that.…

The common condition of patients is therefore not an illness, but that of having been or being hospitalized in an asylum and undergoing or having undergone a process of exclusion. This is social exclusion, but also often exclusion in family terms, something which also affects short-term patients.

SHORT-TEM PATIENT: Why were they sent here? Because they couldn't survive outside, because outside they harmed the society in which they lived, and so they came here.

LONG-TERM PATIENT: What you say is not true, there are many who are brought here in order to get rid of them.

SHORT-TERM PATIENT: And then why do they want to get rid of them, you tell me? Why do they bother? They are a pain, I think.

The short-term patient begins to understand that one of the reasons for admission is "being a nuisance." And it is significant that the long-term patient was able to also elucidate their feelings of exclusion in terms that were acceptable.

On the other hand, for some time, and perhaps this even continues today, the short-term patient tried to defend himself from the annoying presence of the long-term patient in various moments of community life (bars, dances, meetings, outings) and has attempted to keep the other away, to create them as someone who must remain excluded. From an analysis of these debates this dynamic appeared similar to that of family members toward the short-term patient. This analogy led the latter to reflect on their condition and to seek an encounter, in a more dialectical way, with the long-term patient. There is no doubt that the short-term patient feels closer and less excluded in terms of external society (and is felt to be so by others). On the other hand, he is also the closest to a crisis of separation, to the problem of critical relationships with the outside, and the furthest from institutionalization. In order to negate these institutions of violence, he seems the most suitable candidate, the closest to the possibility of taking on a sense of responsibility. In reality, precisely in order to exclude others, the short-term patient tries to use the privileges of the "good" institution for himself, and sometimes strives to disengage from the commitments that the institution asks of him. But soon he realizes that there is no "good" institution that is not also "bad," and that does not also have another aspect, that of violence, for those who do not conform at a time when a difference between "good" and "bad" is requested. This contradiction arises precisely when the fact of this distinction is claimed by the short-term patient for his own advantage — and only for him. Everyone then does the same thing and struggles to have the norm "on their side." Long-term patients say that "those from ward A" are selfish: "they are here on holiday." The others respond that they also need care and that "they are also sick." They feel the need for a similar status. As we will see later, as things become more clearly understood, a common dynamic of a different kind emerges.

Medications and Medical Negation

The negation of the traditional hospital took place through the negation of the violence and oppression that preceded and accompanied the administration of certain "therapeutic" treatments. Even today, after the decline or disappearance of certain somatic treatments, the prescription of drugs is of great importance. There is no doubt that medical power is also connected to this type of relationship, even independently (to the extent that this is possible) from institutional conditioning. Facing a patient and saying to them, "you need this medication" means positioning oneself as a source of power and not as a simple consultant. This can, in some cases, make the struggle against oppression appear as fake or even useless if I, as a Doctor, retain this power of domination and control as mediated through antipsychotic drugs. At this point, a question arises that represents a precise, real and, practical contradiction. Negating violence means negating the nuances of violence that accompany antipsychotic medications: drowsiness, difficulty in concentrating, lack of energy, unpleasant side effects. But does it also imply a further negation in terms of denying the prescription of a drug? Does negating a traditional hospital mean negating a hospital altogether? There have been moments in the course of our community history, when it seemed necessary to give a positive answer to these questions.

Raising these problems has sometimes meant that patients have become responsible for certain choices and rejected all medication. In meetings, it was said by more than one that the possible need for medication ought to emerge from a collective discussion and no longer be solely based on the judgment of doctors alone. There was a generalized anxiety about these refusals. But if the staff accepted the presence of this anxiety, it was because they wanted to try to share in the possible anxious nature of the patient in order to create a new connection with them, to be available, and free themselves from cultural and scientific conditioning. On other occasions, it was decided that medication would still be offered to the patient without insisting

that they take it, and there would be a chat if it was refused. This obviously opened up, on the medical side, the issue of medication needed for those with epilepsy, which cannot be ignored, and this emerged as a kind of institutional crisis.

The imposition of medical authority thus enters into the realm of oppression if it acts within a rigid and unquestioning institutional framework. But, on the other hand, if it accepts the possibility of protest and refusal, it must also accept the risk of further consequences from this. The abdication of all responsibility does not seem to be an acceptable alternative to an oppressive type of relationship.

The Staff and the Institution

During a community meeting, there was a discussion about the organization of a game of *briscola*.[8] This was a proposal initiated by a ward, or rather by a group of patients and nurses from a ward. It was decided, in this ward, that the registration fee for the game would be variable: nurses would pay double. Here are some excerpts from the discussion.

NURSE A: Now I'm not criticizing the difference in costs, but this has never been discussed with the nurses as to whether it's okay or not.

DOCTOR A: Excuse me, but there is a committee, a group of people who organize something, who set rules, so that others can participate (or not).

PATIENT A: But it's fair that other people can make observations.

DOCTOR A: Yes, because what nurse A meant was this, it seems to me, that this group can discuss things, and thus listen to the opinion of others. It's a group of people who organize something and then discuss it. It's clear that if something needs to be changed, it should be changed.

8 An elaborate card game much played in Italy.

PATIENT A: A game of *briscola* was proposed, with the registration fee as the same for everyone, that is, with everyone is the same level — and there were people who said, "no, that is not fair."

DOCTOR A: It seems to me that what nurse A wanted to know was whether nurses also participate in this group.

PATIENT B: Can nurses participate too?

PATIENT C: There are even doctors. There are also nurses. Nurse B is part of the organizing committee. I brought the proposal forward in order to discuss it here; no decision has yet been made.

DOCTOR B: This seems to me to be an important thing, the possibility of a group of people from a community taking an initiative is being discussed. It seems to me that this initiative, this possibility of initiative by a group of people, including doctors, nurses, patients, is being discussed or in some way criticized. I was saying that it would be interesting if nurses A and C, who have made some criticisms, clarified whether in their opinion this initiative, before being proposed, should go through a series of checks, even if it was legitimate. According to nurses A and C, if a nurse participates in an initiative, they should first consult the other nurses. So, at this point, it seems to me that this issue needs clarification. Because then why should a patient participating in an initiative consult all the other patients first, why should a doctor participating in an initiative consult all the Doctors?

During the debate, it was clarified that the intention of nurse A was to look further into the issue, to "listen to what the community says." However, the problem remains that nurses tend to respond to a new situation through making themselves more available — something which is connected, however, to a deep need to constitute themselves as a class. A key episode was represented by a staff strike.

The strike, autonomously decided by the union, envisaged the absence of half of the ward nurses and all of the general ser-

vices ones. This, while risking to radically undermine the work of the institution, was perceived by other members of the community in different ways.

A majority of patients did not express dissent but rather, among some of the more advanced sectors, forms of active solidarity, expressed in a meeting as a refusal to perform any substitute work that could be postponed. Other patients showed some impatience and discomfort, and in one case there were lively protests. The same contrasts could be found in the medical team. Although the right to strike was not questioned by anyone, it was observed that its methods could have been less rigid, and that furthermore an active exploitation of the agitation was unfortunately possible not so much against the employer, but against the new institutional system. This problem sparked lively disputes, but one seemed obvious. The staff found a moment of identification and strength in being able to differentiate themselves from the patients, who are largely powerless, deprived of any right to strike, and unable to go to the administration headquarters with signs and whistles,[9] as the nurses did as a group. It was actually an unusually extensive protest. A trade unionist or a politician would have spoken in this case of "the maturity of the workers." There is no doubt, in short, that this was an example of anti-institutional action, of protest. The sometimes passive acceptance of the new situation in the hospital was changed thanks to an act of active presence, a choice, which suddenly pushed relationships with patients and the *équipe* into a state of tension. While with respect to the former, as mentioned, it was a choice of differentiation, toward the latter the dynamics were less clear, most obviously in terms of a challenge to medical power, which is usually seen as oppressive, even if not on a bureaucratic–disciplinary level. It is useful in this regard to quote the words with which a "free" representative of the staff (that is, someone not particularly linked to the internal commission or the union) intervened during a community meeting

9 Striking and protesting workers and others often use whistles during protests.

that was looking to take stock of the situation with respect to the three significant parts of the hospital:

> Empowerment increases our professional efficiency and creates an initial availability which, however, tends to move backward over time without finding any corresponding response, and indeed in some situations it can even be exploited. Unity leads to teamwork which is the most important feature for a community like ours with therapeutic aims. However, in a community we must recognize that all of its members have the same rights, but when our opinions and decisions are discussed and accepted only if they agree with programs already previously laid down by medical staff, we do not feel part of things, but only useful to them. So we find ourselves constantly facing new situations that often create forms of anxiety in us, which we accepted because we were convinced of the goodness of the system, but which were difficult to overcome precisely because we feel that we are not held in high regard or taken into account. However, we would like to underline that for us the system is not identified with any person, so the difficulties of relationships, although they naturally influence performance, have not compromised the purposes and the essential sense of a desirable outcome, namely the improvement and reintegration of patients into society, which is what we all want.

It seems clear enough that the dialectic between support and protest places the staff in a difficult and contradictory situation. Being available to patients without falling into institutional dependence, in other words, "managing to be autonomous," poses this problem at its highest level.

Faced with the many open questions and the contradictions uncovered by the process of negation, it may seem insufficient to affirm that the life of the hospital continues through a confrontation with these key questions, with an awareness of not being able to overcome these contradictions because they are one of the outcomes of those insurmountable antagonisms linked to

"external" society. On the other hand, by looking at these questions we do not necessarily resolve those therapeutic problems or social problems that have reference points in the planning of global political solutions. Therefore, the plan seems to become either too ambitious or impossible, lost either in a kind of utopia or in everyday forms of banality.

However, the negation of the traditional hospital, which is a daily activity and one that accumulates experiences while sometimes grinding to a halt, keeps tensions at a high level and involves an ever-increasing number of people (patients, relatives, technicians, politicians), becomes significant precisely because it manages to transform things in a qualitative sense but also intensifies in terms of numbers: the number of open wards, the quantity of people who begin to exchange ideas, and the sum of patients who participate in various activities independently of any directly paternalistic or pseudotechnical advice. What is felt from time to time as a "conquest," the opening of the latest ward, the increase in the number of patients on a mountain holiday, the increase in the number of those who are allowed permits to leave the hospital, the frequency of permits, and so on, develops as something that looks like reformism but is connected to that initial act of negation.

Another issue that should be clarified is that linked to the negation of authority. A negation of violence without a negation of authority, it could be argued, can only lead either to a benign but equally oppressive form of paternalism or to scientific-type reasonings that claim to predict and clarify everything. Both of these possible stances appear as further mystifications in terms of collective debate and protest. It is worth noting, however, that there is also a form of negation that confronts this type of problem, namely the negation of exclusion. Negating exclusion (and therefore both violence and forms of oppression that are its effective tools) does not imply an absence of authority. Engels wrote that a "revolution is certainly the most authoritarian thing

there is."[10] Authority can be overbearing but does not equate to overbearingness. An example can be seen in the doctor–nurse alliance, where the authority of one can sometimes, if overbearing, unleash unresolved tensions onto others — who are usually the patients. A bureaucratic–disciplinary attitude, which is typical of traditional hospitals, is authoritarian and institutionally violent, even if disguised by cold or courteous appearances or forms of benevolence. Allowing authoritarian attitudes to face protest and criticism, which might imply protests against the entire institution, is the most important shift for those who want to move from institutional forms of leadership toward real leadership. This does not imply a situation of totally shared leadership, which can only be seen as utopian,[11] but rather a struggle for the negation of institutional violence via a transitional phase, in which the passive acceptance of oppressive forms of power is replaced by the rejection of this role and the use of power for social transformation and consciousness. The risk that this does not happen is huge. We must remain aware of this and never stop accepting and seeking a confrontation with reality.

10 Frederick Engels, "On Authority" (1872), trans. Robert C. Tucker, in *Marx–Engels Reader,* ed. Robert C. Tucker, 2nd ed. (W.W. Norton and Co., 1978), https://www.marxists.org/archive/marx/works/1872/10/authority.htm.

11 Gianfranco Minguzzi, "L'alternativa al 'leader'," *Che fare* 2 (1967): 21–27.

The Women's C Ward: The Last Closed Ward

Letizia Jervis Comba

QUESTION [Q]: Doctor, have you been working here for many years?

DOCTOR: Since 1945. I had the women's B, C, and D wards. For fifteen years I had all three wards.

Q: Was there a difference between the women's C ward and other wards in the past? Was it a ward with particular characteristics?

DOCTOR: Each ward had its own characteristics. For example, in B there were the mostly agitated patients, in C there were the physically ill, and in D there were the so-called workers.

Q: When did this ward take on its current appearance? How has it changed over the years?

DOCTOR: Things changed after Professor Basaglia arrived. Before, the agitated patients were sent to B, and if they calmed down they could go to the other wards, C or D. They weren't sent to B as punishment, but because the staff and the whole setup were better equipped to handle them. There were also more places in B. C was made as it is now when B was opened. Naturally, all the patients from B had to be redistributed, and the best ones had to be chosen to stay in B. But almost all of them left B because they were the worst.

Q: And they came to C?

DOCTOR: Almost all of them came to C. Those who tended to try to escape, those who had some erotic tendencies. The physically ill patients, those who were already in C, stayed there. As D was opened, some patients from that ward also came to C.

Q: In these past five years, have patients been sent to C, perhaps even for a short period?

DOCTOR: As a punishment? Well, there was a long period when patients were threatened with being sent to C.

Q: So, the C ward replaced the B ward.

DOCTOR: Yes, [but] naturally without forms of restraint, all the straitjackets were immediately removed and soon afterwards the restraint beds went as well.[1] The restraint beds lasted another year, I think, and they were not really for the agitated ones but for epileptics or old ladies who kept getting out of bed. But they were terrible, even if it wasn't a cruel form of restraint. It looked terrible.

Q: Since when has C not been used as a ward, let's say, for "punishment"?

DOCTOR: About two years. Until two years ago, there was still this habit of saying, "I'll send you to C." And that was what happened. But it was more of a threat. Then an excuse was often found not to send them, but it was a kind of sword of Damocles.

Q: But has this been happening since C became the last closed ward?

DOCTOR: Yes, but the characteristics worsened because the worst elements were put in C. So, effectively, it was thanks to the C wards that the other wards could be opened.

Q: Do you think there was a major difference between the two C wards — male and female — apart from the different number of patients? In other words, why did the men's C ward open when the women's C ward was still closed?

1 These were special beds with forms of cages over the top of them.

DOCTOR: First of all, men don't have the problem of erotic tendencies. Then, there are more women, in my opinion, who tend to try to escape, or who seem to attempt to run away. While in terms of violence, it seems that when a fight happens, men are more violent.

Q: But, if there was this tendency to run away among women, why have we seen in recent times that almost none of them wanted to leave the closed ward to move to an open ward?

DOCTOR: Well, first of all, because they're women. They tend to stay in their own environment, in their own home, and then, maybe they were treated better by the female nurses than the men were by the male nurses. You may hear female nurses raising their voices sometimes, but deep down they always care about their patients. In the past, female nurses used to give something to the patients: biscuits, chocolates, and sometimes take them home, even for lunch. Besides, women never expressed the desire to go for a walk, unlike men, who have this great desire to go out. Women mostly asked to go home, but not to go out to the hospital gardens.

Q: Do you think the attachment of the female nurses to the patients had an influence in determining this?

DOCTOR: The female patients are more institutionalized than the men, as are the female nurses. There is a habit of doing the same thing year after year, which remains.

The history of the women's C ward can be written, like all stories, through dates, statistics, details of events: the "facts." Perhaps, less coldly, it can also be experienced through the eyes of those who have worked there over the years. But why do we want to try to look at this past?

The last locked ward of the hospital contained one hundred female patients in October 1967, and no "fact" can give us the measure of the violence that separated these individuals from the new direction of the hospital.

In this place without history institutional efficiency has frozen the invalids from the infirmary, the severely mentally handicapped, and the elderly and demented, as well as some "notori-

ous runaways" and women with sexual problems, and they have been accompanied by some "good" patients who can help in the internal running of the ward.

On how they were gathered here, medical intelligence can only provide a few explanations or attempt a kind of justification. The bedridden invalids are often just the result of a lack of care, a femoral fracture that didn't heal properly, leg amputation, post-stroke paralysis that wasn't treated and for which a wheelchair for the patients is not available. The claim is: "what difference would it make for them if the doors were not locked, as they are bedridden?" For the severely mentally handicapped and the demented, the need to protect them becomes confused with the desire to do so with minimal effort. And it is said: "what sense would it make to unlock the doors for them, if they don't even know how to open them, and they moreover don't even know where they're going?"

To this core of people consigned to a locked space, "physically unfit" for freedom, were added others, those ejected from wards that were opening or had opened, or not removed from a place they had inhabited for years. Were they "psychologically unfit" for freedom? Beyond this generic label, very little can be said about them in terms of medical knowledge, except by resorting to scientific classifications as an excuse, or diagnoses linked to psychological intelligence, which are rich in subtle objectifying methods of classification. But we can try to analyze this institutional violence in a different way.

The removal from one locked space to another was connected to a sense of institutional efficiency, perhaps for the last time in such a crude and blatant manner. In order to open the other wards, gradually, the "problems" (real or fantasized) that seemed to seriously threaten the "success" of these openings were consigned to that locked space. Those who had run away once, maybe five years earlier, or stood staring at the door for days on end, were sent away and locked up, so that the opening of a ward would not be delayed by overanxiety on behalf of the staff (nurses, doctors, the director), and so that this "operation" [of opening] could be repeated. Because a complete opening,

immediately, would have been ideologically perfect but not a real possibility. For the patients, these transfers were yet another confirmation of their total subjection to the institution, of their ahistorical objectification.

It would be interesting at this point to analyze how this subjection happens. Erving Goffman's "moral career of the mental patient"[2] indicates the stages of this process. In this way a body, the body of the patient, is negated in terms of its individuality and appropriated by the institution (this process is described by Basaglia in his *Body and Institution*[3]). We believe that the stages undergone by men and women when they enter the institution are not identical, because the process of "dispossession" follows cultural patterns in adapting in different ways to bodily experiences. But this is not the place for this kind of discussion; through different paths, both men and women arrive at the same final condition of institutionalization.

The removal from an open ward to a locked one also has another meaning: an exclusion from the "better part" of the hospital, which, being open, rejected any disruptive elements and utilized the last asylum-type structure — a locked ward — in order to create a distance between itself and others, the worse ones (the real mad people?). For more than five years, that is, since the liberalization of the hospital began right up until a few months ago, the C ward has performed this particular function: women who tried to escape or who had sexual problems, patients who were a source of disturbances to the community ("problems," as they were later called, a dehumanization which was also linguistic) were sent to the locked ward, both temporarily and permanently.

What meaning did these measures have? Was the transfer to the closed ward a simple organizational measure due to the insufficient "management" of certain difficult cases by open

2 See Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Anchor Books, 1961).

3 Franco Basaglia, "Corpo e istituzione: Considerazioni antropologiche e psicopatologiche in tema di psichiatria istituzionale," in *Scritti,* vol. 1 (Einaudi, 1981).

wards, or was it a punishment, that is, a sanction with a value that, starting from a kind of "new hospital ethics," contributed to strengthening that experiment through the setting of an example?

A second alternative would argue that the transfer to the closed ward be considered, on the one hand, a purely prison-like coercive measure, while, on the other hand, it could have been seen simply as a reinstitutionalization within the hospital.

In each of these alternatives, the key to the question lies in the possibility of "purely" technical solutions, which in any case have taken on wider meanings, and their "purity" has been contaminated by violence.

Finally, we must consider a third group of people who are now in the women's C ward: the patients who have settled in this ward, who have been there "forever" without there being a specific reason to keep them there. For years, we didn't talk about this group, and they were inextricably confused with the others, with this indistinct and locked up "residual" hospital population. Institutional violence appeared as a kind of forgetfulness toward them.

Even at this point, we could look for organizational explanations, and often a question of functionality would emerge. There were the patients who have "always" cooked or helped to care for the elderly, and are thus kept on a ward to meet the needs of the other patients. Their importance is underlined and privileges are granted to them so as to mask the objective state of "forgetfulness" and "closure." For example, there is the freedom to have the door opened for them whenever they ask.

In every sense, despite different contexts and justifications, the career of the patient in locked wards underlines forms of *violence* and exclusion. They are punished due to real or fantasized "guilt" or simply forgotten. They have been actively and constantly separated from the movement in the rest of the hospital.

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

people, faced with the possibility of leaving the closed space for a wider, new, "free" dimension, have preferred not to do so.

The difficulty of leaving the ward finds a first explanation in the analysis of the relationships internal to the "total institution" that is the locked ward, but this differs depending on the relationships between that ward and the rest of the hospital. We could refer to the deep bonds that have formed between patients and staff and the nature of hidden violence they assume: small favors, privileges granted (or withheld) from time to time, which are often essential in terms of a patient's life, are most chilling when they are apparently the result of exchange ("I will give you a box of biscuits for cleaning the hallway"; "You can stay in this bed if you don't get agitated"; etc.). Behind the appearance of these pacts, there is always the possibility that they will be broken. In the relationship, one is the stronger part, who has the power to decide if the pact is good and if it must be respected.

There is no longer an equal rule for all. The relationship of the weak with the stronger other takes place at the cost of subverting the general conception that "power" is handed down and is regulated by "moral values." Here the opposite is true. The nurse not only owns the rule, the value, but is herself the repository of it to such an extent that she becomes the norm or value itself. In a state of total dependence, the patient cannot decide.

In the completely closed hospital, a change of ward can be situated as a form of gratuitous favoritism, so that the support of the transported object is purely an accidental act. But what does this mean in the context of a hospital that is opening or is completely open apart for the women's C ward? In other words, which real choices, what "decision-making power" is available to the patient of a closed ward in the context of an open hospital? Or what is the relationship between these two realities?

When we initially spoke of the women's C ward as a "frozen island outside of history" we were using an analogy between the asylum-society relationship on the one hand, and a closed ward–open hospital relationship on the other. The asylum is, in society, an isolated island, which is used and exploited in a precise way through its function as a "last stop," but because of

this very function it cannot be seen as part of the living and real context of things that change and are changing. The asylum is a world without history. Time stops at its gates. Inside, the days follow one another in an indistinguishable way, they are identical and always empty, and every evening one needs to etch a cross on the wall to give a sense of time to this indefinite existence.

The last days, the final hours before admission are seen as a "recent past" (even if the correct date of that admission is cited, which might date back twenty or thirty years). A girl cries, she is two years old, she has never grown up, and the twenty-year-old daughter who comes to say goodbye to her mother cannot be the same person as before, and her presence does not cancel the anguish derived from that abandonment. Many people [inside the asylum] do not know their own age or their birthday, even if they might know the year of their birth and can do simple calculations. A striking fact that happened "inside" (yesterday or ten years ago) is remembered in an identical way. It is not history, it is myth.

The hospital begins to have a history — we could also say that history comes to the hospital — when society enters the asylum, breaking its isolation. And the way this happens is mediated through the people who, so to speak, "take society inside," and are no longer just the bearers of a custodial task delegated to them. Indeed, the "pure and simple" entry of capitalist society, based as it is around the division of labor and a hierarchy of roles, has already happened and in the sense of where paternalism (or "soft institutionalism," as Basaglia calls it) has replaced an old authoritarian regime (which might be dubbed "hard institutionalism") and has covered the same old power relations with a humanitarian mask. And if this change has not yet taken place, society itself will act, so that these "islands of backwardness" will disappear.

There is therefore a connection between the social system and an institution that tends to modify itself in ways that are designed to support that same social system. So how can new connections be created?

Basaglia highlights a form of "antihierarchical voluntarism"[4] as the only way in which relationships within the institution can be modified and the institution itself— be it tendentially overturned or destroyed—can undergo change. This is no longer a matter of getting rid of one role at the entrance to the asylum in order to assume another, nor is it a matter of "having the same role" both on the inside and the outside.

The "society" that entered [the asylum] is marked by contradictions. At its hierarchical head are the holders of institutional power. Doctors have argued for a form of "antihierarchical voluntarism" by accepting, indeed, by seeking and provoking, conflict with others "without taking into account" their institutional roles. An awareness of the violent implications of these traditional roles has become possible. We could, in a straightforward way, argue that these implications have always been both kept alive and negated at the same time, but this does not mean that there has always been an awareness of the problematic nature of this situation. Rather, it implies that choices have been made in daily practice from which, as time has passes, different possibilities for protest and conflict have been created.

Some wards were opened before others, and meetings began with some groups of patients before others, while some initial "privileges" were often lost or acquired by different groups. The women's C ward is the ward which has remained closed for the longest period of time, whereas the similar men's C ward opened on July 14 of this year [1967]. Now the unlocking of all doors is inevitable. This is an act which leads to physical freedom and strips staff of prison-like attributes—as concretely expressed in the key itself—and forces them into a new relationship with patients. The possibility of escape gives each individual a range of action which is seen as "threatening." "Control" can no longer be exercised over passive objects ("the locks and the ill"), it can no longer occur "without taking into account" these new characteristics.

4 Basaglia, "Corpo e istituzione."

But if these new opportunities for protest and conflict are not to merely become an ideological proposal on behalf of doctors, which protects their [institutional] identity, and if they are to become a form of reality for the patients, it is necessary for the latter to have appropriated their own reality and their own bodies.

If we trace the path toward the liberalization of the hospital (as analyzed elsewhere in this volume), we come across the moment when the doctor regains "real power" over the patient, taking it from the nurse (who managed this relationship in the past). In this way, the doctor has at the same time "liberated" the nurse from their prison guard-like role and begun to understand the patient.

By making the patient the object of care and attention, they create the patients as a body: a sick body. But this sick body is there specifically for the doctor. At the moment when the doctor recognizes this fact they emerge from a form of classification, from transparency, and become an opaque object, gaining a more material form of reality. When the doctor steps away, the patient remains under the nurse's gaze, and this changes their form of existence, because it is no longer recognized in the same way. Their objectivity is confirmed by the interchangeability of roles (and forms of existence) that are assigned to them and which are always decided by another. They are not yet the subject of anything. The contradictions of the institution are opened up before them — and within them, in their own bodies — and they can once again be absorbed by the institution.

On the other hand, the "liberation" of the nurse coincides with the possibility of being released from the anonymity of their hierarchical role and engage in personal initiatives in terms of a relationship with the patients. This can be seen, following the initial indications of the doctor (or perhaps, more correctly, as included within the initial indications of the doctor), and, by underlining generic types of professional qualifications, in the ways that they interact with the "sick body" and care for it humanely … and without obvious violence. This is a necessary step, albeit not a sufficient one. If the nurse (and the

doctor) only go this far, this contradiction is once again resolved in a new kind of objectification, turning the "mentally ill" into a "sick person like everyone else." The encounter will take place around the object-body of the patient, making all other relationships irrelevant. Once again, the reappropriation of the patient's own body will be rendered impossible, since only occasionally will they be allowed to *have* a body — an objectified ghost of their body — and opportunities will escape their control, depriving them of the possibility of making them their own in a time-restricted context.

To move from the anonymous nature (alongside a reassuring set of rules) of one's role without immediately seeking a new anonymity (a new reassurance) in another rule-based role implies — for a nurse (and for a doctor) — a recognition of the contradictions and ambiguities that arise due to the decline in hierarchical power between their existence in society and their existence in the institution. Often, the way to contain the anxiety that arises from this awareness consists in reproposing within the hospital a set of "external" models and values, and using them *tout court* (without the mediation of hierarchization).

It is no longer forbidden for a nurse to read the patient files, discarding the absurd pretence that they should treat everyone, anonymously, in the same way. Indeed, behind these skeletal pages, which are monotonous in their presentation, one looks for an indication of an individual way of being, the story of a person.

It is no longer seen as absurd to speak to the patient and say something that is not an order. And what happens if after years of silence, of a kind of "mutism," there is a response at last? The more this respone is listened to, the more it enriches itself with personal content.

But, even more tellingly, it is no longer forbidden for the nurse to talk about themselves. And in the identification of a nurse as a person who is open to connections and is present in the moment, the dimension of reciprocity is there, albeit in a way that is not yet developed.

In the context of an institution which is analyzed and negated (if not yet overturned, and has perhaps not yet emerged from its technical sense of being out of time into history), these individual and diverse positions, which are not yet part of a preestablished plan and are both complicated and conflicting, represent a real sense of a contradiction. And the patients reflect themselves within this. And in these margins of dysfunctionality, they put themselves forward as a presence, part of these contradictions, and no longer as a purely objective being. They see the urgent need to emerge from reification (to accept, in a transitional way, their own reality) by observing those in front of them, in the search for the real limits of their own body. They can finally and narcissistically reflect themselves in the nurse and gather from them the content of the cultural features around which the social model of the body is expressed.

In order to travel down this road, the women on ward C encountered a particular obstacle, linked to the structure of that ward: permissiveness.

In ward C, women can do anything they want. There are those who eat with their hands, throwing to the ground what they don't want, others make obscene gestures toward the staff or other patients. Some use foul language. There are those who take advantage of the slightest distraction of the staff to expose their bodies, behind the bars of the window.

No one is scandalized.

These gestures have been stripped of their provocative content. They are frozen under a gaze that does not see them. The patients have become disorderly, inappropriate, obscene.

So obscenity in this context is not a provocative gesture but a distance at which those who tolerate it place themselves, stripping it of all meaning, and indeed using it to objectify those who perform it, exploiting its regressive features in order to reduce it to the crudest form of reification.

Permissiveness is, in a close world, linked to distance.

The hierarchy that exists among patients is evidence of an effort that is made to avoid being continually invaded by the obscene. But in this "recovery" of distance for oneself, the objec-

tification of the other is underlined. And this game is reproduced because there is always someone else higher up the hierarchy who can objectify the patient. Once again the nurse becomes a custodian of values (and power).

But even among the nurses, hierarchical relationships are reproduced, power is taken away from collective forms of management, and there is the humiliating training of a "rookie" and the recognition as leaders of those who have best taken on the role of routine management of the ward.

All this serves to remove any sense of an encounter between people in terms of relationships. It also conveys a specific conception of an institutional–asexual woman whose body is, at best, present only in the dimension of the obscene (which is no longer frightening, because closed and deobjectified, sterilized). In addition to this, at the women's C ward, there is already, as a "nursing station," an attitude of medical objectification toward "physical patients" through their body (even if poorly cared for, as with the bodies of the poor in general) and in ways which are inseparably linked to a sense of institutional detachment. These therefore cannot be used, even as a first step that could then be negated, for the recovery of a different kind of relationship.

In contrast to these obstacles (which perhaps, as such, are not so different to those of a male ward), a socially and culturally determined model of the female body can be identified. And this has been seen, over the years, both through a free attitude of the nurses and via other institutional changes. In fact, as nurses and patients have moved from the locked wards, even if only on limited occasions, into the broader field of the now liberalized hospital, first opportunities for comparisons have allowed some contradictions to emerge. Some nurses have felt uncomfortable in being confined to a hierarchical role and to a kind of maternalism and found themselves in contradiction between this reality and the need to see in a more conscious way, which did not deny them any specificity or the historicity of their position as a woman. And the patients discovered other signs, outside the ward: the introduction of the hairdresser, the importance given to clothes, the way the women on the other wards moved

around (also the result of the attitude of the doctors, the director, other nurses, and all those within the institution), and this revealed possibilities for reapproaching a lost form of identity.

And so in the ward, the patients saw themselves reflected in the nurses and then connected to their values, referring them back to themselves in an ambiguous way, thinking about neither their relationship with the nurses nor their identification with them, but merely grasping at those fragments of reciprocity that had become available and made them their own, which left them within a contradictory and difficult situation.

In this context, which allowed for an initial and incoherent emergence of one's own body, cultural determinations do not appear as forms of learning and are closely connected to conduct, to behaviors linked to the world. Rather, they enter into a dialectical relationships, they limit them, making them accessible (but also, and often, inaccessible) to interconnections.

Now the cultural determinations of our society have proposed a model of a woman through the formula of a "second sex,"[5] for whom objectification no longer occurs only in the individual and in the individual relationship, which then exposes itself to a dialectical encounter, albeit one that is both generic and generalizing. Women are constantly an "Other" and cannot recognize themselves as a person *on the same terms* as a man, as well as always defining themselves *in relation* to men.(The historical stages of this process are those linked to processes connected to the division of labor, where there is no place for equality).

We can look schematically at the models that society proposes. The woman–female, culturally represented as a "happy housewife," has been described by Betty Friedan[6] as the product of an advanced consumer society. Happily involved in motherhood, slave–mistress to a thousand appliances, aestheticians of themselves in order to "win" a man, she is the avid consumer of the product that capital puts on the market. Although far from

5 Simone de Beauvoir, *The Second Sex,* trans. H.M. Parshley (Jonathan Cape, 1963).

6 Betty Friedan, *The Feminine Mystique* (W.W. Norton & Co., 1963).

our socioeconomic level, this "future" presents itself to many workers in the form of an illusion of freedom.

For others, achieving dignity in the world of work corresponds to a higher level of women's emancipation. But "emancipating oneself," like freeing oneself from slavery, is still something which remains within a similar dialectic, and the woman–man who claims to want to overturn a system finds herself simply contributing to its functionality. Not only does she enter the world of production as capital desires, but she theorizes this integration as "liberation," mystifying its meaning.

The same happens with a temptation of omnipotence that is connected to a combination of the two types of figures: a woman capable of managing both home and work, able to "listen" and ready to "discuss," a clever manager of her own masculine and feminine qualities. This continuous tension develops into a constant sense of availability to a world of consumption and production without the possibility of finding common explanations for this double form of alienation.

> In a consumer society, women are brutally objectified. This reveals the deep hypocrisy of a structure that offers women frequent opportunities for "emancipation" while simultaneously encouraging them to sell not only their labor but also themselves as objects of consumption. "Feminine qualities" such as beauty, immodesty, and unscrupulousness undergo change and at the same time appear in dialectical opposition to other "qualities" such as honesty, modesty, virginity, and "style," which in turn are nothing more than tools for the commodification of women as "objects."[7]

The female body is commodified, urged to sell itself as an *exchange value* in the eyes of men. And the way in which women experience this total objectification is a form of passivity.

7 G. Pirella, "La proprietà privata," *Che fare* 3 (1968).

> Isn't what is recognized as a natural attitude (passivity) the result of an unnatural balance that forces her to create a distance between herself and her own body, so that she can experience it as an object for herself and for others?[8]

In living in her own body, a woman thus encounters her own commodification, beyond the deceptive aspects seemingly proposed through apparently different social roles. The division of labor has infiltrated the individual relationship between man and woman, brutally cutting away the "most fragile of all perceptions,"[9] the experience of one's own body, from the woman-subject to which it should have belonged in order to deliver it to the system.

The very possibility, for women, *of being their own body* seems to indefinitely elude them, just as the possibility of escaping their own exclusion also seems difficult.

The exclusion of women when added to the exclusion of the mentally ill has clearly led to the regressive nature of female wards as compared to male ones and the extended and continued closure of ward C.

But today, even these women can be seen in every part of the hospital. Since November 22, 1967, a door to the women's C ward is also open. In this greatly expanded space, new reference points emerge with new possibilities for relationships. Alongside the available female models within the ward, alternative figures gain in importance (among which, in particular, the long-term ward patients who have assumed a leadership role). Often, these models refer back directly to those proposed by the outside world and accept its pointers. The most coherent proposal here is provided by religion, in terms of the rejection of the body through which their being-in-the-world is realized and in a structure that denies the individual any role which is not a social one (thus recovering a sense of authority at a "steri-

8 Franca Basaglia Ongaro, "Donna-uomo," *Che fare* 3 (1968).

9 See Maurice Merleau-Ponty, *Phenomenology of Perception*, trans. Colin Smith (Routledge, 2002).

lized" level). In another sense, however, a nun also reintroduces values of "honesty, modesty, and virginity" and connects them with a matriarchal role, which is traditionally feminine, and the values of thrift and the worthy preservation of order, thus — again — justifying their role. But even in the secular world,

> the maternal role toward men can partly compensate women for having to live in a position of mediation. This is a dangerous game that weakens both sides, in order to mutually protect them: the man determines a regressive level into which the woman is forced; and she, in defending herself by enveloping him with "maternal" care, tends to make him — in turn — regress as well.[10]

In this context, traditional models of housework and cooking are proposed to the patient, along with obedience and order.

Thus Antonia, an elderly patient, a mother, and happy grandmother, proposes her benevolent yet firmly authoritative matriarchal values. Her authority is linked to her age, a sense of ancient wisdom derived from experience and the awareness of her own intelligence. She engages a dialogue with authority, recognizing its unquestionable goodness and seeking confirmation from it. She does not consider the traditional values of the housewife — knitting, cooking — as negligible when she can perform them independently, but she naturally tackles organizational and managerial tasks when they are "acts of peace." Many have been influenced by her enlightened conservative rule.

However, the overcoming of institutional routine does not only happen via this kind of path. Since the dialectical opposition between "modesty" and "beauty" enters the hospital daily with the visits of young women, young nurses, or social workers, as well new patients from observation wards who represent the other face of "modern" femininity, which has appropriated its right to sexual pleasure by expressing a need to appear as

10 Basaglia Ongaro, "Donna-uomo."

a seductive object in the eyes of men. The mirror, the lipstick, the graceful shirt, seeing one's own body, touching it, adorning it, finding it "beautiful." All these acts do not reach beyond the boundaries of personal identity and fail to reach those levels, because the male world (both individually and socially) act as those that provide justification for this behavior.

This inevitably leads us to another question: does it make sense for the patient to reclaim a sexualized body, which she is forbidden from enjoying in sexual relationships? We could respond with Merleau-Ponty's words:

> A sight has a sexual significance for me, not when I consider, even confusedly, it's possible relationship to the sexual organs or to pleasurable states, but when it exists for my body, for that power always available for bringing together into an erotic situation the stimuli applied and adapting sexual conduct to it.[11]

There is thus a form of sexual conduct — a meaning in the reclaiming one's sexualized body — that is only to be found within social relationships, and for which an individual relationship has a central meaning (and there is a form of suffering in its absence), but is not necessary (while its absence can be necessary).

But those people who bring the values of the external society "inside" [the asylum] through work are not housewives, and in their active participation in the world of work, they are aware of another aspect of the feminine sphere. Some go through this out of necessity; others have taken on characteristics of "emancipation" and propose (in a way which is hidden) the "male" values of a career, freedom from the family, competitiveness (and exploitation).

Rebellious by nature, Ada has always refused to be integrated by the institution into the classic canons of the good, hard-working patient, which judged her first as someone who was

11 Merleau-Ponty, *Phenomenology of Perception,* 181.

"agitated" (she was often kept in a straitjacket) and then as an "impulsive" character. Today, like a girl who looks for some confirmation of her need for independence outside the home, she spends only a small part of her day in the ward. She is often at the bar, always at general assemblies, and present in all "social" occasions of community life (dances, parties, outings). Her participation in discussions is particularly important when they examine general issues. She often grasps essential themes linked to community life and puts them forward tirelessly. Fragile and insecure in terms of her personal encounters (where there is any sense of an invasion of her space, she tends to defend herself with some gusto but with difficulty), she has chosen the social sphere as the privileged place to express herself, and in it she uses all the resources at her disposal, from the bourgeois family values of courtesy or personal care to a sense of intellectual criticism (which can become aggressive).

Thus, these examples, which demonstrate how each person can now take control of themselves in different ways within the hospital, only confirm the influence of external society, with all its contradictions, within the hospital and the ways in which the hospital becomes a relatively small-scale model with contradictions that are easy to integrate.

However, the patients of ward C, who were the last to have had their doors unlocked, were the first to have to face a reality that no longer contains a "beyond," a closed space in which inconvenient forms of denial can be relegated. Thus, all that is left at that point is to confront reality, in which those limits that the external society does not want to be violated emerge in a dramatic way. But it is the people who still pay the price for them.

PAOLA: It's difficult to describe in a few words a person who has been able to survive her own destruction and has personally paid the price, and is still doing so, of her past history. In her harshness and cynicism, we recognize a constant call to our desire to deceive she confronts us all with her sense of destruction and her survival, knowing she has been

excluded and crushed in so many ways, but she refuses to accept this as her destiny.

A woman cannot accept the loss of her identity forever. She cannot live a total negation of herself. Perhaps she can place herself at a distance that implies an awareness of her own exclusion, a sense of belonging to the broader category of the excluded, an awareness of the violence of the system and a need to *act* (against it) like the others who are excluded in a process that takes the body denied by immobility toward history.

It cannot be a privilege of the hospital to negate roles, which everyone would then find themselves assuming again upon reentering external society. It has become essential to be the same — outside and inside — and no longer just a carrier of values from the outside to the inside. Anti-institutionalism, the antihierarchization of roles, and the antidivision of labor with the ambiguities of our practice which we are forced into inside — all need to be taken outside.

The unlocking of doors is a necessity, but there are no rules about how it should happen. Numerous problems arise, at different times, when each ward is "in the process of opening." In October '67, in terms of the women's C ward, the last closed ward, these issues were widely discussed, in various settings and from multiple perspectives. The particular interest of the debate that we reproduce here, — in which part of the *équipe* participated, but not in a complete way given the absence of some key members involved in the institutional work of the two wards concerned for various reasons at various times — lies, in our view, in the fact that these issues are addressed from the point of view of a fully open hospital, and the anticipation concerning a new reality is inextricably linked to the analysis of the ongoing reality.

JERVIS: It seems to me that there were two problems: on the one hand, the problem of the timing and methods of opening in relation to the hospital's evolution and the different concrete situations that arise in various wards. This

is a problem that is connected to the needs that arise in the hospital as it is today. While five or six years ago, an opening could be carried out rapidly, as an action that disrupted the asylum, today an opening takes place within a reality that tends toward a community and is no longer seen as a simple subversive act against the asylum. The other problem seems to me to be a more fundamental one, that of the meaning of an open ward. At a certain point, we asked ourselves, "what does an 'open ward' mean?" And ultimately, "what are the reasons for opening a ward?" This is a problem that has been posed both because different levels of ward openness can exist, and because even the most apparently complete opening can be half-hearted, "mitigated," and ultimately mythologized, so one has to ask whether this category is valid in itself, or if it only has meaning within the context of the specific ways in which it is realized.

BASAGLIA: This is precisely the problem. It seems to me that whether the opening is implemented within a fully asylum-like situation or the opening of a ward at a time when the rest of the hospital is already "open" in the deepest sense of that word, that these are always moments of negation, that is, a locked ward is always an asylum-like ward even if it is in an open hospital. The opening of a ward is always a disruptive action and is always a moment that implies the dialectic of negation. I cannot think of an opening as a conceptual act by people living within a closed system that needs to be opened. I think of an opening as a "revolutionary" act and a "revolutionary" act is not an elaborated act, it is not in itself a "mature" act, rather it is an immature act. Let me explain: a specific action is carried out and can lead to a maturation of the overall situation in a certain direction, but the opening in itself is a disruptive act which, in relation to the norm, is considered an act of immaturity, but only because a "revolutionary" act does not recognize the norm, it is outside the norm. Therefore, the "revolutionary" act does not consider the sanction associated with the norm; it does not recognize the norm,

a disruptive action apparently leads to a situation of "chaos, disorder, anarchy."

SLAVICH: It seems to me, however, that this way of acting describes something which is a little bit "anarchic," rather than a progressive practice or a "revolutionary" one of the subversion of a norm, as in the norm we are discussing that requires that in a psychiatric hospital there must be closed wards.

JERVIS: I don't agree. I think a "revolutionary" act represented by the opening of the ward can be seen in two ways: either as a necessary development, as the culmination of an evolutionary process whereby, when the objective conditions exist, it opens up. But before that, there must be preparation so that certain contradictions are resolved. There are forms of personal evolution that reach awareness, and thus finally there is the overturning of the norm, etc. This is the traditional sense of a "revolutionary" act, so to speak. Or there is a slightly different and new, quite current idea, which I think Basaglia referred to, namely the revolutionary act as a stance, as a decision that in a sense anticipates the times, which pronounces itself at a time when objective conditions are not yet mature and does not wait for the objective conditions to mature but anticipates and forces them. If the objective conditions are truly mature then there is no revolutionary act, but only an automatic overturning.

BASAGLIA: Let us hypothesize that certain groups of nurses in still locked wards spontaneously decide to open them. This would be like waiting for a "quiet" system without any internal tensions and without stimuli to suddenly decide, through a democratic form of mystification, to change its ideology in a radical way.

SLAVICH: But the "revolutionary" act in a locked ward does not seem to me to be just the opening of a door. It is the people, the consciousness of the people living in the ward that create a system, the context of a ward. And in my opinion, it is primarily a matter not so much of acting to impose the

opening of a door, but of carrying out a series of acts that are subversive with respect to the system's rules, to change the consciousness of the people in the ward, and thus to more profoundly influence the situation toward an opening.

basaglia: We are faced with the usual problem of vanguards. There is little to add here. If we had thought in terms of "educating" the hospital about an opening and about the ideas of new institutional psychiatry, I believe we would still be sitting around talking. In reality, we have driven the situation forward. This may have been an "immature" action, but only apparently so, in my opinion, because I do not think that there are really moments of objectivity against which the maturity of an action is measured. We cannot be objective, we must take sides and make choices, otherwise we could not do what we do.

slavich: Certainly, we take sides, we act subjectively, sometimes even in a partisan way, if we want. But in each of these actions in order to achieve an outcome we have always needed a certain amount of time, and even in this particular case I think a series of acts is necessary, among which the opening itself is part of the process, and not the beginning. In this way the opening of the ward loses any magical significance and becomes a simple and intermediate act of a process toward the real opening of a ward. The simple physical opening of the ward must be preceded by a series of preparatory acts, carried out within a determined time — which should not last forever — linked to a consciously chosen strategic direction.

basaglia: Why are the nurses anxious about the prospect of opening a door? Because it is outside of the rules, and consequently they are still subject to the fear of sanctions.

casagrande: But when you, Slavich, talk about a series of well-planned, conscious acts, etc., do you presuppose that all ward openings must be done in a certain objective way?

slavich: But no, why would that be the case? We need to carefully study the situation in each ward and act accordingly. This requires a certain amount of time, which

absolutely must not provide an excuse for those who do not want to open the ward, but it cannot practically be reduced to zero, which is finished when it is decided that "we must open."

JERVIS: However, these periods do not unfold in a process of evolution with certain determined stages. It seems to me that you understand them in this way, whereas I think that the opening is not part of a process of evolution, but an act that intervenes from the outside to push forward the evolution process.

CASAGRANDE: In my opinion, the opening only occurs when the "revolutionary" act of opening itself is performed, 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 emphasize the objective component.

SLAVICH: But it's clear that this is an "objectivity" filtered through the subjectivity of the doctor and the group of people who are rethinking the situation subjectively. I fully agree that we should not wait for the result of an objective analysis… but we still need to carry out an analysis. And I also agree that without an intervention, which might be seen as spontaneous, nothing or almost nothing could be done here.

CASAGRANDE: However, if doctors, as you say, do not suddenly perform the acts of opening and wait, respecting a certain sequence of events, if they think and rethink about the decision to act, this decision seems very subjective to me and not something that arises from events.

BASAGLIA: If we leave the decision to open the ward to the community, as we understand it, it would be necessary for everyone, truly everyone, to be convinced that this should happen.

SLAVICH: Indeed, I think that since a ward is made up exclusively of people, the way to open the ward is to act to change the people.

BASAGLIA: I would like to say to Slavich, when we began with this new kind of institutional action there were just the two of us, now there are at least a hundred of us here. And this action was immature, negated, it was a type of action that was absolutely not objective for anyone. It was a series of acts done by a specific small group that decided to do certain things that then led to certain results.

SLAVICH: So, when you say, "then led," they were certainly subjective actions, but not instantaneous.

BASAGLIA: Instantaneity concerns, for example, the moment when a ward is opened. Today someone said at the meeting: "It's true that the doctors put the key in the lock, but it was the patients who turned the key." Today this has been stated, and it can be stated because perhaps the patients have developed to some extent, just like us, a certain awareness of the situation. But when we said, "let's open the door." By opening the door we placed ourselves outside the rules, and we were all afraid of what might happen.

JERVIS: However, the problem is also to consider why this initiative was taken; it is an unfortunate coincidence, although probably not a random one, that the small group who decided to open a ward is represented by the hierarchy of the institution, namely the director, the doctors. And this creates a somewhat ambiguous situation, because this group practically identifies with the greatest concentration of institutional power.

BASAGLIA: Well, let's say that the vanguard in this case could only identify with the highest concentration of institutional power. Because it would have been very difficult, perhaps, for "the island of the excluded" to develop such an awareness, to reach a level of consciousness of their exclusion to be able to say "let's open the doors" and especially to find the means to do so.

JERVIS: It seems to me that Slavich is referring to the need for this vanguard not to be, after a certain number of years in which the hospital has experienced a community-type situation, represented only by hierarchical leaders, namely

that it does not necessarily identify anymore with the pinnacle of power, but that it is a vanguard that involves a minority of people.

This minority must involve middle groups, and this seems to me to be correct. In a sense, it is a pity that after a certain number of years of a therapeutic community, we still find ourselves in a situation that was fully justified at the beginning, namely that the initiative for opening a ward always comes from the top. At the present moment, this vanguard should spontaneously recreate itself within the community at intermediate levels, among the nurses, for example, or, in the most optimistic hypothesis, among the patients.

BASAGLIA: This speech is equivalent to saying, paradoxically, that if a revolution has been made in a state, why after a few decades, by the force of example, does another state not make its own revolution? Our hospital consists of eight wards of which five have been opened, then six, then seven, it seems to be a continuous process, but then we have arrived at the last ward which struggles to open: why? In my opinion, in this last space there are rules that are still present. And these rules must be broken, this is the only thing that should be done.

JERVIS: I believe we all agree on this.

SLAVICH: Of course, I don't think we are discussing whether it is appropriate or not to break this rule and norm. Rather, at least in my opinion, we are discussing how to break it. In my opinion, it is necessary for a true power group to be established within the ward, even in open contradiction with other groups, which is clearly aimed at opening the ward, and that the instance of opening is not represented only by the doctor.

BASAGLIA: In any case, this power group would be such because we participate in it. No, I do not think we can wait for the evolution of the ward to open it.

JERVIS: On the other hand, we must realize, and perhaps be quite satisfied with the fact, that at this moment in the hospital there is pressure about the opening of the women's

C ward that no longer comes only from us. It comes from many nurses from other wards, from the patients as heard in the meetings, and I think, also from some nurses from the women's C ward.

BASAGLIA: If there is no rupture which leads to the opening of a ward, it might open anyway, but in a potentially reformist manner, because time will have already been allowed for the reconstitution of a norm which, in my opinion, risks nullifying the meaning of the opening itself. Moreover, it seems to me that even the men's C ward at a certain point was opened by force, because not all the nurses agreed.

SLAVICH: Not all, but some did. And this "consensus" had taken quite a long time to develop. It seems to me that it was not so much about convincing the nurses of the "goodness" of the opening, of which they were already convinced, but primarily about acting to organize the proponents of the opening as a power group. Secondly, it was about reassuring them that, when the closure of the ward was "broken," the automatic connection with punishment and rules was also broken.

JERVIS: I would like to ask you something, with which I seem to disagree: let's say that within the closed ward all the staff were against an opening, that is, there was objectively a condition of immaturity, and at the same time strong pressure from nurses and patients and from all the rest of the hospital to open up this last ward. In this case, I believe that the ward should be opened with an act of rupture, while perhaps you think that time should be given to the vanguard to organize the opening from within. In my opinion, the problem is that in a certain sense at this moment the opening of women's C ward is still something supported largely by the management team and to a lesser extent by the patients and the rest of the hospital. In my opinion, the women's C ward must be opened from the outside, given the current state of affairs. We, if anything, must try to avoid it being opened only by the director, by the team of doctors. In a sense, it should be opened by a

mass of nurses and patients from the rest of the hospital who force the ward to open and adapt to the new situation.

SLAVICH: Let's keep in mind that this has never happened in the seven wards that have opened so far. The first four wards were clearly opened thanks to the direct intervention of doctors, and the last three predominantly through an internal process of evolution, even if this ultimately had to be linked to a series of actions and pressures from the medical team. However, it is a fact that in this case we are facing a particular situation because this is truly the last closed ward which, as Basaglia said earlier, represents and symbolizes the persistence of the asylum.

BASAGLIA: The fact is that starting from this particular case, our discourse can only become typically and exclusively political.

JERVIS: It must be the nurses from the other wards who say, "enough with all this rethinking and these hesitations, we must open and help to open women's C ward." Then the people inside will have to adapt.

SLAVICH: However, we should also be concerned about the effect on the cohesion of the staff group on the ward, for the purpose of its therapeutic role toward patients after the opening. We must ask ourselves the same questions, whether we are inside or outside of the institution, no longer carrying "values" from outside, but conveying anti-institutionalism and antihierarchical roles to the outside world, as well as an attitude which is against those divisions of labor into which we are constrained by the ambiguities of our role on the inside. However, we should also be concerned about the effect on the cohesion of the staff group on the ward, in terms of the possibility of their therapeutic approach to the patient after the opening. We should think about the influence of this kind of siege by the other wards, that is, an imposition of superiority resulting from what would be seen as a new norm, namely the "moral superiority" of an open ward over a closed ward.

BASAGLIA: In ward C at the moment nothing is going on, and certainly there's no sense of unity among the nurses as long as the ward remains closed. Opening it up brings anxiety, and anxiety in this case is certainly the most important element of the ward's therapeutic dynamic.

SLAVICH: This anxiety enters the ward long before the door is opened.

BASAGLIA: It's there now. Fortunately, there's a situation of uncertainty due to the fear that the ward might be opened.

JERVIS: Look, Slavich, why is there this uncertainty within the ward? Because the people in the ward know they won't be the ones making the decision. If the ward staff knew that it would only be opened when they wanted it to be, there probably wouldn't be any anxiety or uncertainty, and the ward wouldn't open. If something is happening now, it's because, in a sense, this opening has already occurred.

SLAVICH: Exactly. The opening in a sense has already occurred from the moment we began to decide to change the ward and to connect it to the hospital's overall dynamics, to act within it even before the doors were opened. In this sense, a process of maturity, as I said earlier, is already underway. Of course, our practice must aim to speed up the process, but it cannot ignore the necessary time needed for this evolution.

JERVIS: The fact is that this evolution began from when we started threatening to open ward C.

BASAGLIA: This is a discussion we've always had, from the beginning with Slavich. I've always been for short timelines. He's also for short timelines but wants them to be a bit longer due to his need to clearly see what was being done. I, however, have always believed that if you give time for those who don't want to move to organize themselves, they manage not to move at all.

SLAVICH: The thing is, all the risks, like those of the openings, we've taken over the years, have been taken, at least to some extent, knowingly, in the sense that before opening any ward we evaluated and studied the particular situation of that ward, carrying out a certain number of operations,

dealing with some forms of resistance, adding some reassurances. . . .

BASAGLIA: It was actually a very limited form of research, because whenever we identified problems, practically speaking, it turned out that the real problems were elsewhere. So perhaps with those operations, we reassured ourselves about something that ultimately didn't allow for reassurance. Deep down, we were well aware that everything we were doing was valid only in that moment, because the problems would then become others. We must not give time to those who tend to delay.

JERVIS: Yes, but among the staff, there aren't merely the representatives of "reaction." There's a great danger, in my opinion, since there's this vanguard that opens the wards with "flags flying," that operates this process of rupture. Since this vanguard identifies with institutional power, there's a risk that some of the more initiative-driven nurses may feel marginalized, and that the possibility of being part of this vanguard is taken away from them.

BASAGLIA: At the beginning of work in a traditional hospital, one can only think of being alone and act accordingly by constituting oneself as a vanguard. In a situation like the current one with a single closed ward in which the reaction of the traditional hospital is concentrated, what should we do? Either we change the staff on that ward, which is also a possibility, or we open the ward with an act of rupture. Otherwise, what can we do?

SLAVICH: In my opinion, we must be wary of maximizing the formulation "all the bad apples are in there." Perhaps it's more appropriate to think of this last ward as having a representative sample of all the positions expressed by the nurses on opening, and that even in a closed ward we can look for the people who can constitute the vanguard of that particular situation. Rightly, we must not give time to those who tend to delay programmatically to organize themselves. However, if in a general plan we can indeed neglect and deny this tendency to delay, in specific concrete situations

we must consider these resistances in order to overcome them, one by one.

BASAGLIA: I think that in the work we do, there must always be a slice of idealism, there's no doubt about that. If we overanalyze the consequences of everything we're doing, we would do nothing, because we would be afraid of our own actions.

JERVIS: But the problem is knowing whose idealism this should be.

BASAGLIA: If possible it should be everybody's.

JERVIS: That's the point. Why isn't it everybody's? What are the consequences of this?

BASAGLIA: But when we try to do something specific and we can't because everyone is not yet at the right point, then we must start with the vanguard, even if this is only us. This is quite a serious problem, even if I really don't know what else we can do. There's a risk in all this, the risk linked to the contradictory situation in which we exist. We're pushed by a system, of which we are still part, to carry out actions against this system that are without doubt deviant. At the beginning here in the hospital, everyone said, "eh, eh, you—the doctors—are well aware of what you want to do!" And in reality, we had no idea what we would do the next day; we confronted different situations in a haphazard way, without real plans, and everything seemed to go well. Then they would say again, "you are wrong, why don't you tell us what to do! If you told us, we could help you, while we don't know what you intend to do, and you only explain it to us at a certain point, when everything is already done." But the important thing was that a need to do things together was born.

SLAVICH: I don't agree on this point, whatever happened in the short term, there were always operational timelines and periods of preparation during which we at least formulated ideas, maybe in order to reject them immediately afterward. By proceeding bit by bit, we tested forms of resistance and even if we then changed these "plans," the fact of having

overcome these forms of resistance didn't go unnoticed. And all this took time.

BASAGLIA: That type of reasoning is possible now, but at the beginning it wasn't. In order to open ward C now, everyone should participate to some extent, and it shouldn't just be the director, with a golden key on a plate saying, "I will open the ward." Now, this would be absurd and, in fact, we constantly try to involve everyone as much as possible, within certain limits, and even the nature of the vanguard has changed, and much of the hospital has become a vanguard.

SLAVICH: I would say that even now it's neither possible nor necessary to wait for the consent of all the people who are inside or work in the closed ward, be they nurses or patients. In my opinion, a deadline should be set, and we should show through a series of actions that the process toward opening is irreversibly underway, with respect for timelines, making it clear that the opening will happen even in the face of some resistance, with explanations and discussions at all levels as to why opening the ward is deemed necessary. It seems to me that this is how an opening can have a deeper meaning, that this is not just a symbolic act, and that it can really have an impact on the internal situation of the ward, which is still typically like that of the old asylum.

BASAGLIA: If, for example, we open the ward up against the will of the staff, what happens to them? There will probably be a fairly violent reaction, openly or not, against us. On the other hand, I think we must take this risk, which is inherent in this process of negation. Negation works in this way; it is somewhat idealistic in itself. To really change the situation of the ward, we must go through negation. It's in essence a dialectical question. It's not a simple "no." Nothing is built on "no," but from a "no" a certain kind of dialectic can develop and build a new reality, and, in our case, a new ward. When you open, you're really "crazy" to open, because in practice, we don't really know what will happen. On the

other hand, this is a type of "madness" that is always around with every practical overturning.

SLAVICH: But I wouldn't say that the act of opening is the only type of "mad" overturning possible. For example, the fact that some patients from the closed ward, who are seen as "ugly" and stigmatized, go to a nice open ward, and that this ward welcomes and manages therapeutically its relationship with these patients against the prevailing opinions in the closed ward. At some point, this too is a kind of overturning, it's a negation that points toward an opening in the face of the closed ward.

BASAGLIA: Indeed, to be able to transfer these patients we had to perform an act of negation.

JERVIS: So here we come back to this issue. What does the opening of a ward mean? Is it a necessary and sufficient condition to change everything, or not? I have the impression that through mechanisms which remain in part obscure, at least to me, there's an organic relationship between the fact that the doors are locked and that within a ward the patient experiences a whole series of cruelties, even if they are not necessarily physical in nature. It seems peculiar to me that such a simple fact as a closed door is so closely linked to a very specific microsociological dynamic within the ward. And this makes me think that as long as the ward is closed, the members of that ward, both the patients and the nurses, find it impossible to understand, due to the dynamics of the closed ward itself, what it might be like to live and work in an open ward, and that therefore, in a sense, an opening always happens from the outside.

BASAGLIA: This is a characteristic of all total institutions: when the situation opens up, all the relationships change.

SLAVICH: Then there's also the contradiction that arises from the fact of our contemporary connections to a larger system that is not the microsociological one of a ward or hospital, the contradictions that derive from a social role and the consequences this has for our own attitudes. . . .

BASAGLIA: From the moment that we open the ward we negate our social role, and if we see ourselves still as working within the rules, we think we have made a revolution and instead we have carried out a reformist act. We were the only ones who came from outside and we were the only people who could open a ward. Afterward, this vanguard has become bigger, there were two of us, ten of us, twenty of us, then thirty of us opening a ward.

SLAVICH: Of course, but in the final analysis, it will always be you and Jervis and whoever else works in there who will open the women's C ward. The pressure of the hospital as a whole toward ward C, if it only expresses itself as advice which says, "why don't you open, you could open like us," is a noncommittal pressure. It's not an act of rupture.

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

SLAVICH: We will finally really be able to discuss the issue of projection from the outside world.

BASAGLIA: Reality will then truly be outside, unless we, out of fear or anxiety, retreat and make the whole hospital into a huge, closed ward.[12] If everything is open this has become an act of reform, we have created a large, liberalized hospital, where there are certain rules, specific sanctions, and then we believe we've solved the problem. Now we are still in a classic moment of negation. In the end, negation is like being in the mountains with an enemy in front of you. And the end of the revolution is when we are integrated by America, don't you think? This is more difficult, it's not like being in the mountains. Our biggest problem will be

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12 After the Miklus affair in 1968, Basaglia wanted to reclose some or all of the wards but was persuaded by his colleagues not to do so.

when we have opened even the women's C ward. There will then be two possibilities: either to really create a fully open hospital or to build a big, closed ward which is apparently open and with specific forms of mediation toward the outside world. But this also depends on how we open the women's C ward.

JERVIS: There is a difference of opinion between Slavich and Basaglia. Basaglia underlines the inevitability of an act of rupture as an act that precipitates a situation that otherwise would never develop. This act is in a certain sense against the rules. On the other hand, Slavich emphasizes the need for the opening of a ward, understood as a step toward a new form of equilibrium. According to Slavich, this opening is experienced as a necessity that at some point unfolds in terms of its successive stages, and at some point a particular phase also becomes necessary.

SLAVICH: Active action is necessary in order to move the situation forward. This is not passivity, or some sort of obscure hope that the situation will develop by itself, but it is a subjective commitment to developing the situation.

JERVIS: But in order to develop things, we end up resorting to exactly what you would claim you want to exclude, the threat of opening a ward.

SLAVICH: It's not about threatening to open a ward, it's about not just opening it suddenly and not confronting the nurses with a *fait accompli.*

JERVIS: Yes, but how can you threaten to open the ward if you're not willing to open it? I mean, you're telling me, "I will threaten the nurses with the opening of the ward, so that they mobilize in the meantime, but meanwhile I don't want to open it and will wait for them to decide." If you threaten to open the ward and threaten the nurses with this opening, then you must be ready to really open it at this point.

SLAVICH: We should tell the nurses this: "we can open the ward in two months if we do this, this, and this," and we should actually do these things in these two months.

BASAGLIA: And then there will be other problems and more problems and then even more problems.

SLAVICH: The new problems will not be taken into consideration. It's not important to resolve all the problems they will pose. It's important that they develop during this time as they see the date of the opening approaching. This is similar to what occurred in the end with the men's C ward. For the men's C ward it was enough that among the nurses there was someone in favor in order to be able to do it. But at some point there was a clear awareness about the inevitability of the opening.

BASAGLIA: Certainly, to carry out an action of this kind, you have to start with a few people. Unfortunately, we always start with a small number.

JERVIS: I would say that we always end up being a few, because if there are many involved it means that things progress too slowly. But the danger is that these few who constitute the vanguard are always the same people, and then that the struggle is seen as being against those who are objectified as enemies instead of being considered as recoverable patients. The danger of a minority vanguard of a barricade-revolutionary kind is the shooting down of possible comrades. So — in our minds — whoever doesn't keep up with our pace not only falls behind but becomes an enemy. This is a very dangerous outcome, because someone who goes a little slower could actually be from our brigade, and shootings have consequences.[13]

SLAVICH: And in fact, at the beginning, we lost many possible allies.

JERVIS: But it's quite strange that the majority of nurses are now on our side. Are they only there out of opportunism? I don't think so.

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13 Here Jervis is using an analogy from the Resistance. His father Willy Jervis had been a partisan and became a famous resistance martyr. Franco Basaglia had been imprisoned for resistance activities in Venice under Nazi occupation in 1944.

BASAGLIA: Perhaps they see no other way of working than this. I mean, they think that it's no longer possible to go back to traditional forms of work.

SLAVICH: I think very few of them now think about the good old days. Maybe there's still someone in ward C.

BASAGLIA: Actually, right now, the open hospital operates with very few nurses. I would say it operates with a part of the nurses who are in the hospital because the others come in the morning and don't know what to do other than clean the floor. In other words, in the presence of concrete anxiety, their anxiety materializes in the cleaning of the floor.

PIRELLA: I would say that this is one of the main reasons for nurses to be against the opening. They lose the meaning of their presence in the ward. A head nurse in one of the first days of the opening of the men's C ward said that it was much better before because he stayed in his office and directed the whole ward from there. Staying in the office while all the doors are open doesn't make sense anymore; patients can open the door and leave.

BASAGLIA: At this very important moment for the overturning of the institution and in terms of the traditional context, anxiety is a condition for working. For example, take those three nursing assistants who came here for an internship, and after the first month they didn't have the courage to go and pick up their monthly wages because they felt guilty. They had been feeling anxious for a month and didn't understand that their anxiety needed to be compensated. In our community work we never quite find our role and we resort to inhabiting a ghost-like copy of that role because we are looking for rules, and we reject rules and norms. But being anxious also doesn't feel good. That is, the moment of negation that we continue to pursue is perhaps the defining element of our community work, but I know that most of you disagree with this.

JERVIS: I agree with this formulation.

SLAVICH: I don't think denial is so negative, negative to the point that it seems to leave no room for dialectics.

BASAGLIA: We seek an undetermined dynamic role, but we absolutely don't know what it is.

JERVIS: Yes, maybe we know what it is, but we continually ask ourselves if it shouldn't actually be something else.

BASAGLIA: I've been a medical graduate for twenty-five years, and I understood what I had to do the moment I came here to do my job. But is it a doctor's job? I absolutely don't know what a "doctor's" or "psychiatrist's" job is within an institution.

PIRELLA: But the job of negation emerges clearly. I remember the first period I was here, one of my concerns was that no accidents would happen. One of my main tasks in a ward that was opening or had opened was to prevent any "inconveniences." So it was essentially a concern about limitations. Then I realized that the traditional ward had to be negated.

BASAGLIA: I wanted to say something else, another of our issues: we do not perform electroshock treatment, we must not give out medication. But, we do prescribe medication in a certain way, and we perform electroshocks, but minimally. We try to negate everything. We will have to go further and understand what these acts mean and deny even these.

PIRELLA: Today, a nurse said something that seemed very valid to me, practically speaking: "Of course, it seems to me that now is the time to discuss whether or not to refuse medication."

JERVIS: But what does a closed ward mean, what does an open ward mean?

BASAGLIA: It seems to me that you discussed this earlier, about this meaning.

JERVIS: Then let's ask ourselves: why do we want to open a ward? I mean, why do all out efforts focus there at a certain point? In many respects, there is an anxiety about a perfectionism in order to be able to say that the whole hospital is open, to be able to say, "I opened that ward," to

have the satisfaction of creating chaos and then finding oneself inside with nurses, patients in the new context of anxiety, etc. But from an institutional point of view, from the point of view of the destruction of the hospital, what does it mean?

BASAGLIA: I would say that from an institutional point of view, it is a personal need that fits with the general meaning of one's political position. It's not that it is our job is to open up wards, but to the extent that we are psychiatrists acting in a given institutional reality, our commitment is to break the institutional nature of the reality upon which we act.

JERVIS: From an institutional point of view, the opening of a ward can perhaps be justified as the violent disruption of a form of balance in the search for another form of balance. With closed doors, the ward has its own balanced form, its own dynamics. By opening the doors, it is forced to seek a new dynamic and a new form of balance.

BASAGLIA: I would say that a new balance only happens when all the wards are open, in my opinion. Now there is still a locked ward that allows us to continue our negation. Later, we will have to go in search of another form of negation in order practically deny everything.

JERVIS: Yes, in short, opening all the wards brings us back to reality. As long as there is still a ward to open, there is basically this false problem of opening the ward. In a sense, it's a problem that absorbs all the other problems. Instead, these will only be clearly reproposed when the last ward is opened.

PIRELLA: The meeting we had about medication shows that the first negation of the asylum reality is the creation of a hospital-like reality. The next step is one we are already experiencing: it's the denial of medical reality.

JERVIS: In this case I agree. When I said earlier that the opening of the ward is not the real problem, I didn't mean that the opening of the ward should not be done because it's secondary; I just meant that I have the impression that as long as all the wards are not open, we remain in prehistory,

that is, we remain in a psychiatric space where there is always a part living outside of time. When all the wards are open, we move on to history.

BASAGLIA: Our problem is to make a therapeutic community based on negation and not a therapeutic community that starts from an already reformed base. Suppose we move with all our staff into a situation as it is now, to an open hospital, what would we do them? Certainly, our attitude would be very different from how it was at the beginning. If we leave here, and another set of clearly different staff is appointed, they will certainly do a different job to us; it would no longer be based on denial.[14]

JERVIS: In a sense, it's very easy now to do antipsychiatry.[15]

BASAGLIA: No, we do nonpsychiatry.

JERVIS: After all the wards are open, we must try to understand in a clear way who our enemies are so as to not weaken a denial of psychiatry.

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

JERVIS: For something to be done after the opening, an antipsychiatric tension must be maintained, otherwise we end up in reformism, in perfectionism.

BASAGLIA: We would be in the impasse common to all underdeveloped situations.

JERVIS: Yes, but at this moment, we are still the destroyers of the hospital. I really believe that to go from breaking the hospital to breaking psychiatry we need to make a qualitative leap.

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14 Here Basaglia appears to predict the outcomes in Gorizia if the *équipe* were to leave, as they in fact did in 1972 when the entire *équipe* resigned, and different psychiatrists were brought in. For this history see John Foot, *The Man Who Closed the Asylums: Franco Basaglia and the Revolution in Mental Health Care* (Verso, 2024).

15 For an analysis of this term and its relationship with the "anti-institutional movement" within Italy see Foot, *The Man Who Closed the Asylums,* 138–44, and Oisin Wall, "Basaglia and the British Anti-psychiatrists, 1960–1970," in *Basaglia's International Legacy,* ed. Tom Burns and John Foot (Oxford University Press, 2020).

BASAGLIA: We are doing it simultaneously: a rupture of the wards, and the rupture of psychiatry.

SLAVICH: By opening all the wards, we are just at the point where debts are abolished and land is given to farmers. But at this moment, when all the wards are open, the problem of the psychiatric nature of our work becomes more urgent.

JERVIS: Yes, but Basaglia rightly argues that there is a way, which is not just any way, in which the opening of the wards should be done. This is already a premise for further negation, for a contestation of psychiatry that goes far beyond simply negating the traditional reality of the asylum. So we are doing much more than just supporting the need to open wards. And therefore there is already the groundwork for future work when the wards are open.

SLAVICH: When all the wards are open, we can start attacking certain power mechanisms internally. For example, the fact that certain patients are forced to save money by certain people. This will naturally be a big problem.

JERVIS: In a sense, I would say that we can be quite optimistic because the opening of the ward is a problem and not an end.

BASAGLIA: It seems to me that then there is the fact that after the institutional denial, the problem of psychiatry emerges.

PIRELLA: At this point, it seems to me that the problem of psychiatry should be clarified.

BASAGLIA: The fact is that in reality we don't know what modern psychiatry is, because it is likely that modern psychiatry is nothing but a perfectionist form of old psychiatry. It's nothing but the perfect hospital.

PIRELLA: Modern psychiatry is nothing but an attempt to make exclusion less evident and more hidden.

It may be interesting to report, as an example of practical verification of the preceding discussion, the times and methods of the opening. The two last closed wards, men's C and women's C, despite the varying degree of involvement of the entire ward in both cases, required constant pressure from what was referred to

in the discussion as the "vanguard," which was made up of some doctors, the psychologist, the social worker, and some nurses, in order to reach a decision that was always a form of qualitative break with the past. The attitude of the patients shifted between ongoing institutional dependence and ambivalence regarding a problem related to the point of the view of the staff. However, some were clearly in favor.

The opening of the doors of the men's C ward took place on July 14, 1967. This was preceded, over the previous year, by a series of liberalizing decisions. The most significant of these concerned the increasing number of patients who had gained the ability to leave the ward whenever they wanted without being accompanied by anyone. In the days before the opening, it was decided to conduct an assessment during ward meetings (with nurses and patients, in particular the former) around the concrete possibility to move toward the unlocking of the doors. The *équipe* and some nurses expressed, with varying degrees of intensity, the need to open the ward immediately, while reluctance and opposition came from some of the staff. The stages of the decision were as follows: initially, it was decided during meetings that this opening would take place close to the date of the annual festival scheduled for the first week of August. Subsequently, due to pressure from the those who were impatient for change (the anxiety of waiting could have been seen as intolerable or absurd, as it was not linked to any specific "preparation"), an opportunity to open the ward immediately — much earlier than planned — emerged. The date of July 17, a Monday, was set. This decision stemmed from a meeting held on July 13.

The next day, the ward was opened and this was marked by a public event. There was even a toast with orange soda, suggested by a patient, a leader from another ward, who had witnessed the opening and wanted to be photographed throwing a bunch of keys away. The decision was thus anticipated through a choice made by the ward, facilitated by the presence of a head nurse on duty at the time who strongly supported the opening, alongside other supportive nurses.

It is worth noting that the final involvement by the staff that had always opposed the opening contained an interesting and contradictory element. It emerged that only through an opening could the ward lose the negative connotation that had made it the place of the final group of the excluded. This became evident through a repeated request from a patient in the ward, who was diligent and "useful" in terms of cleaning work, to change wards. The obvious impossibility of saying no to this request, which helped the transition from a closed to an open ward, made it clear that rigidly maintaining a position of refusal would only keep the ward in a state of degradation and "confinement." The "best" among the patients there would have left over time, and from the rest of the hospital there would be a constant temptation to transfer the "worst" there. The opening of the ward thus responded not only to a decision made by the "vanguard" but also to objective and undeniable needs. Paradoxically, the closed ward in an open hospital was forced to negate itself.

In the final months before the opening of the men's C ward, the existence of a similar problem in terms of the female half of the hospital had been almost completely overshadowed. This continued even after the opening of the last closed male ward, as if the success achieved in fully opening one half of the hospital did not allow any reflections about anything else. When attention turned to the women's C ward, the general meeting became the natural home for a rediscussion of the problem. The last closed ward became seen as everyone's fault, but especially that of its nurses, who felt that they were implicitly accused of not taking a step that everyone now expected from them. This problem was taken further through the setting up of a weekly meeting for the nurses from all the female wards. Here, the nurses of ward C were further accused by their colleagues, in a situation which verged around a feeling of inevitability and paralysis. They felt that they were being made into "scapegoats" of the hospital, and this was not an entirely unjustified feeling. Within this group, during this period, a small minority began to link up with the ideas of the vanguard, but it failed to create

a structure or find a leader opposed to those individuals who quietly continued to sabotage the liberalization of the ward.

The result was an almost fatalistic adherence to the plan for an opening up, and in the end a passive attitude toward the director and the *équipe* who "would open the ward anyway."

This avoidance of responsibility effectively gave the équipe the task of setting an opening date. Initially, it was *suggested* that this was imminent, "before Christmas," within a generic timeframe that allowed for a postponement of any "preparation" for this opening (in particular, the transfer to open wards of some female patients, and some "issues" as identified by the patients and nurses of the origin ward and as discussed and accepted in the destination ward). A deadline was then made more urgent, "within a month," so that "preparations" could be accelerated. But it was clear that all these preparations could be easily seen as insufficient terms of guaranteeing the possibility of any opening, and that the time until the deadline was linked to some ambiguities.

So, on the evening of November 21, during the weekly meeting of all the nurses, the director asked the question, "why not tomorrow?," and nobody wanted to object.

The internal dynamics of the nursing group as a whole had undergone a visible change, and the nurses took on the responsibility of managing the ward after the opening, of dealing with a new situation, while refusing to embrace it for themselves as free protagonists of this overturning.

An Institutional Contradiction: The Alcoholics Ward

Domenico Casagrande

BEN: I am against alcoholics living among themselves, and if someone asked me to join the *social community,*[1] I would immediately ask why. I prefer to live together with the others because for me the problems of alcoholics are the same as those of others, like other patients affected by other illnesses, let's call them mental illnesses if you like. Personally, I am against this [separation] because when living with other alcoholics in other institutions, I heard people say things like, "we are not crazy, we are just alcoholics." But, I think that the problems of us alcoholics and those of other patients are the same.

CASAGRANDE: Apart from the reasons you mentioned, which seem to concern the general problem of the relationship of alcoholics with other patients, are there, in your opinion, other reasons more closely related to the structure of this hospital, or not?

BEN: Yes, it bothers me to see an alcoholic ward on its own, for example, to see the nurses who, unlike their colleagues

1 This is the title given to the small alcoholics ward which is the subject of this chapter.

in other wards, do not wear uniforms, to see the alcoholics together, often cooking for themselves and so on, it all seems unfair to me. I would prefer to see the alcoholics with the other patients, not only because they have the same problems, but also because then [if you followed this logic] you would need to have schizophrenics with schizophrenics, depressives with depressives, and so on, while here everyone tends to live together.

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

BEN: Yes, exactly. In fact, I talked to other alcoholics who unfortunately are not now here and asked them to come with me to participate in this meeting, and they replied: "No, we don't want to be there in the alcoholic ward with the others — that is not us."

This dialogue was taken from a recording of one of the daily meetings of the only ward in the hospital that has been established using a method of judgment linked to the scientific description of diseases. In this ward, which is called a "social community," there are seventeen alcoholics. However, the patient who is talking here is not part of this nucleus but some time ago asked to take part in the meetings of alcoholics as an observer. After a period of about ten days, during which he participated in an apparently passively way, when one of the patients raised the issue of how those living in this ward are considered by the other members of the community, he intervened, as laid out above, and questioned the validity or otherwise of the existence of this structure in relation to the institution as a whole.

As is clearly shown through this dialogue and indirectly confirmed by the issues raised by the patient in the alcoholic ward (also cited above), Ben emerges as a lucid and clearheaded spokesperson concerning a contradiction among many of those who live and act in the hospital community, whether they be patients, doctors, or nurses.

Ben's critique is supported by various grievances that have emerged over time, culminating in splits and ruptures.

The hospital has free movement and free communication within its grounds, where these contradictions are laid bare and are often present at all levels. Now there is a crisis that requires a reconsideration of the meaning of the alcoholic ward, a crisis that became clear, given the above conversations, during a meeting of the *équipe*, where there was an analysis of the reasons for the existence of a ward that until then had seemed the most advanced and obvious solution [for alcoholics] in terms of the general organization of the hospital.

The alcoholic ward was established a year and a half ago, in April 1966. This was a difficult period in the history of the hospital. Two wards were still completely closed, community general meetings had been going on for about six months, and not all wards were running meetings. We were at a moment when from the ongoing institutional overturning, and the negation of the old concentration camp-like organization of the hospital, which led only to human degradation and the stripping of people's dignity, the groundwork had been laid for the creation of a new type of organization whose evolution over time was unknown and unclear. In such moments, anything that negates the traditional institution had both value and significance. In other words, anything which happens is a good step. This was the moment when the therapeutic community took shape and began to develop within the hospital. However, it would be wrong to think that this ward was created just to be up-to-date or fashionable. On the contrary, its establishment corresponded to a real need, as with all the changes that preceded it those that will follow. The roots of this ward's formation occurred when the admissions ward was being modernized.

After the rebuilding work had taken place, the patients, who during these works had been divided into groups and housed in different buildings, found themselves reunited. However, they still carried with them different characteristics that had gradually formed and consolidated during the previous division of patients. Thus, on the one hand, we have the "dispensary"

patients (those admitted with public healthcare support) who have the option to refuse hospitalization, enjoy greater freedom of movement, live in rooms separate from the others, and have better food. Alongside them were the psychotics, who were seen as those who needed the most assistance because they were weaker and had greater difficulty in integrating with others, and who, until then, had participated in a psychotherapy group established to overcome their weakness and help their integration with other patients. Then there were the alcoholics, who until then had also participated in psychotherapy sessions, aiming to exploit the fact that these patients spent various hours of the day together, forming a closed group that tended to minimize its contact with other patients. Finally, there was a group consisting of neurotics, depressives, "organic patients," and the elderly.

There is thus a problem of bringing together these four categories, which certainly do not correspond to any sense of shared scientific needs but rather indicate four different social characteristics resulting from particular situations. How can we not see the dispensary patients as privileged? And aren't the psychotics the "incomprehensible" ones, those who are considered the only true "crazy" patients, from whom we must constantly differentiate ourselves and whom it would be better to shut away in a closed ward? Aren't alcoholics the spoiled ones, lacking in willpower, in need more than anything of a firm hand? And finally, who are the others if not people who are hospitalized just in order to rest or to escape any work commitments, or just old people who complain, or people who cry without any purpose — in short, "troublemakers"?

Bringing together patients who range from the privileged to the oppressed and from the guilty to the pariahs is certainly not easy. It does not seem like a good solution to extend psychotherapy groups to others, both for theoretical reasons and, even more so, for practical ones. In fact, there is not enough time to continue even with those that were already in treatment, and, moreover, it becomes extremely difficult for a doctor to play the dual role of psychotherapist and community social therapist.

However, the problem was still obvious, and the most appropriate way forward, it seemed, given that a wing of a long-term patient ward was now available, was to remove the alcoholics. But why them, one might ask, and not any of the other categories?

There were many considerations that led to the choice of that group: first of all, it was the strongest and the largest, it was the one with the highest number of relapses; we are working in a region with one of the highest incidences of alcoholics. Furthermore, their separation would seem to allow for the greater possibility of cohesion among the remaining categories. We were moving toward a new experience whose outcome we could not be certain about and which we hoped could lead to positive results in terms of alcoholism.

Thus begins the life of a new ward, which starts from an initial nucleus of patients including all those who had been part of the psychotherapy group. As places become available due to patients leaving, other alcoholics are admitted, mostly from the admission ward. The criteria for selection were based around the high number of relapses and difficulties in dealing with social problems. Therefore, in this new ward, patients with long-standing alcohol dependence were always admitted, many of whom have had various previous experiences of hospitalization in traditional environments, with several episodes of different forms of acute intoxication in the past and signs of psychological deterioration. Moreover, for the most part, these are people who have already been "sectioned," that is, according to the terms of the 1904 law for psychiatric assistance,[2] have passed the observation period and are therefore committed to the hospital and also suffer from forms of social stigma.

This ward is completely open and holds a maximum of seventeen patients. To date it has registered the presence of sixty-

2 A law relating to psychiatric hospitals and procedures. See "Legge 14 febbraio 1904, n. 36: Disposizioni sui manicomi e sugli alienati. Custodia e cura degli alienati." https://www.normattiva.it/uri-res/N2Ls?urn:nir:stato:legge:1904-02-14;36@originale.

two people. It is run communally according to principles of self-government. Daily meetings are held in the evening and attended by patients, doctors, and nurses, and decisions are made together. These meetings represent a moment of checking in and raising of questions, with all the limitations and contradictions that this approach entails (see, for example, the chapter on self-government in this volume). In the evolution of the ward, different phases can be teased out.

At first, there was a refusal to cooperate. Absences from meetings were common, everyone tended to do their own thing, and there were attempts to create their own space outside the ward. But the difficulties they found in their relationships with others, due to the development of bad faith and mutual misunderstanding that were established between the alcoholics and the non-alcoholics, led to their return to the group. Participation becomes more active. By now, a "community culture" is becoming a kind of common heritage, and there is a gradual recognition of a collective therapeutic purpose uniting doctors, nurses, and patients. The first ward governed by the therapeutic community becomes a model to follow. Unity is found in moments of discussion whose subjects range from elementary matters like food to more complex issues that also involve a greater sense of responsibility. Patients gradually become aware of their decision-making possibilities in the management of the ward and the formulation of the rules that govern it. They begin to see it as something of their own, something that belongs to them and is no longer arbitrarily imposed from above. Initially, indeed, they saw themselves as separated from the others, and as no longer allowed to stay in the admission ward. This seemed to bring them closer to the fate of long-term patients, which is why they tended to reject this new arrangement and tried to distance themselves from it, and to sabotage it, but when they experienced difficulties in relation to the others, they returned, discovered new possibilities there, felt reassured, and tended to defend this arrangement. It is this initial period, in fact, that sees those who avoided the ward then seek to integrate themselves at the level of the general community, while some of those who

tried to interact with the general assembly experienced difficulties there, were stigmatized by others, and cannot deal with the complaints they sometimes receive. When they then manage to reach a position of responsibility (such as the chair of the meeting), they cannot carry out their task properly. Their attempts at exploiting this situation for their own ends are almost always debunked from the beginning, once they appear defenceless in front of the others, without anywhere to hide. At the bar, where everyone can have a daily beer, they often are refused service. That is, they realize that they are the *alcoholics of the hospital,* for whom there is no understanding. If someone shouts, argues, or becomes annoying, the community in the end can tolerate this behavior, and if someone drinks a few too many beers at the bar and then makes a scene, in the end this will be understood and tolerated, but if it is someone from the alcoholic ward, then this margin of tolerance no longer exists, suddenly it disappears, and the alcoholic becomes a scapegoat for a series of tensions. The ward meetings during this period often ended with long silences, and the few interventions by patients tended to underline a climate of oppression or vaguely persecutory feelings that are a sign of their rejection by the hospital community. Thus the need to create one's own space arose as an alternative to the exclusion created by others.

A second phase then begins, which we could define as one of adjustment. More and more initiatives are taken, and there is a distribution of tasks. In this period, some stand out for their abilities, gathering consensus. Thus, the first leaders emerge, who are those who propose initiatives and carry them and involve others. They act as spokespeople for the ward in general community meetings and are an alternative reference point for doctors and nurses. [But] when the alcoholic tries to build relationships with other wards, they still feel defeated and this underlines their sense of marginalization. This leads, on one hand, to a consolidation of their faith in the group, where they feel reassured, and, on the other hand, to a realization that they have found a different way to relate to others, one that is not based on alcohol dependence. Within the group, they realize

that they are no longer confronted with a blind and objectifying form of power, which makes them feel powerless, constantly stigmatizes them, and forces them into dependence as an only possible form of relationship, albeit one which is both objectified and objectifying. They do not experience a situation that oppresses them, but rather a conflictual situation in which they are constantly offered alternatives. It is no longer others choosing for them, but they find that there is the possibility of being themselves. However, they experience this only in their ward where they gradually discover their ability to stand up to others and discover that they can live in a group without hiding or lying. They feel "understood and accepted," but when they are outside their group they constantly feel labeled and forced into a role they cannot accept. Therefore, they seek in their group a set of evolving and reciprocal relationships through a search for clarity and awareness, and increased unity. In this phase, the ward becomes stronger and becomes an example to other wards thanks to certain activities (trips, dinners, outings, parties). It also established relationships outside of the hospital, both through these initiatives and by increasingly involving family members in meetings. It was during this period that there was a tendency to reject the label of "alcoholic ward," and the term "social community" was used by patients and nurses in a symbolic attempt at rejecting a sense of exclusion, underlining the communal aspects of an ongoing experience. However, connections with the rest of the hospital community became increasingly rare.

The participation of alcoholics in general assembly meetings became sporadic, and on the few occasions they did intervene, they did so as a group to use that arena for a specific project, and they were the only group who do not take part in collective trips. Individually, they try to hide to some extent as a form of protection, while also putting all their efforts into bringing the ward to an advanced position in terms of the hospital experience. This is their way of reacting to the exclusion from the community, which they responded to by establishing a ward which leads in terms of its activities but that also tends to exclude others. Now

they feel they have something positive to show to the others and they see that other wards are following their lead. The peak of this process was when the entire general meeting decided that for the trips the following year, each ward should be responsible for its own organization. The alcoholic ward in this way fell for an illusion — into thinking it had won a battle. Now the entire hospital is open, and everyone has the possibility of free movement. Communication between the various ward and patients is also freer. There is a greater possibility for an exchange of views, and a greater need for discussion even outside the institutional settings represented by various meetings. The alcoholics realize that they are too limited in terms of space and they feel the need to expand it, and they are now aware that ultimately the mechanism that led them to hospitalization is the same that led other patients to be hospitalized. They have become aware of their exclusion from society. It seems logical for them now to attempt to unify with the rest of the hospital. Thus, a party is organized by the "social community for the hospital community," and they are praised and thanked by everyone for this. This is considered the right time to move forward. However, some significant facts are not considered during this kind of counteroffensive.

For some time now, it has become clear that some patients from other wards, after advice from doctors and after being accepted into the alcoholic ward, then displayed forms of behavior which appeared to be regressive in some ways. For example, there is the case of Giovanni, who was offered the possibility to transfer to the alcoholic ward, where it was thought that he could better address his difficulties. He experienced this invitation as an order. In the days that followed, he continuously disrupted the ward. When asked for an explanation, he claimed to have been forced to transfer because he realized that, if he had refused, he would not have prevented the doctor from eventually achieving, through persuasion, the same outcome. While this behavior did challenge the authority of the doctor, who was seen as representative of a form of oppressive authority, on the other hand it underlined the rejection of a condition that was experienced negatively. This tendency can also be seen in two

other cases of former patients of the alcoholic department who, admitted due to a relapse to the acceptance ward, refused this transfer, but actively and spontaneously participated in meetings. Often, during the meetings of the various wards or the general assembly there were discussions about those who had abused alcohol after being given permission to leave the hospital or after temporary absences and had annoyed everyone upon their return. These people were often threatened with being sent to the alcoholic ward, which was therefore no longer seen as a place of privilege but rather as a place of punishment.

When the alcoholic tries to connect with the rest of the community, they find a different reality from that which they had imagined. The open forms of communication of the hospital present contradictions that they had ignored when living in the closed world of their ward. So when they participate in general meetings, they suddenly realize that their ward, which they had so jealously defended and believed to be the best of all, is considered by others as a place of punishment. They feel that a phrase that has circulated for many years and which they have also utilized, "if you're no good, we'll send you to C ward" (the closed ward), has been replaced by, "if you drink and annoy us, we'll send you to the branch bar."[3] They realize, therefore, that they are even more stigmatized than before. The complete opening up of the hospital, in fact, has led the community to discover that those who were confined, those who were kept locked up either because they *did not understand,* or because they were *bad,* or because they *ran away,* and therefore were *irresponsible,* were ultimately just like everyone else. It was only chance that led to them being the last to be "liberated." In essence, these people who were locked up demonstrated a sense of responsibility within the new spaces granted to them and, at the same time, underline, in a clear way, the difficulties for alcoholics in taking possession of their own space, which is either expanded or

3 A term used in Friuli-Venezia Giulia for private bars which can be identified by the sign of a branch. In the hospital this term was often used to indicate the alcoholics ward.

restricted in ways which are not appropriate to their needs. So now it is the alcoholic who becomes the irresponsible one, the one who breaks the rules.

At this point, they realize the difficulties in moving to the alcoholic ward. They see the ward not as a place created by the institution to try and help them and support them, but to help themselves in terms of the self-destructive behaviors they sometimes engage in. When they come into contact with other wards, they realize that the tolerance of others toward an alcoholic is high, and that only when a line is crossed mechanisms of exclusion come into play, which then leads them to the alcoholic ward. At this point, they have a choice: either to fight against this exclusion and join the others, recognizing themselves as themselves, or give in to another defeat.

Alcoholics who arrive in the hospital are already outcasts in a society that does not understand them and does not accept the weak, so it excludes something that it does not want to recognize as part of itself, objectifies these people and removes them in order to avoid any sense self-examination.

The alcoholic is therefore entrusted to the institution in order to be invisible, to be kept away, and perhaps returned to society in a different form. "Give them some pills to stop them from drinking." "Make them better." "When they don't drink, they're so good, they listen to me, they do everything I say, it's when they've been drinking that they always have something to complain about": these are often the phrases that accompany these people upon admission. However, they then find themselves in the same situation as all the other patients and rebel against this situation in the only way they know: by taking advantage of the freedom they have by drinking and engaging in disruptive behavior. Here, however, they also experience a new possibility in terms of relationships. They become more attached to the group in which they find themselves, where they no longer feel rejected, and they use it as a space to experiment. In the group, therefore, they become stronger and tend to compete with the rest of the community. At the same time, they become aware of their exclusion, which is also that of the other patients

of the community, and in which they finally manage to recognize *themselves.* However, when they try to establish an equal form of relationship with other patients, they find themselves forced back into a previous situation. They are not seen as Luigi or Mario but are "the alcoholic," they are guilty, they are *different*. They are the only group where, when all labels are set aside, they still experience their own stigma as a burden. They are thus objectified again, forced back into a space from which they desperately tried to escape; they fall back into an even more tragic situation than the one they had tried to leave behind because they are aware that they are the *excluded* in a community of the excluded. Their role at this point becomes extremely difficult. There are too many fronts on which they now must engage and they are overwhelmed by an anxiety that they can no longer manage dialectically, so they try to challenge the institution that has confined them to a *ghetto*. They try to destabilize the institution by using the weapons it has given them, not in a constructive way, but destructively. The only thing then can do is to destroy this ward that has proven to be so contradictory within the new situation that has evolved. It is against this background that the ward enters into crisis. This crisis, therefore, has a meaning and a purpose. The institution can no longer ignore this situation; it must embrace it and understand it.

We here include some of the most significant passages from a recording of a meeting of the *équipe* looking after this ward:

BREGANT:[4] In my opinion, what has changed in the ward is the system. I mean that the system's dynamics have frozen with the almost total absorption of all initiatives. In some ways, we have experienced an involution. Now we must ask ourselves: what should we do? Should we look for new initiatives and greater flexibility in the awareness of each individual? I don't know, but I feel that somehow the system needs to be revised and reviewed.

4 A psychiatric nurse.

CASAGRANDE:[5] It seems to me that before seeking solutions, we must ask ourselves why such a situation has arisen. At the beginning of the experience, one of the problems we sought to avoid was for the group's maturation process to occur without giving rise to those disruptive forms of action that had been seen in the past. Now, however, we find ourselves confronted with this kind of reality, and, in my opinion, this fact has its origin in the problem of integration between the social community and the hospital community.

TRONCAR:[6] The fact is that every time the social community has come into contact with the general community, it has adopted the technique of trying to exploit it for its own ends without challenging itself.

BASAGLIA: If we think about the personality of the alcoholic, it is undoubtedly difficult to imagine that, in a community situation like ours, they can question themselves to the point of leading to a crisis. They are unlikely to take these risks. I believe that as a group they are powerful enough to defend themselves from an attack of this kind from the hospital. Instead, I think we should discuss what Casagrande said. How can we see these alcoholics? They are people who drink excessively, many of whom are forcibly admitted, against their will, and are then sent to that ward because that's what the general community or the doctor desires. Perhaps there is a pedagogical attitude on behalf of the community that creates certain situations. But there is more to it than this. This is a particular kind of alcoholic ward compared to other similar wards, because it is a community that lives among another community of patients.

CASAGRANDE: In fact, I have often wondered why alcoholics here, who acknowledge their dependency, refuse to be

5 Domenico Casagrande, psychiatrist, and responsible for the alcoholics ward at this time.

6 A psychiatric nurse.

called alcoholics, as happens, for example, in Alcoholics Anonymous.

BASAGLIA: Of course, because in our case, this is a community within another community that views alcoholics in a specific way.

TRONCAR: Here, every time someone says they are an alcoholic, they are immediately made to feel guilty in some way.

DI CECCO:[7] Yes, but we hear every day, "I'm here because I have a great dependency on alcohol and I can't stop drinking."

BREGANT: I would like to provide an example, Giuseppe B., who initially denied being a drinker, and in the end acknowledged his dependency, but did not want to call himself an alcoholic.

CASAGRANDE: Indeed, it is clear that they reject the label of alcoholic because, for them, it is a form of stigma that negatively defines them. They are then forced into a situation of weakness compared to others, with little or no possibility of defending themselves.

PIRELLA:[8] I wanted to point out that some alcoholics in the observance ward readily admit to having this problem, and I think that this happens because these individuals are not in a situation of social marginalization and therefore do not feel the need to defend themselves from a shameful and degrading accusation.

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

BASAGLIA: I would say, though, that the central point is that raised by Pirella, namely the relationship between alcoholics and nonalcoholics in the hospital.

PIRELLA: Indeed, there is a social characterization of the alcoholic compared to the nonalcoholic, and vice versa. This is a misunderstanding that exists, as between the "good" and the "bad." Indeed, the person who is bad is never

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7 A psychiatric nurse.
8 Agostino Pirella, psychiatrist.

understood by the good, and vice versa: they are two poles of an antinomy. There are therefore two categories: that of the excluded and that of the nonexcluded. And I would say that the situation of alcoholics in relation to the rest of the hospital is one of exclusion.

BASAGLIA: However, this dynamic of exclusion starts in the other wards. In fact, other patients are never told that a certain person is schizophrenic or is a neurotic, and so on, while the only one still labeled in this way is the alcoholic, and even if the others are stigmatized, they are not labeled. In the former case, the person is up for discussion, in the latter, they are not.

Following this discussion, it is clear that everyone is now aware of the crisis, and there is a strong desire to do something, to intervene ("search for new initiatives ... the system needs to be revised and reviewed," as the nurse stated in the beginning). After this meeting, new solutions were put forward:

BREGANT: The individual who leaves the hospital is placed in a situation of distress, so we need to provide them with external help.

DI CECCO: The hospital must also extend to the outside world. . . .

PIRELLA: We could transform the ward and no longer admit alcoholics, and perhaps create a small unit for the recovery of those long-term patients who are more institutionalized.

CASAGRANDE: That could be a good idea.

But all these statements, in their search for a solution, are nothing more than an attempt to mask the failure of the original plan. This experience was born from a practical kind of choice linked to the way the hospital was changing and was backed by a form of practice that looked to prevent exclusion. But these two aspects of the same reality contradict each other: the therapeutic and practical choice and the rejection of exclusion. Institutional reality, which has been modified by this experience that

was originally born out of necessity, now reveals its own internal contradictions in its need to reject it.

The Crisis of Psychiatry and Institutional Contradictions

Giovanni Jervis

The main purpose of this chapter is to examine some problems faced by a management team (the *équipe*) in a psychiatric hospital. These are issues that can be approached from a series of perspectives. Firstly, there are those that arise directly from the concrete experiences of *one* specific *équipe,* which in this case is represented by the staff of the provincial psychiatric hospital of Gorizia. Secondly, there are problems that refer to the general position of those working in any psychiatric institution within a specific social reality. Finally, there are problems linked to even more general considerations that derive from the choice of one's theoretical analytical tools within an institutional context.

The problems we propose to address arise directly from a particular set of practices, that of a psychiatric hospital, and cannot be immediately generalized. Their origin and their scope for empirical verification remain sectoral and are limited to the field of action of daily work within an institution. Moreover, the same criticisms that look at and attempt to change an institution from within will inevitably expand into an awareness and the taking up of positions that have meaning beyond its specific borders.

Beyond a sense of any "critique of the asylum" and indeed from within such a position, there is a series of positions, which are also linked to actual experimentation in practice, that go beyond themes linked to the "humanization" and "modernization" of psychiatric care. Inevitably, new problems also arise that are not strictly institutional. These problems are connected, on one hand, to a more detailed understanding of asylums themselves, which show their links with society, while on the other hand, they also refer to a series of theoretical reflections that call into question the entire field of psychiatry and a crisis in terms of its outlook. Finally, the crisis of psychiatric institutionalism not only refers to a general critique of institutions in a narrow sense but tends to call into question, along with psychiatry, the entire sense of the validity of "technical separateness" as a particular form of division of labor and as a repressive form of institutionalization of power.

We are convinced that an analysis of asylum institutions and their crisis provides a way of understanding and a series of fruitful operational criteria for unpicking, in a series of in-depth studies and enquiries, some of the "cultural" deceptions that seem increasingly necessary today in order to maintain society's status quo.

It is important to realize, from this point onward, the presence of a double and connected danger in any such analysis: that of empiricism and that of unverified and generalized abstract ideas.

The danger of empiricism arises from an inability to apply appropriate tools of theoretical analysis to the starting point of all asylum criticism: anger at the inhumanity of traditional asylums. This sense of anger risks leading to reforms that are imprisoned by the same structures that generated it. Any proposal for an empirical reform of the psychiatric hospital will lead to an ideology linked to a therapeutic community, which only postpones addressing the fundamental problem. On the other hand, reformism is the first response to the typical attitude of psychiatrists managing asylums who fail to take responsibility for the situation. Sometimes in good faith, they believe that they cannot

really change their institution and hide behind actions of politicians and administrators, who are not creating the right laws, or regulations, or enough funding. In reality, the images associated with the asylum (with oppressive, old, crowded spaces, poverty in both people and things, neglect and technical delay, latent and explicit violence, brutalization connected to inaction) fully justify the temptation to call for empirical reform. Something must be done, immediately, to change even slightly this very serious situation. This need merits respect and should be encouraged and underlined, even more so given that it is clear that the organizational structures of asylums can be changed by those doctors working within them, if they want to do so. The anger we have referred to must lead to the identification of responsibility and indeed of precisely identifiable responsibility.[1]

So, while on one hand the idea of the responsibility of doctors working in asylums demonstrates both the possibility and the need to "do something," even in terms of straightforward empirical reformism, on the other hand, it is true that this reformism is precisely where the real intentions of those promoting these changes can be understood. At this point, either reformism is seen as a solution to the problem of the asylum, or it becomes in itself a limit, 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 form of denunciation, a wide-ranging, extremist, and imprecise from of critique. This may also have positive aspects in some cases,

1 The experiment in Gorizia demonstrates, if nothing else, that even one of the most traditional asylums can be radically changed in structure without any help in terms of legislative, administrative, or financial terms and without any real difference in the social and psychosocial context between Gorizia and elsewhere in Italy. We might add that, in this regard, the main difference between the situation in Gorizia and that of the rest of the country probably lies only in the high percentage of problems linked to alcoholism, an aspect that certainly does not facilitate the type of work we are engaged in. As for the advantages resulting from the relatively small size of the province where we operate, it is undeniable that they are largely outweighed by other particular disadvantages, including above all the lack of adequate financial resources [note in original].

and this author believes it does so despite appearances to the contrary, given that an "angry" form of contestation may be the best way to counteract old "scientific," "objective," and "balanced" criticisms of a social system. However, it is not clear that such a critique must begin with the asylum itself.

Referring to some socializing group therapy techniques used in psychiatric hospitals as "modern" tools within more or less unchanged institutional structures, in Gorizia, there has been talk of "sociotherapy as an institutional alibi." In reality, the discussion can be taken further, and if today we often refer to therapeutic communities rather than asylums, it is also possible to understand an idea of "therapeutic communities as institutional alibis" and finally, following from this, a crisis of "institutions as alibis." The danger of these subsequent challenges lies not in their extremism but in the ease with which they can lead to consensus. They are too easily welcomed in an abstract sense as generically nonconformist and "revolutionary." For the same reason, far too many people have enthusiastically aligned with superficial narratives around the "myth of mental illness" without clearly understanding the difficulties and contradictions involved in the (necessary) deconstruction of the traditional image (both in its "vulgar" and "scientific" aspects) of madness.

While a radical critique of clichés, stereotypes, and alibis is required, this can only happen with relation to practice. This does not necessarily have to be institutional practice. But it is important to check if institutional practice allows for the sufficient experimentation of positions that, considered in isolation, might be accused of abstract forms of extremism. In this context, we should add that while on one hand the need for new forms of criticism always precedes their verification in practice, on the other hand, it is also true that criticism cannot be discussed without starting once again from a form of contestation and new practice that has been verified. Thus, every completed experience tends to be validated by its own success and therefore immediately constitutes its own ideology. But it is also from the rejection of this ideology, that is, from self-criticism, that further contestation tends to arise.

At this point we come to the issue of the specificity of psychiatric organization. The traditional defense of the psychiatric institution always starts from an appeal to technical specificity: the mentally ill must be treated because nobody can deny that they need help; they must be treated in a particular way because there are technical difficulties and limits (which can only be evaluated by competent individuals) that prevent faster, more effective, and less unpleasant forms of therapy. If we take this kind of approach, whose false nature we will return to, there are no direct relationships between forms of psychiatric care and the ways in which society is organized. The latter, which evolves in terms of a sense of "progress," may well provide better medicines, more beds, more qualified personnel, and more welcoming and better-organized premises, but forms of care will always be decided upon by psychiatrists based on their knowledge.

Before returning to this point, we should also be aware of an opposite danger: that of asserting that the psychiatric organization in a given country is perfectly consistent with the dominant social structure. Yielding to this temptation, it may seem a relatively simple task to resolve the problem of mental illness by linking them to social contradictions and to argue that therapeutic care organizations directly obey a logic of power. The dangers in this regard are to assert that power (and, more concretely, capitalist power) is a homogeneous system, devoid of contradictions, identifiable in "capital" or in the rational plans of an elite of neocapitalists; and to consider, in parallel, that psychiatric organizations are modified and structured without contradictions according to dominant political plans. In reality, we should consider the idea that psychiatric organizations are "backward" or "different" with respect to the institutional needs at the level of society in general, that is, they still have to some extent their own history and specificity. Only at this point will it be possible to examine the "anachronistic" character of institutional structures and to trace, historically as well as in the analysis of the present, relationships between psychiatric hospitals on one hand, and psychiatric ideas, dominant ideologies, and the

most immediate needs linked to the preservation of social order on the other.

At this point we will move on briefly from the problem of mental illness, that is, of the "specificity" of forms of therapy that according to some make psychiatric institutions necessary as such. From this perspective, it is possible to see structures of psychiatric care as ways of controlling deviance. If we look at the historical origins of psychiatric hospitals and the current justification for their existence, according to common opinion, state laws, and their internal regulations, then it is clear that the constitutive function of such institutions is not therapeutic but repressive. Asylums defend citizens from specific individuals who exhibit deviant behavior, once doctors have established that such deviance is due to an illness: that they are "dangerous to themselves and others or a public scandal,"[2] and then they are separated from society. Starting from these premises, the problem can be seen in a broader context and analyzed according to various points of view.[3]

> The institutional framework is constructed by social norms. Such norms can be violated; they are sanctioned by violence. The motives to break social norms derive from anticipated satisfactions of drives. We have always interpreted the world through the eyes of our needs; and these interpretations are sublated in the semantic contents of everyday language. It is then easy to see that the institutional framework of a society fulfills two different tasks. First, it consists in the organization of violence that can compel the repression of the satisfaction of drives, and second it consists in a system of cultural transmission that articulates the mass of our needs and anticipates

2 This is another reference to the text of the 1904 law. See "Legge 14 febbraio 1904, n. 36: Disposizioni sui manicomi e sugli alienati. Custodia e cura degli alienati," https://www.normattiva.it/uri-res/N2Ls?urn:nir:stato:legge:1904-02-14;36@originale.

3 It should be noted that in the following text, the term "institutional framework" is used in a broad sense, in a way that is different to our understanding.

> claims to the satisfaction of drives. These cultural values also include interpretations of needs that are not integrated into the system of self-preservation — mythical, religious, utopian contents, that is, collective consolations as well as sources of philosophy and criticism. Part of these contents are repurposed and serve to legitimate the system of domination.[4]

This system of domination undoubtedly includes psychiatric hospitals. As for the "contents" under discussion, they also concern the ideology of mental illness and custodial ideology. The legitimacy of all "organizations of violence" dealing with people whose deviance is attributed to mental disorder is based on these ideologies. However, the role of these ideologies is not limited to a straightforward explanation or justification that justifies the horrors of the asylum, just as the horrors of the asylum are not the only way in which the organized repression of that "anticipated satisfaction of drives" cited by Habermas is expressed. The culturalized image of madness and its repression not only contains an overall justification of psychiatry as a form of spe-

4 Jürgen Habermas, "Praktische Folgen des wissenschaftlich-technischen Fortschritts," in *Theorie und Praxis: Sozialphilosophische Studien* (Suhrkamp, 1963), 353: "Der institutionelle Rahmen ist aus gesellschäflichen Normen gezimmert. Solche Normen können verletzt werden; sie sind durch Gewalt sanktioniert. Die Motive zur Übertretung gesellschaftlicher Normen stammen aus antizipierten Triebbefriedigungen. Wir haben die Welt immer schon mit den Augen unserer Bedürfnisse interpretiert; und diese Deutungen sind im semantische Gehalt der Umgangssprache augehoben. So ist leicht zu sehen, daß der institutionelle Rahmen einer Gesellschaft zwei Aufgaben erfüllt. Er besteht erstens aus einer Organisation der Gewalt, die die Repression von Triebbefriedigung erzwingen kann, und er besteht zweitens aus einem System kultureller Überlieferung, das die Masse unserer Bedürfnisse artikuliert und Ansprüche auf Triebbefriedigung antizipiert. Diese kulturellen Werte führen auch Interpretationen der Bedürfnisse mit sich, die im System der Selbsterhaltung nicht integriert sind — mythische, religiöse, utopische Gehalte, d.h. die kollektiven Tröstungen ebenso wie die Quellen der Philosophie und der Kritik. Ein Teil dieser Gehalte wird umfunktioniert und dient der Legitimation der Herrschaftssystems." The author originally cites from the Italian translation: "Conseguenze pratiche del progresso tecnico-scientifico: Nota a una discussione," *Quaderni Piacentini* 32 (1967): 87.

cialized theorization set up in order to protect the “healthy” but also serves to redirect desires for freedom, defining the latter as the freedom of what is “legitimately healthy,” in opposition to madness, which is an image of a freedom which is not tolerated.

It is 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 medical power. On the other hand, it is important to recognize that this is an area where specific psychological dynamics come into play.

The importance of these psychological dynamics can only be hinted at here, even considering that it would be very difficult to accurately analyze them through research. First of all, we can look at the meaning of prisons. The exclusion of criminals in prisons is a direct confirmation of the honesty of those citizens who are outside and therefore an instrument of social cohesion (“belonging”). The excluded in prisons are necessary in order to place a safe and unbreakable barrier (in both directions) between order and disorder. It is also quite clear which acts lead to imprisonment. As for the institutional sanctions applied to madness and, therefore, psychiatric hospitals, it is easy to observe how no one knows exactly how to avoid these outcomes. Not only that: each of us feels in some way that exhibiting forms of “healthy” behavior is a laborious and always fragile state in the face of psychic disorder. The latter is close to us, but hidden; always repressed, but not far away. Hence, the asylum identifies itself with the need to make a 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 “acceptable” behaviors. Learning normality here is not simply the search for balance but the mutual reassurance of belonging to a world where everything must be controlled and safe. Those who pay a due price to keep their mental health intact are aware, in some ways, that their sacrifice is too high not to constitute a form of privilege.

If the mechanisms of violence within society are also used as ways of creating this exclusion of madness, this implies that the attitude of exclusion toward the mad is already permeated by institutionally approved violence. On the other hand, society's own violence is controlled and sanctioned. Only the psychiatrist is essentially free to operate inside the asylum outside of any social control and is invested with a power that society is happy to delegate to them. The system continues to protect its victims (including in prisons) only to the extent that the sanctioning of deviance determines in its subordinates behavior that can still be included within an ethics of violence and productivity. The mentally ill, the irrational lowest of the low in terms of social rationality, are crushed because they are the only ones to completely break the rules of the game. Institutional psychiatry is free to direct all society's violence toward the mad precisely because, identifying these groups in the mentally ill, societal norms expel from itself an "incomprehensible" and "dangerous" image linked to the possibility of turning into something "disordered" and different. The healthy defend themselves from a temptation to reject forms of coherence that are also forms of complicity by projecting onto these defenseless individuals an aggressiveness that they are not allowed to use elsewhere and that constantly runs the risk of destroying them. For the healthy, the acceptance of a socially determined "reality principle" imposes an objectification outside of themselves of any possibility of breakdown. Their being "normal" is thus confirmed by the inhuman mask they apply to the mad. In refusing to recognize themselves in the latter, they willingly accept the inhumanity of their subordination.

The exclusion of the mad is sanctioned and justified by psychiatry. If there is a general "culture" of mental health and illness, there is no doubt that the psychiatrist participates in it. Psychiatrists do not live, however, in an abstract institution themselves, but perform a function that is located within the terms linked to roles and a general ideology of medical power. Elsewhere, in relation to a well-known argument by Talcott Parsons, the ideology of medical technicality has itself been largely

seen as a form of mystification.[5] The doctor is an individual who possesses power, and to exercise it they need to accept the myth of omnipotence that the patient lends them. The psychiatrist, however, unlike a GP or surgeon, is invested with a much greater power and does not rely on their technical omnipotence in order to act on a specific part of the patient's body but acts globally on the patient, who belongs to them.

At this point, there are legitimate doubts about the ways in which psychiatry fails to define the particularities that bring deviant behavior within its competence. However, there is also another problem, which concerns the danger that the scientific demonstration of the presence of a disease underlying anomalous behavior serves to justify an abusive overreach in terms of the technical definition of deviance and therefore favors technocratic proposals which lead to discrimination, repression, and reeducation linked to deviant behaviors. It could be argued that these psychiatrists, who as specialists tend to bring within their psychobiological universe problems that are connected to social issues, are dangerous reactionaries. And this may be true. They could be seen merely as servants of power who, while hiding behind their incomprehensible techniques, strive to conceal and transmit, together with scientific knowledge (or without this), very specific ideological forms of reasoning linked to the defense of historically defined values and interests. In reality, the reactionary character of the use of the concept of deviance by psychiatrists does not imply any kind of political and ideological choice. The very idea that a particular form of deviant behavior can imply a technical definition in medical-psychiatric terms implies that deviance in general could be defined according to criteria that have nothing to do with sociological relativism and therefore are beyond any possibility of political criticism. Similarly, a definition of some forms of psychiatric deviance

5 Talcott Parsons (1902–1979), US sociologist. This may be a reference to his work *The Social System: The Major Exposition of the Author's Conceptual Scheme for the Analysis of the Dynamics of the Social System* (The Free Press of Glencoe, 1951), which appeared in Italian in 1965.

inevitably refers back to general models of normality. The danger therefore lies not so much in an "abusive" extension of the technical-psychiatric definition of deviance, but in the fact that this definition, even if applied to few cases, immediately tends to assume a universal character.

Traditional psychiatry had on this point, until a few years ago, an apparently solid defense. According to positivist psychiatry, behavior is abnormal (at least in theory) not because of its actual characteristics, but because it is nothing other than the direct external manifestation of a disease linked to the 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 nature of madness and all mental disorders consists of. A disorder has some intrinsic characteristics that define it as such — loss of functions, disintegration, death — not the 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 ended up occurring on an empirical and fragile level. By referring back to the naturalistic medical practices from classical antiquity and by bypassing the Enlightenment and "moral" premises linked to the birth of modern psychiatry between the late eighteenth and early nineteenth centuries, positivist psychiatry consolidated its positions at the end of the last century by discovering the syphilitic aetiology of progressive paralysis. The presence of treponemes in the brains of paralytics provided the basis for constituting a "model of psychosis" from which all other interpretations of illness in the psychiatric field could be derived and seemed to promise a form of reconciliation between psychiatry and general medicine.

It is often argued that this "organicist" view of mental illness was overcome thanks to the "dynamic" conceptions introduced by Sigmund Freud and his successors, and that the old model of mental illness as brain disease has been superseded by the realization that neuroses, and probably also the main psychoses, do not develop on any demonstrable lesion substrate.

This "modern" conception is still partial and debatable for a number of reasons. First of all, it is not at all clear that Freud constructed an interpretative model of mental disorders which was substantially different from a mechanistic one. While acknowledging Freud's merit of having operated the first and most decisive break from the old schemes, it could be argued that he introduced a new type of mechanism, which was equally deterministic and ahistorical. Secondly, the idea that in many behaviors labeled as "mental disorders" there is an actual "disorder" (whatever this term means) linked to higher nervous functions is not at all to be dismissed too lightly, and in any case refers to extremely complex problems. Thirdly, it is debatable whether positivist psychiatry has really been based, in practice, on a model of disease borrowed from general medicine. Throughout the nineteenth century and up to now, psychiatry has continued to define its field of action by marking the external boundaries of a taxonomic system based on the grouping of "typical" behavior disorders into medical classification systems and subsystems. In other words, these forms of classification, in the context of the impossibility of making psychiatry into a science, have continued, in practice, to create an empirical system based on the phenomenological description of behaviors, rather than on the reconstruction of objectively verifiable dysfunctions that it was not possible to unveil. The crisis of positivist psychiatry was actually linked to a whole series of other factors, which can perhaps be summarized in the impossibility to classify behavior disorders as objectively describable phenomena in naturalistic terms. In part, there is no doubt that this was an empirical failure, a general sense of bankruptcy. Psychiatry, whether considered within the scope of medical disciplines or human sciences, has kept very few of its promises. Little or nothing is known about the cause of the vast majority of mental disorders. As for therapy, the situation is not much better, and while it is known that drugs have little more than a symptomatic effect, there are still numerous doubts about the importance psychotherapy. The failure of "medical" psychiatry theoretically led to a series of other attempts at synthesis, which constitute 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 previous writings of Emil Kraepelin, or Joseph Babinski, and compare them to "modern" ones: to Harry Sullivan, to Ludwig Binswanger, to R.D. Laing. What is striking amongst clinicians in the late nineteenth century is their extraordinary respect for facts. Mental illness is there, present in the gestures of the schizophrenic as in the cerebral cortex of the demented. For the scientist observing them, these were identifiable forms of sensory stimuli, objects to be collected and processed as systematic forms of data. Mental illness is a system which is to be discovered, totally enclosed in itself, but endowed with its own laws which are still partly unknown, separated from the observer who does not participate in any way in their world. The very concept of behavior seems to vanish constantly from the psychiatrist's interpretative categories. The mentally ill are an isolated entity that only *functions* (and functions poorly), *they do not actually behave.* But for this to happen, the psychiatrist must reject their own categories and any relationship between subject and object and demonstrate that the patient, which is objectivized in a pure way, is not as such because they objectify them, but because they belong in themselves to the world of facts dealt with by science. This objective world cannot be subjected to any interpretative category for the good reason that facts reconstruct themselves according to their own categories, provided that the scientist collects them in sufficient numbers and with perfect neutrality.

We know today that modern science operates in an entirely different way. Facts no longer speak for themselves, the observer is present in all research, and not outside of it, with their own practical interventions, their own interpretative categories, their own ideology. Empirical naturalism and the immanent metaphysics of positivism have been overcome and definitively destroyed. For psychiatry, this destruction has been on one hand particularly radical, and on the other both partial and ineffective.

Theoretical premises have undoubtedly been laid for the overturning of medical empiricism and objectifying forms of positivism. This happened in two stages: first with the demystification of the traditional separation between "healthy" and "sick" carried out by Freud in the field of psychopathology; secondly with the discovery of the "human" (with all the ambiguities this term may entail) character of psychological dynamicsthat traditionally were considered "ill" carried out by existentialist psychiatrists. The destruction of the asylum-type justifications of madness dealt with in this volume has not only underlined the impossibility of considering the mentally ill according to special criteria, different from those used for the healthy, but it has also demonstrated that the "scientific" problem of "disorder" does not exist to the extent that the behavior of certain individuals is artificially reduced to a functional alteration of the nervous system. The error is not in supposing the possibility of such a functional breakdown, but in identifying it with "altered" behavior. The latter, on the contrary, can be correctly understood only if inserted in the dynamics of interpersonal and social relationships that have shaped it. Even in those cases where it is possible to link behavioral "disturbance" to a brain lesion ("illness"), this lesion is merely an intermediate point in a series of preceding events that contributed to its cause and in a chain of subsequent events that determined the individual's way of reacting to their inferior state. What can no longer be sustained is the "natural" character of the illness and the possibility of a direct cause-and-effect relationship between the more or less hypothetical brain dysfunction and the way the "patient" manages (or fails to manage) to live with others. In most cases, however, the hypothesis of a brain lesion appears unfounded, artificial, or irrelevant, because the interpersonal disturbance only makes sense within the context of that social dynamic that progressively shaped it, creating its *own* patient, and gradually excluding them from the possibility of maintaining social relationships. From this perspective, even the examination of the patient by the psychiatrist tends to lose its traditional character, that is, it now takes place within the framework of an interpersonal relationship that is no

longer that which separates people into "psychiatrist–patient" but becomes a comparison 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 in front of them lies not in the imbalance between health and illness but in a power imbalance. One of the two people has greater power, sometimes absolute power, so they can define the other's role according to their own language. We will return to this point later.

On a practical level, however, psychiatry has remained mostly linked to medical empiricism and has continued to borrow from its values. Even today, the majority of university professors, with the same gestures as their nineteenth-century predecessors, lead the mentally ill into the lecture theater and "demonstrate" them to the students, just as they would show a cirrhotic liver on the anatomical table: the movements, the vocabulary of the mentally ill continue to be "facts," not actions situated in a context. In this way, the practical objectification of madness accurately reflects the *management* of the mentally ill by psychiatric institutions.

Contradictions have been discussed between modern anti-positivist psychiatry and psychiatric practice as a medical discipline and as institutional practice. In reality, there are relationships between these two apparently opposite poles, and it is worth examining them.

Following Sullivan, all the more current and aware forms of modern psychiatry have become aware of the fact that mental disorder is no longer posed as an individual problem, within the objectified body of the patient, but can be correctly experienced only in its interindividual aspect. The criteria for an understanding of these interindividual problems have remained fundamentally those derived from psychology and psychoanalysis. Instead of studying how social and political problems influence group dynamics and determine them in their historical and material form, the tendency has been to expand psychological and psychiatric examination toward the societal sphere and remove it from a political critique.

In this way, a premise has been laid for realizing the old Enlightenment dream of rational control over all deviant behaviors, as they are always due to psychological disturbances and emotional issues. Psychiatrists have thus accepted from above a broader form of mandate, and mental illness has been reinterpreted as psychological dysfunctionality within all social relationships. Psychiatry has thus delivered itself, bound hand and foot, to the custodians of societal order, responsible for defining norms, deviations, and sanctions according to their criteria.

A sector of modern psychiatry has become aware of this problem and has understood that it operates and creates theories in line with societal values that cannot be defined in psychiatric terms but instead define the nature of psychiatry. One area where this awareness has taken shape is that of power imbalances and the differences in roles and values that determine the concrete nature of the doctor–patient encounter. Social psychiatry and interpersonal psychiatry have examined both the sociocultural context in which the patient is defined as such and the "therapeutic" relationship as a system of psychological interactions. Psychiatry itself, as a psychiatric practice, has become the object of psychiatry. Here too, however, the psychiatrist has only raised their level of investigation. By considering themselves, in their relationship with the patient, as objects of their own discipline, they have confirmed the substantial validity of the latter. The psychiatrist has continued to accept a social mandate while recognizing its conventional nature. They have accepted, for example, that a young criminal or antisocial individual may be considered ill or not depending on social norms, that neurosis is a collective problem, that the mother of a schizophrenic may be, in a sense, sicker than her son, that individual therapy has no greater significance (and perhaps less) than family group therapy or work groups. They have accepted to be held accountable to their opponents for the fact that psychiatry tends to integrate an individual according to the needs of power and they have even accepted the idea of needing to be treated no less than their patient. What they could not accept was to throw their identity as a power contractor in crisis and subordination to the defini-

tion of norms established by power. They remain masters of the situation.

Although, as mentioned above, the psychiatrist–patient relationship is experienced as a "crisis," the patient continues to be examined within that relationship through the lens of a new set of theories which, although they have rejected traditional psychiatry, has not been able to renounce *itself*, its claim to scientific validity, its connection to norms and values.

Psychiatry has thus laid all the groundwork for its own destruction but has not been able to draw the consequences of this possibility. The continuing presence of psychiatric hospitals are a testament to this failure. The theoretical foundations of psychiatry have dissolved, and psychiatry continues to exist as a pure form of power. It is important to specify at this point that, in all likelihood, the coercive power of psychiatry will probably not decrease in the future, nor does it soften in terms of a "free" relationship with a well-off patient who lives under the illusion that they are choosing their own therapy by selecting their own therapist or clinic. Industrial psychiatry on one hand (in the sense of reeducation in terms of productivity and consumption) and institutional psychiatry on the other are probably destined to widen their field of action. Just as the role of the psychiatric specialist, along with the psychologist, psychoanalyst, and sociologist, is to reeducate the citizen to consume or toward support for power structures regardless of whether or not they have what we continue to call forms of "mental disorder." This is true even in the case of the changes under way within coercive psychiatric institutions which tends to create a way of managing the excluded who cannot immediately be reintegrated, asocial or antisocial people who are increasingly produced and expelled in and from industrial megalopolises. The increase in admissions to hospitals of the "maladjusted" or "vagrants" indicates an inevitable move toward more extensive forms of psychiatric repression in the years to come. Modern psychiatry has already forged the theoretical tools necessary for these new tasks.

Institutional reform is only partly linked to 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 those sedatives that are currently available, but also that there is always an empirical basis on which it is not so difficult to begin to break the vicious circle created by the asylum system. If institutional violence disappears, so does the violence of the mentally ill, and the latter group undergoes change, losing those psychotic characteristics described in old analyses — "catatonic," "agitated," "lacerating," "dangerous" — and reappears in its true light: in its aspect, that is, of a person who has been psychologically violated before and after entering an asylum. The mentally ill lose their "incomprehensible" characteristics to the extent that they manage to see their distress in a context that respects its existence and explanations.

However, further problems then arise, and it is the patient who raises them with the doctor. Today's crisis in modern psychiatry offers us the tools to understand what really happens in a liberalized institutional context and allows us to push the destruction of the institution much further. Once the doors are open, this process intensifies and tends to become irreversible, but new contradictions also arise.

The internal contradictions of the institution can be seen in the difficulty of abolishing the subordination of patients and in overcoming the dangers of paternalism. External contradictions include the fact that the asylum space is not destroyed, because society continues to send its excluded back to those places, linked to specific legal rules. Former patients struggle to find work or are faced with the same dynamics of family and social violence that led to their hospitalization. The hospitalized person discovers that they can be free as long as they are inside the institution but cannot leave when they wish without triggering specific repressive mechanisms.

The progressive internal destruction of the asylum system tends to create a living space where the use of self-governing tools seems to promise a solution to all problems linked to coexistence, but it is the external society that continues to impose insurmountable limits and indeed constantly intervenes to pre-

vent the renewed hospital from becoming a kind of island outside of the world. To the extent that internal problems are not "resolved" with "democratic," "communitarian," or "progressive" organizational measures, discussed and constantly rediscussed, they inevitably end up confronting with real issues, which do not concern the marginal problems within a life based on self-satisfied communitarianism, but the impersonal and bureaucratic aspects of societal violence. In a provincial psychiatric hospital there are no risks which are typical of private therapeutic communities, where even the preselection of patients in relation to their income and types of illness constitutes the basis for a privileged form of protection against the impact of society outside. In these state hospitals, on the contrary, asylum laws, the lack of understanding from politicians and administrators, bureaucratic rules, and above all *poverty,* the lack of resources, and the powerlessness of patients are the real facts that prevents any kind of mystification about these experiences.

We have analyzed these features of a psychiatric hospital undergoing transformation, in order to better understand the characteristics of those ambiguous people who meet with patients both as part of an internal reality and as a representative of external society, be they caregivers, doctors, or nurses.

The place of the nursing staff does not concern us here, although they are of primary importance, but a comment on their role is useful in order to define the particularly ambiguous role in which doctors finds themselves. Even in the most traditional psychiatric hospitals, it is easy for nurses, beyond the "arbitrary" nature of their power over the patient, to establish a direct relationship with them in a way that a doctor can never achieve. Both cultural affinity and a proximity over many hours in a day favor this relationship, which remains *personal* even when it is expressed, as often happens in old-style asylums, through openly sadistic mechanisms. The feature that marks this type of relationship is its lack of rational forms of mediation, of ideologies expressed in an objective way, of scientific mapping.

But there is almost always a kind of mediation between the doctor and the patient. We are not referring here to the classic asylum situation, where one cannot even speak of a "doctor–patient relationship" because this relationship does not exist, but to an institutional context which is undergoing change, where the doctor's attempt to relinquish their institutional power clashes with the irrevocable nature of cognitive superiority, which is also linked to cultural and class privilege. The doctor's *reflections* on their relationships with patients, something which is also part of the analysis in this book, is the ultimate expression of a form privilege that tends to be reflected in an intellectual image that doctors form of themselves and of the patient with the help of education and theoretical tools that the patient does not possess. All the more concrete problems that make the role of the psychiatrist so ambiguous are expressed around this classic imbalance.

In a psychiatric hospital undergoing change, the *équipe* experiences its discomfort as a division between an adherence to traditional roles and values and an anti-institutional tension devoid of new roles and clearly defined values.

The *équipe* is always responsible for the "smooth operation" of the hospital in the face of public opinion and legal institutions and is well aware that its possibilities are limited by limits to social tolerance, by the good will of a public prosecutor, and by the fact itself of encapsulating to the outside world an image of social prestige that partially protects it from the violence of those who believe and rule that the hospital should be closed and the patients be "safe" inside. Yet, the *équipe* tends to reject this institutional mandate, and this is not a trivial refusal. Their social role calls for them not to impose the breaking up of an institution, but to manage it and help it survive; and not to renounce those forms of psychiatric technicality that validates repression, but to use those forms in that way; and not to criticize the oppressive or integrative role of psychiatry, but to provide legitimation for the "seriousness" of this discipline in such a way as to justify oppression and integration; and not to promote the power of protest of the excluded and oppressed, but

to defend the privilege of those who exclude and oppress; and not to create a democratic and horizontal structure in the hospital, but to reflect, in an absolutists way, the hierarchical structures of external society; and not to subject their manipulative techniques to continuous criticism, but to provide society with "modern" forms of assistance and structures that do not exceed any limits imposed by laws and cultural mores.

The denunciation of the asylum has today a scientific guise, or at least it is expressed according to a critique which is theorized. On the other hand, if modern psychiatry has come to negate itself, it does not tell a psychiatrist how to act in order to relinquish their own mandate. The only advice available concerns the need for the doctor and the patient to confront each other and seek new roles, in some way forgetting to be doctors and patients. But a role imbalance exists in a *de facto* way, and a patient is locked up in the institution while a doctor continues to live according to the values of freedom, rational intelligence, and their own social responsibility.

In other words, a "liberated" institutional reality once again presents the question of psychiatry as a problem.

Difficulties also arise at the level of the patient, as they are unable to reappropriate their sense of separateness and criticize this state, and at the level of the doctors, as their attempt to renounce their superiority and privileges places them into conflict with themselves. The most important contradictions, however, concern the doctors, who unlike patients do not have to conquer their own freedom in order to survive and reintegrate into the world, but need to throw off their cultural and class-based context in which they enjoy privilege. The doctor remains anchored to this social position, to a way of thinking connected to their class, to the presumptions bestowed by their scientific education, to an ideology of productivity, of ownership (including that of intellectual property), to forms of individual oppression. Freeing oneself of all this is not easy, not even as a first step. Pure choice is not enough, and neither is a kind of benevolent and neurotic form of reparation, nor a naive form of improvised community approach.

All of the features of the anti-asylum "movement" are complicated by the fact that they do not take place in the context of a request 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 patient lives in a world of separateness. As the excluded, they are the scapegoat of the coercive organization of exploitation in the outside world but are not directly exploited. They are the dregs and the extreme victims of social violence, but since they are expelled from the world of productive violence and entrusted to institutional violence, they cannot oppose the political world of production, because the latter has separated them from all possible interlocutors. The relationship that always exists between exploitation and exclusion is hidden, and patients who tend to reappropriate their own exclusion as separateness and to oppose that exclusion do not have the appropriate tools to challenge the exploitation that originally caused it. The patient in a psychiatric hospital cannot be compared to the producer of goods or services, working in a system that demands from them the "free" alienation of their labor. They are alienated as a person in the institution and are useless to the system to the extent that, after the coercion of hospitalization, their institutional presence now only indirectly contributes to society's stabilization.

The second factor that holds back the anti-asylum movement is the persistent presence of medical intelligence. The most typical example here is that of the psychiatrist who advises the patient (obviously, "for their own good") to take some medication that will help them sleep if they are tired, to control themselves better if they are angry, or to detoxify if they have been drinking. The patient is (also, and not always) *treated*. They can in some cases treat themselves, take a sleeping pill if they can't sleep, and, in any case, they are treated by other patients. But the destruction of the institutional role of the doctor here sees one of its most confusing limits to be overcome. Even if the doctor takes off their white coat, agrees to chat with the patient, or is driven in crisis by them, they still effectively use their superiority: the authority that the patient attributes to them, even

before they claim it through violence, allows them to impose their therapies.

On the other hand, the renunciation of medical power, even when it happens, risks reaffirming the subordination of the patient in another form. The proposal to destroy the asylum institution from within never arises, in practice, from the patients, but from the caregiving staff and organizational leaders. The latter use the power derived from their social mandate to create conditions that allow patients to challenge institutional power. But they remain the representatives of power and as such are for a long time the agents of the patient's liberation, before the patients can act autonomously. The anti-institutional role of the doctor resembles that of an "active" educator who encourages a sense of freedom in the hope that their students will come to challenge their own pedagogical role.

Within the institution, freedom does not exist in fact, nor can it be passed off as inner freedom in the absence of objective freedom. We could reply to this observation by saying that freedom does not exist even in the external world, and that the institutional sphere at least has the merit of making unfreedom explicit. We also need to argue that the external world at least offers an opportunity to link one's rebellion to a world of work and to a revolutionary political practice. These possibilities in the context of the psychiatric hospital appear both remote and difficult to understand. Thus, the consciousness of exclusion is often still experienced by the patient as a kind of accidental form of injustice, as an imperfect application of rules, while this doesn't lead to a criticism of the rules themselves. On the other hand, the psychiatrist has already lost any illusion of objectivity and knows they cannot distance the patient from themselves by objectifying them through diagnosis. But while they can privilege a concept of deviancy and remove it from a sense of punishment, they find it very difficult to propose a practical way of moving toward a critique of the traditional concept of deviation in itself.

For this to happen, we need a revolutionary form of practice. On the other hand, as we have seen, it is evident that the psychi-

atric hospital, even an anti-institutional one, does not privilege this type of action. The destruction of the psychiatric hospital is political work, because traditional psychiatry, by dissolving itself, has left psychiatrists and patients directly facing issues of societal violence. However, this practice does not resemble the typical characteristics of revolutionary action.

This explains some of the limits to patient consciousness. For the patients, it is understandable that values linked to healing continue to be seen according to conformist definitions imposed by the society outside, that is, which function as attempts at integration, rather than according to the much more difficult position (which is also more difficult to sustain even on the psychological level) of criticizing societal structure themselves.

For the *équipe,* when they are unable to work with new forms of antipsychiatric thought and practice, the risks of simply continuing to act exclusively within the contradictions of their old role are evident.

We might seem close, here, to a simple statement of impotence. However, once the practical limits of an anti-institutional action *starting from psychiatric hospitals* have been sufficiently and clearly stated, it is also necessary to advocate for a new overturning and to recognize that it is possible to negate the specificity of psychiatry.

For the patient, this overturning is possible to the extent that anti-institutional practice already contains within it the rejection of a principle of authority. For the *équipe,* this kind of practice makes sense only as long as it records not only the uncomfortable nature of psychiatry itself but the promotion of protest endowed with a more general meaning and scope.

Others may join this protest, but it is already present in the first choices that were made. The fact that psychiatrists from various parts of the country have gathered to experiment with anti-institutional work in Gorizia is due neither to luck nor to the inevitable coalescence around a "school" linked to the existing imbalances within Italian psychiatry, but rather thanks to a series of analyses and political choices. In this sense, the critique of traditional asylum psychiatry as a system of power essentially

aims at two outcomes: 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 daily life is based; and on the other hand, to draw attention to a world, the institutional one, where the violence of man's exploitation of man is absorbed as a need to crush the marginalized and to manage and render harmless those who are excluded. Psychiatric hospitals can teach us many things about a society where the oppressed are increasingly distanced from an understanding of the causes and mechanisms of their oppression. In a moment when political criticism has begun to bring into the fold even those who have been designated to be marginalized, the unrealistic aspects of antipsychiatry can show us, in a form of theorization which is clearly ahead of its time, some of the possible ways we could create a completely different society.

Institutional Overturning and Shared Outcomes

Franca Basaglia Ongaro

A *total institution,* as defined by Erving Goffman,[1] can be considered as a place where a group of people is labeled by others, without any alternative to an imposed way of life. Belonging to a total institution means being subject to control, judgment, and the plans of others without the ability to intervene to change the functioning and meaning of that institution.

In the case of a total institution such as the psychiatric hospital, the custodial purpose of the hospital staff marks — at all levels — the cohort of patients, who are forced to understand the protective measures taken against them as the sole meaning of their existence. The only possible identification within these total institutions, for the patients, is with the need for defense from them as expressed by "the healthy." This means that the recognition of one's own identity by a patient is linked to a well-defined stereotype, embedded in the physical and psychological structures of the institution, of the patient as the person *against whom healthy people must defend themselves.* In addition to this coercive character, based on a sense of protection, the psychi-

1 Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Anchor Books, 1961).

atric total institution presents the key features that make up its reality (a cause and at the same time effect of every coercive institution) as entirely unproblematic. The patient, once they are associated with the hospital, is defined as *ill,* and their every action, participation, or reaction is interpreted and explained in terms of this illness. Institutional life is therefore based on the absence of a value, which is defined *a priori,* of the patient, who is objectified irreversibly by their illness, which thus justifies, on a practical–institutional level, the objectifying relationships established with them. In this sense, the overturning of a psychiatric total institution should consist in a break with this coercive system and in a problematization, at all levels, of the entire context.

It is clear that this is not a simple form of *reversal* that would leave things as problematic as in the classic institution. Instead, this overturning should act within a context that connects the different sides of the relationship in order to negate their clear opposition. This means that contradictory terms such as slavery and freedom, dependence and autonomy, *cannot be understood as opposites.*

If these abstract categories are linked to the practical context of a psychiatric hospital, the opposite of coercive authority should be absolute permissiveness that would force the attending staff into a coercive situation themselves; the opposite of slavery, symbolized by the closed hospital, should be the freedom of the patient to become the sole arbiter of their situation; the defeat of authority and the absolute power of doctors should correspond automatically to the complete autonomy of the patients; and issues of dependency should be resolved by reversing the poles of the relationship.

But the reversal of a situation implies only a switch in the terms of the problem without actually changing anything in the type of relationship that binds them together.

On a practical level, considering one of these examples of *coercive freedom,* it is evident that the only possible meaning of the concept of freedom should correspond to the condition of a patient who — previously locked up, coerced, labeled, objecti-

fied by the institution — finds themselves free to choose from a number of *possible* alternatives. There will still be ambiguity in terms of the subjective limits implicit in the need for an objective context for freedom.

In order to *overturn* a closed asylum, two elements are required, which are, however, more closely related and interdependent than is usually assumed: 1) the objective condition of a patient which allows a transition from one reality to another, and 2) the subjective condition of those who create the reversal, but who also embody the social values of "rules," which will define the limits beyond which *freedom* will *appear* unsustainable.

It is clear that the transition from one condition to another (coercive freedom) depends on the ability of those who determine the reversal to deal with a new situation, more than it depends on actual objective conditions. In other words, the freedom of the patient and the level of permissiveness prevailing in a psychiatric institution are inversely proportional to the need of doctors and the attending staff to defend themselves against those under their care. In this case, a clear division between *positive* and *negative* experiences will continue until one is aware of being able to cope with the negative. Once this awareness is reached, there are only situations which need to be overcome, since the positive is nothing more than a known negative that is not feared.

An example of this can be seen in a brief excerpt from the report of a community meeting, with the subsequent discussion report of the attending team. What has been discussed here becomes clear in the italicized commentary:

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The assembly is disturbed by the presence of a somewhat noisy and brain-damaged person. Apparently, little attention is paid to the disturbance he causes. However, Elda leaves the assembly because the person approaches her chair. . . .

In the discussion within the *équipe*, the opportunity to allow disruptive elements, such as mentally retarded or brain-damaged individuals, to participate in the meeting is discussed. One doctor argues that their presence leads to a general regression (also due to the identification of the patients at the lowest level, who are projecting themselves onto them). Preventing their access, however, would be — for another doctor — an arbitrary act, in the sense that the staff would always have the possibility to establish the limit of "participation or personal experience" necessary to justify the presence of a patient of this type in the meeting. It is clear that if an institutional reality also includes the presence of these patients, and if doctors take a discriminatory attitude toward them by "misleading them, or making sure they are not accompanied if they need to be in order to be at the meeting," it would sound like a form of medical support for a general form of exclusion.

However, the fact that Elda was frustrated by this threatening presence does not only have a negative meaning, or in any case it can offer the possibility for different movements and reactions. If Elda is faced with something dangerous that she cannot confront, the institution cannot resolve her discomfort by eliminating the existence of the person who produced it. Elda should have been helped in another way to cope with the situation, through the general involvement of the meeting in the problem she was experiencing. If this had happened, Elda would not have felt alone at that point, and having overcome such an anxiety-inducing experience would have helped her reach a higher level of tolerance. Otherwise (as actually happened), regression is more likely than rehabilitation. Eliminating opportunities for interaction between different levels of patients means maintaining the barrier between positive and negative experiences, revealing the limits within which it is believed possible to handle the situation. This would highlight the need, on the part of the institution, to "stop" before creating a situation it does not feel confident about facing. 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 it is assumed that

one does not know what to do or cannot see the contradictions of the situation. It cannot therefore be argued that — beyond certain limits within personal experience — the participation of that individual in the assembly was negative, but that beyond a certain limit of disturbance the institution is not yet able to handle the situation.

The overturning of an institution should therefore imply a simultaneous overturning at both extremes of the context in which it operates, through the negation of the values that support, at all levels, the condition in which the institution operates. Only in this case would freedom lose the characteristic (which is typical of permissiveness) of controlled concessions from above and that of turning a coercive situation into the straightforward supremacy of those who were previously subjected, and become the overturning 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 are at the mercy of a small controlling group underlines the nature of a relationship between the institution's supporting structures. On one side, there is an *équipe* that carries forward its social mandate which is of a custodial nature, determining, according to the values of the society it represents, the level of regression of the patient that can best ensure the smooth running of the institution; on the other, the patient who, in order to defend themselves from the anxiety and the problematic nature of their objectification and their position at the complete mercy of others, tends to increase the level of regression produced by the illness and the definition originally given to it.

If this is the real situation of a total institution, it is clear that if the problem of its overturning is not posed within a sense of a relationship that, on the one hand, binds the various actors involved in a relationship, and, on the other hand, the differing features of the reversal (coercive freedom), there is the risk of simply reversing the terms of the situation without changing the elements that have determined and maintained that condition.

A similar problem arises in overturning the principle of authority at a staff level. In institutional reality, the leader of the *équipe* exercises power over the group, as they are the only one who, due to their social role and position, has the tools that "authority" typically uses to defend itself and create distance from what it wants to dominate. But in the case of practice carried out to try to reverse a principle of authority, the reversal of the values on which our hierarchical society is based must occur both in the leader and in the group, through a process of negating their points of reference.

In the leader, this denial can pass through the dilution of their power into autonomous and complementary roles, which tend to destroy the image of the leader as an arbitrary authority, stripping it of the impure elements attributed by pure power or the power of the role. Its denial would then be realized in reality, through the negation of one of the real aspects of its role, represented precisely by an implicit social mandate (hence, a constant mismatch between the negation of one's power through dilution into autonomous roles and the preserved social responsibility intact in a "managerial" figure). But this negation would be valid and real only when the situation, originally born from the voluntarism of a leader who took on the practice of the rupture of an authoritarian–hierarchical system as a personal choice, proves mature enough to make a position born as a personal choice irreversible; when, that is, the leader can no longer "go back" through an authoritarian act to restore a different balance of power. Only then can the negation of authority be implemented in reality, through the establishment, on a practical level, of a dimension that prevents the artificial division of power that can be given and taken away at will.

On the other hand, the reversal of a principle of authority by the group requires the negation of the values implicit in it, that is, through the negation of the competitive and antagonistic mechanisms typical of bourgeois reality, which would lead to experiencing the denial of authority enacted by the leader as the acquisition of personal power and authority. The autonomy of roles coincides — even in perfect correspondence with so-called

dominant values — with the acquisition of power. Therefore, what could appear as a reversal of the principle of authority might actually correspond to its consolidation on a different level. The obvious ways in which an acquired, automatic autonomy could be experienced by the group might not make the link between autonomy and responsibility equally automatic. What the leader's action and the group's action have in common in institutional overturning is a responsibility toward a common purpose that should prevent any shift to personalism. Autonomy without responsibility is the first step in an action where decisions can be made without bearing the consequences. Responsibility in autonomy becomes a highly gratifying personal achievement, but the common purpose within responsible autonomy requires constant mutual checks, which often place both the group and the leader's autonomy into crisis.

In an *équipe,* if the transition from autonomy to responsibility within a common purpose does not occur, unconscious and ideological resistance could occur from both sides, making it difficult to separate psychological reasoning from real objections on the one hand, and on the other, we might see a recognition of the leader as a classic form of authority with the additional behaviors of total adherence, servility, and mutual instrumentalization, typical of the master–servant relationship.

What is evident is that the overturning (if it wants to be defined as such) needs to occur at all the levels of which the institution is composed, through the negation of the levels of integration into the value system on which the institution is based and therefore the society of which it is a product. Otherwise, one would remain within a system of communicating sectors, where one would limit oneself to reproducing, from time to time, the same mechanisms that have conditioned and continue to condition the situation one wants to reverse.

The difficulty lies in the concept of a *common purpose* that should be simultaneously a prerequisite and an indispensable condition for the practice of overturning, and, at the same time, something constantly verifiable in reality, therefore something that cannot be given once and for all. In fact, the confirmation

of the existence of such a common purpose can be seen only through actions whose results are unpredictable, since there are no reference models capable of ensuring the outcome of an *overturning,* once its premises are known.

However, having recognized the various possible contradictions within an institution undergoing a process of overturning, it might be useful to identify what could be the final outcome, for all of its parts.

Going back to the beginning, one could say that the aim of the asylum (and thus of all the power roles implicit within it) was exactly the opposite of what might have been the aim of the inmates. The asylum institution existed in order to depersonalize the problem of the patients, for whom the only possible identification remained the hospital structure, created in order to destroy them. In this way, the inmate was forced to participate in that unique purpose, collaborating in their total dehumanization.

In an institutional *overturning,* a rejection of the institution could be the first common step at all levels, from inmates to the *équipe.* But, to the extent that institutional reversal coincides with the general problematization of a situation (and therefore with the conquest of freedom, at all levels, which requires a common sense of responsibility), it also overlaps with a general and individual crisis, where everyone finds themselves in the condition of seeking their own way of defending themselves in order to survive the anxiety of a relationship from which there is no escape or protection.

It is clear that a process of institutional overturning requires different degrees of accountability (which implies different levels of denial in terms of reference points) — as can be seen from the problems that have emerged from a series of meetings, and some extracts from those discussions are reported here:

April 20–28, 1967

The problem of beer is being discussed. Too much is being drunk (beyond the agreed limit of one beer per day), and "solu-

tions" are being proposed: both its abolition or a total liberalization (as in the dialectic between coercion and freedom).

Some newcomers, who are not directly affected, propose a complete ban. They are told that when beer sales were not allowed in the hospital, many alcoholic drinks were "smuggled in." Prohibition served as a stimulus. Vittorio (an alcoholic) intervenes, saying that the problem is about being accountable to others, that is, to the community. F. adds that it is also about being accountable to oneself: "wine harms me, so I don't drink." Pirella points out the possibility that someone, who may be well aware that wine is harmful, might want to drink precisely for this reason, that is, with a self-destructive purpose (there are some who agree with this, as if it were a well-known fact). Basaglia intervenes, saying that if the patient does not take responsibility, a doctor cannot be responsible for his relationship with the patient. If the patient is irresponsible, how can the doctor be responsible for something that does not exist?

Overall, the alcoholics seem both attracted to and repelled by the possibility of accountability. The hospital is, for them, a refuge to turn to when they give in to alcohol and can no longer cope with their addiction. If even the hospital assumes, in their eyes, the problematic face of their daily life (if there is the same possibility, if it is left in their hands, to drink in the hospital), it loses its function as a refuge to become a place where they must continue to test themselves, measure up, and become accountable. On the other hand, prohibition serves only for the period of hospitalization, not as a form of education in terms of self-control. If the institution limits itself to merely banning alcohol, its action remains within the limits of a "suspension" of the problem (which authorizes the alcoholic to resort to other ways of drinking), in the sense that, for a period, it will protect alcoholics from themselves. Their relapse would also be seen by the institution as a demonstration of their level of addiction. That's all there is to say. The alcoholics, on the other hand, seem to prefer this condition, which does not involve them as it makes no direct appeal to them as a subject, they will then be free to drink "smuggled" beer in order to "take revenge" on this form of institutional prohibition.

Various proposals have been put forward that continue to oscillate between complete prohibition and total liberalization:

a) Completely liberalize beer sales with a limit for everyone;
b) Move the sale to the wards instead of the bar, so that the bartender's responsibility is diminished and divided among the different wards;
c) Liberalize, but with time restrictions;
d) Create a separate kiosk for the sale of beer only, which would allow for greater control;
e) Gradually increase the price of beer after the first bottle.

Some proposals retain a coercive–punitive–restrictive character (price increase, time restriction), while others tend toward a greater sense of accountability within the community. The reactions of the meeting were mixed:

i) In alcoholics like A., the need for the issue to be resolved by the authorities, in the hope for a complete abolition of beer sales, is clear. *Obviously, he does not feel strongly enough to decide for himself whether to drink or not, and he wants an authority to compel him to do so, and for this reason he will feel authorized to retaliate in some way (by drinking).* The anxiety he feels from being free and accountable is such that it becomes unbearable. At the end of each session he aggressively concludes by proposing to delegate to the doctors the responsibility for the decision.
ii) Some nonalcoholics argue for the liberalization of beer sales, driven by a total scepticism toward alcoholics: if someone wants to drink, let them. They will learn from their mistakes and understand on their own. Once the law is made, a way around it will be found [a well-known cynical Italian saying]. With prohibition, they will continue to find ways and means to drink. People are what they are: nothing can be done!
iii) Renato (not an alcoholic, but someone subject to unexpected forms of acting-out) openly moves between the

idea of free beer (why not cognac and grappa as well?) and total abolition, with the threat of locking up transgressors in "cells." He continues to shift between the proposals of concession and prohibition, depending on his need for authority or total permissiveness without ever personally taking responsibility.

iv) Furio points out that beer was not "granted" by the doctors, but it was collectively decided to agree to drink only one bottle a day, which is very different. If the doctors were to grant freedom to the hospital, the situation would not be much different from that of a traditional hospital, where the doctor is the only authority. The authority of the doctor has not disappeared, but is reduced by the presence of groups of patients and nurses who challenge it. To talk again at this point about liberalization or total abolition would mean openly declaring a failure with regard to the commitment that everyone had made to a collective form of decision-making. *(Here a dangerous blame game could come into play, with the usual outcomes that accompany it.)*

v) The patient in charge of the bar explains how the *problem of beer* arose. He could no longer maintain the control that he had in the past. (*The general crisis is therefore also linked to his defensiveness in the face of this problem, which relates to permissiveness as closely linked to both objective conditions and any subjective possibility of coping with the situation.)*

The terms of this debate, of which only the fundamental elements have been summarized here, continue to shift between a need for authority (to eliminate or reduce the anxiety produced by the dimension around which the entire institution tends to act: accountability), and the need to achieve a sense of freedom that comes through the conquest of one's own responsibility. This concerns the patients. However, the same mechanism is present in the *équipe* (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 their levels

of anxiety (with a further need for defense and retreat) that an overturning entails.

In this sense, if the overturning is implemented for each role of the institution through the negation of its institutional aspects (both for patients and for nurses and doctors), the negation of the institution and institutionalism would become a common goal for all. To the extent that each component of the institution is objectified in its institutional role (tied-up, oppressed, classified, ordered, in different ways), institutional negation as a *symbol of the struggle against any system of oppression and abuse* becomes a qualitatively collective movement that goes beyond its communitarian aspects, which are present in the classical concept of the therapeutic community. Here, the breaking of a traditional bond between the institution and its components remains within the institution itself, without affecting the value system that underpins it.

If, therefore, anti-institutionalism were to prove to be a real common goal, in the practical context of the institution, the *protest* of the patient would become the only valid way of negating an institution that oppresses them at all levels, and this could occur through the denial of each person's own institutionalism (which corresponds in the patient to the regressive role they assume in order to defend themselves, as well as in the doctor and nurse to the regressive role of power) in a subsequent phase, which could lead to a common set of actions working at the same level and for the same purpose, and go beyond the division of people into roles. In this way, a dialectical movement within the protest itself could be identified, which could push the situation further forward, using contradiction as a road toward a subsequent reversal of reality. This solution does not aim to resolve conflicts, but to address them at another level.

However, if the qualitative leap of identifying a common purpose has not yet occurred, the reality of an *institution that negates itself* can easily find itself entangled in a regressive–antagonistic phase, which would highlight the failure to deny the institutional aspects of each part of the relationship. This misunderstanding could then continue through a search for

a "democratization of relationships" that would risk being an end in itself, shifting the overturning situation to the level of a bourgeois concept of interdisciplinarity (each person seeking confirmation of oneself in the other, while keeping intact one's own area of competence). The democratization of relationships within an institution that negates itself can be justified as a *problem* only in the moment of the negation of an action that, as a proposal of a reversed reality, poses itself as antiauthoritarian and antihierarchical. But it should not exist as a *problem in itself* in a subsequent phase, where it would only serve to slow down and confuse the meaning of this activity.

Any discussion remains open here about the meaning of institutional overturning, its limits, and on the source of these limits: whether they come from the level of denial in which this process moves ("We are never completely contemporaneous with our present history"[2]), or if they could be the expression of a more hidden problem of which the nature is unclear: the problem of the democratization of relationships as the ultimate institutional mystification that could turn out to be less "overturned" than it believes itself to be.

2 Régis Debray, *Revolution in the Revolution? Armed Struggle and Political Struggle in Latin America* (Verso, 2017), 18–19.

APPENDICES

It is considered appropriate to include, in an appendix, two articles that reflect two particular aspects of the current moment: 1) the problem of the incident and its significance in a reality undergoing reversal, where a misstep or error can confirm, in the eyes of public opinion, the impossibility of an action that openly reveals its flaws and uncertainties, while every other institutional reality seeks to conceal them under its own ideology; 2) the problem of managing an institutional reality that, even when denied, must survive to continue demonstrating the necessity and urgency of a negation of the current reality, at all levels.

The Problem of the Incident[1]

Franco and Franca Basaglia
March 28, 1968

Any [violent] *incident* that occurs in a psychiatric institution is usually attributed to the patient's illness, which is seen as the presumed and only cause of any unpredictable behaviors by patients. Insofar as psychiatry has defined the mental patient as impossible to understand, the psychiatrist, who is legally obliged to supervise and protect the patient, is permitted to abdicate all responsibility for violent or seemingly chaotic behaviors. Psychiatrists are responsible to society, which has delegated to them the control of abnormal and deviant behavior along with the means for transferring to the illness all responsibility for those behaviors, without considering the possibility of therapeutic risks and failures as in other disciplines. The psychiatrist's task consists of reducing a patient's subjective experience to a minimum by totally objectifying them within an institutional system which is designed to avoid all that is unanticipated or unforeseeable. The psychiatrist secures their control of the situation by fixing institutional roles through legal frameworks (the jurisdiction of a local attorney general), internal administrative rules (connected to the provincial administration which oversees

1 The word *incidente* may be translated as "incident" or "accident."

the hospital), and scientific diagnoses that define the patient's chronic malaise, which is often seen as uncurable.

In this institutional space where abnormality is normative, the unruly, unbalanced, or disturbed patient is tolerated and excused according to stereotypes linked to mental illness, just as, in the same way, murder, suicide, or sexual assaults in more open institutions are justified and explained as expressions of unknown and unpredictable mechanisms connected to psychiatric syndromes. Hence, neither psychiatrist nor the environment can be held accountable for what are defined as *incomprehensible* acts. The abnormal and uncontrollable impulses of what is defined as an *illness* are considered sufficiently explanatory.

However, once we become closer to the patient, no longer viewing them as an isolated entity enclosed within an incomprehensible and unpredictable world, but rather as an individual forcibly removed from the social reality to which they once belonged and uprooted by an institution that assigns them only a passive role, then the institution itself becomes implicated in their behavior. Every event becomes reconnected to the environment in which they live.

A *violent incident* can therefore be considered from two contrasting perspectives, each corresponding to the different ways the institution views the patient.

In the first instance, there is the classic, closed, custodial institution where efficiency is central and the patient is, therefore, treated primarily as an object. If the patient wants to survive the abuse and destructive power the institution inflicts on them, they must identify with its norms and rules. Whether they conform through servile and submissive behavior or whether they resist with deviant and insolent actions, the patient is nonetheless determined by the institution. The rigidity of its rules and the one-dimensionality of this reality continue to lock the patient into a passive and dependent role that allows no alternatives beyond objectification and adaptation.

Thus it is that by establishing a reality with no alternatives other than regimentation and fragmentation that the institution

dictates to the patient how they must presumably act. These signals are implicit in the absence of any goals or a future for the patient, which in turn reflects the absence of any alternatives, goals, or future for the psychiatrist, who is appointed by society to control abnormal behavior with a minimum of risk.

Everything in this coercive environment is provided for and controlled in order to avoid that which must not happen. In a reality that exists solely to prevent it, freedom can only be experienced as a *forbidden act,* denied, impossible to achieve. The shaft of light from an open door, the unguarded room, the half-open window, the knife left lying about, all present an open invitation to destruction. The patient's identification with the institution means that they can only interpret freedom as an act of violence against themselves or others. This is the message and the logic of the institution. Where there are no alternatives and no possibility of choices or the taking on of responsibilities, the only possible future is death, Death presents itself as a rejection of an unbearable life; as a protest against objectification; as an illusion of freedom; as, in short, the only possible plan. It is far too easy to see this death wish as part of the nature of the illness, as traditional psychiatry would have us believe.

In this context, every action that in some way breaks the iron grip of the institutional regime gives an illusion of freedom but is nonetheless equivalent to death. The *escape* from an institution is an attempt to avoid that other future which is death and to experience the sensation of controlling one's destiny. But inevitably escape ends in capture and continued enslavement or in a death.

Paradoxically, the only responsibility that the institution attributes to the patient is responsibility for the incident which it hastens to blame on the patient and their illness, rejecting any connection to, or participation in, the tragedy. The patient, who has been stripped of all responsibility throughout long hospital internment suddenly finds themselves as totally responsible for this one "free" act, which almost always coincides with their death. The closed asylum, a dead world that objectifies patients

with dehumanizing rules, offers only one clear alternative: death, as the illusion of freedom.

In this sense, an *incident* is merely the expression of a patient's *experiencing institutional regulation to the bitter end,* taking its message to its most logical final conclusion.

We could shift this discussion from hospitalized mental patients to anyone without an alternative, without a future, who cannot find a place for themselves in the world. Their exclusion indicates to them the only possible step to take — an act of rejection and destruction.

In the case of the open institution the goal is to try to maintain the patient's subjectivity, even if this is to the detriment of general organizational efficiency. This goal is reflected in every institutional act. When there is a need for patients to identify with the institution, they identify because they see their personal goals and their future reflected in it. It appears as an open world that offers alternatives and a real sense of possibility to the patients.

In this environment freedom becomes the norm, and the patient becomes accustomed to exercising it, which means taking responsibility, self-control, managing one's life, and understanding one's illness without the biases of medical science. For this to occur, the institution must be totally involved in the material and psychological support of the patient. This entails breaking the rigidity of roles; ending the objectifying relationships where one person's values are taken for granted while the others' are not even recognized as values; the creation of alternatives that allow patients to struggle against the closed world defined by institutional rules and that give them a sense of being inside a space that fosters a continued existence. This means that the only way the institution will now protect itself is through the participation of all its members in developing a community, in which institutional limits are set by the presence of the community and the possibility of reciprocal struggle.

This is, of course, a utopian description of an open institution. There are contradictions within such a reality just as there are outside it. What is essential is that it the institution does not

try to mask or hide these contradictions, but rather attempts to face them alongside the patients and point them out when they are not immediately obvious.

In this context, an *incident* is no longer the tragic result of a lack of supervision, but rather an indication of the institution's lack of support. The actions of the patients, nurses, and doctors can sometimes fail or there can be discontinuities where *incidents* can still occur. Omissions, misunderstandings, failures, and betrayals of trust have logical consequences, but in all these instances the illness plays a relatively minor role.

The *open door* becomes a clue to understanding what the *door*—and the isolation and exclusion of patients—means in our society. The open door acquires a symbolic value as the patient comes to realize that perhaps they are not after all dangerous to themselves and to others. This discovery then leads them to ask why they have been forced into such horrible and exclusionary conditions in the first place.

In this way the open institution fosters the patient's understanding that they really are excluded. Its *sole symbolic function* is to demonstrate what has been done to the patient and the social significance of the institution that has locked them away.

On the other hand, the open door represents a contradiction in a society that bases its safety and equilibrium on rigid and tight social categories that maintain a division of classes and roles. Psychiatrists and nurses inevitably become aware of this contradiction as they find themselves in situations where they are part accomplice, part victim, and forced to uphold a social order they now want to destroy, The open door makes the psychiatrist aware of their own enslavement to a system for which they serve as silent, unknowing double agents.

What possible meaning do *escapes* and *incidents* have in this context? They are directly related to the institution's degree of openness to the outside world and to the social nature of that world. The alternatives that the open institution offers can still come up against society's refusal to carry them out. The open door leads, inevitably, to the outside world where society and its violent rules, discriminations, and abuses continues to reject,

deny, exploit, and exclude the mentally ill, who represent one of many disturbing elements which justify the existence of the institution.

In such a situation, who is responsible? A mental patient can be released and then find that they are rejected by their family, friends, and co-workers — by a reality that violently dismisses them as superfluous. What can they do except either kill themselves or kill whoever symbolizes that violence which is used against them? When this happens can we really speak only in terms of mental illness?

The Problem of Management[1]

Franco Basaglia

When analyzing a static and fixed institutional situation with fixed and closed patterns, many elements — and often the most essential ones — are difficult to understand thanks to forms of labeling that rarely corresponds to reality. If, however, one begins to analyze — as we have tried to do — a psychiatric institution undergoing change, or rather in a permanent crisis in our understanding of a place where we work, this becomes even more difficult, considering the aim that this action looks to achieve: the replacement of a schematic model with something that does not merely limit itself to being a *nonmodel* but rather seeks to have within itself the possibility of posing as an *antimodel,* capable of destroying a tendency to settle into new patterns as opposed to traditional ones. This implies the destruction of psychiatric institutions, not only as a real form of overturning of the coercive system on which they are based

1 This article is linked to ongoing informal discussions amongst the staff of the psychiatric hospital of Gorizia, and to those with Gianni Scalia, Gian Franco Minguzzi, and Franca Basaglia Ongaro, with whom the article "Dare il nome all'oppressione" ("Giving a Name to Oppression") is soon to be published in the journal *Recherches* [note in original].

This specific article doesn't actually seem to have appeared in French, but it does appear in Franco Basaglia, *Scritti, 1953–1980* (Il Saggiatore, 2017).

but also as part of an understanding of the *global* level on which this hierarchical–punitive system fits, which requires a global discourse instead of one specific to psychiatry or to which a psychiatric can be connected. Thus this is a form of psychiatry that not only tries to negate itself but wants to see itself as antiscientific (where science is understood as an ideology that always supports the values of the dominant class), through a necessary transition from a simple countertransferential position toward a dialectical one. Only through a crisis and via a permanent form of self-criticism will it perhaps be possible to be able to ensure that this new form of psychiatry does not present itself as a complete form of science.

With the therapeutic community, the *first phase* of our anti-institutional action can be defined, in general, as *countertransferential,* in the sense that direct contact with an institutional reality has forced us to attempt what is essentially an emotional reversal of this reality, rejecting the violence with which it has always been managed. The encounter with patients within an institution entrusted with their custody and care has implicated us in an existential way as accomplices and architects of the inhuman conditions to which they have been reduced, forcing us to undertake a form of anti-institutional practice that aimed to turn the *negative* aspects of the asylum into a *positive* kind of psychiatric institution where the mentally ill can be seen as people who have a right to be treated. Hence the original meaning of our practice — as a kind of reparation.

However, the identification of the mentally ill as the socially excluded who have paid a price in order to ensure our own tranquil existence has allowed us to take a further step, which consisted in identifying the common features of all the excluded, leading us to search for a relationship between the *excluded* and what excludes them. In this work, it has become evident that what was happening in the psychiatric institution was common to all the other institutions on which our society is based. Every institution is dedicated to institutionalizing those entrusted to it, whether they are psychiatric, educational, familial, punitive, etc.

This *second* phase can be defined as the *rationalization* of the countertransferential moment, which requires an awareness of our position — and therefore of the role of the institution in which we operate — in relation to the social system of which it is a part. In this sense, the therapeutic community, as a scientific realization of the primitive countertransferential response, could be the concrete expression of a new science,a social psychiatry, which, by questioning the social and environmental factors that create mental disorder, attempts to remedy them by establishing technically efficient and humanitarian psychiatric services. But the discovery of a "social virus" as responsible for the disease still sees psychiatry in a countertransferential, although rationalized, context, because it merely expands its range, establishing internal and external psychiatric services that have the task on one hand of fixing the disasters caused by its own institutions and, on the other, of softening and mitigating social conflicts.

In this way the analysis of the problem moves from the countertransferential to the sociological terrain without, however, losing its meaning as a simple establishment of the facts, typical of an investigation that limits itself to considering its object of research as *given*.

Proceeding in this way, it is clear that any institution created by the economic system in which we live is, thanks to that very fact, functional to it, which means that all institutions are tasked with managing the contradictions of the system itself. Through the creation of specific categories, the system guarantees itself the possibility of generalized control that safeguards it against any surprises and shocks. In a series of institutions, we thus have different forms of *excluded* or *codified individuals,* whose specific exclusion always serves the function of the society which created them. Any contradictions are masked by scientific ideology (each institution will be guaranteed by its own specific ideology) that defines boundaries in terms of forms of competence.

Now, as it is clear that all institutions are functional to our economic system, a further awareness is arrived at that could be defined as a moment of *political rationalization.* In fact, to the extent that they are functional to the system, institutions are

directly linked to the values of the dominant class that creates and determines them, demonstrating how their function consists in maintaining these values and ensuring their effectiveness in manipulating an entire society. Any actions within an institution which is functional to the system cannot therefore be limited to the simple humanitarian reversal of any specific situation but must act *in terms of the functionality of the institution in the face of the system itself.*

However, once the process of institutional reversal has begun, within a social system that tends to negate any movement that might alter its overall equilibrium the contradictions deriving from the existence of an institution that denies its own institutionalism become clear. The existence of a therapeutic community is seen as acceptable as long as it appears to be a new *model* of psychiatric care and therefore as a proposal for a reformist solution in terms of clear sets of social contradictions. This shows us that we have fought against the system that has shaped an institution in a way that best serves its own needs and can allow for a new internal outcome which is able to overcome its own contradictions through technically advanced solutions. Thus, our practice can assume a meaning that is extremely reformist and tends toward forms of integration that do not correspond to the goals we set for ourselves.

The problem now is what the next step might be if we do not wish, after a period of political rationalization, to move backward toward a countertransferential situation, as the only possible act within a system that tends to overturn its own negation in ways which actually affirms its own power. As long as we remain within the system, our situation can only continue to be contradictory: *the institution is simultaneously denied and managed, illness is simultaneously placed in brackets and treated, therapeutic action is simultaneously rejected and performed.* Is this the sign of the countertransferential nature of our denial, or is it an expression of the limits within which our action is constrained and beyond which there is no other alternative? The only possible overturning that goes beyond the institution and does not transform into its confirmation at a different level 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 intended to guarantee the values of the dominant class.

But, now, are we sure we can start to focus on the "disease"? What is the "disease" — in our psychiatric institution — after a series of acts that have freed the mentally ill from the institutional and scientific forms of control they were subject to? Or does the weight of the still hospitalized patients — who, not having any possibility of finding any external *social solution,* we are forced to continue to manage — prevent us from doing what we want to do, and force us to create a *new* institution in order to survive? Is this a sign of our impotence, or is it an inevitable consequence of the fact that we still operate within the system?

When our hospitalized patients tell us, "you have convinced us not to be mad in the way they told us that we were: we are excluded, rejected. However — mad or excluded — we are still here, in a hospital that protects us and supports us. Then, in the end, what are we?," they are raising a problem in the precise way we ourselves are experiencing it. Could we say that, as long as the institution is forced to manage a "sick" person who retains their status as a person cut off from civil life because they are not suited to it, we cannot yet speak of an "illness"? There are other blocks to remove, and it is no longer the institution that can do this. It is society, that economic–political system that is called into question by these people within a psychiatric institution, for which there is no reason or justification.

To truly address "illness," there should be the possibility of encountering it outside of institutions, that is, not only outside of psychiatric institutions (which might imply forms of "sectoral" reform or prevention), but outside of every other institution whose function is to label, codify, and fix in specific roles those who belong to them. But is there really an outside on which and from which we can act before these institutions destroy us? Can it be argued that the aspect of "illness" we see is always, in any case, its institutional face? It is clear that any attempt to break from the "norm" is absorbed as one of the aspects of a narrative

within the same structure. If "illness" can be understood as the condition of someone who is outside the norm, the institution is the punishment that aims to bring the abnormal back to normality. It is a place, within the norm, for deviations from the norm.

The argument could go as far as to claim that the one who is defined as "sick" (outside the norm) is cured of his "sickness" when they come into contact with a form of punishment, not only through the reality of the encounter with the harshness and violence of the institution, but also through the fact that they are now seen as working within the "norm," and the expressions of protest that aimed at being outside of this, for that very reason, lose their original meaning.

A hospitalized person then becomes sick in a different way, with an institutional illness, corresponding precisely to the imposition of a *role of abnormality* that has found its function and meaning *within* the bounds of acceptability.

The process of separation from reality that various institutions (family, school, factory, etc.) attempt to carry out with mentally "ill" people, through a forced kind of de-responsibility, is reversed at the moment of their entry into a psychiatric institution where they are reinvented as unproblematic and nondialectic individuals thanks to the one-directional aspects of those institutions — and find themselves living in ways that are functional to those institution and their history and are thus reinserted into a system as an object of an institution which is functional to it. The only moment of real historicity (which is nonetheless difficult to identify since there is no place *outside* of these institutions) — that of "being outside the norm" — is denied to the patient through the imposition of forms of institutional historicity to which they are forced to adhere. Hospitalized patients are thus not seen as things, are stripped of any sense of responsibility, and are viewed as unproblematic and nondialectic. But in a psychiatric hospital they still fulfill a function that supports the system, precisely because they are categorized and defined within the institution.

In this sense, the presence of the so-called "norm" within a psychiatric institution can be contradictory, since the explicit function of the institution is to contain what is beyond the norm. Until the system establishes that the psychiatric institution is a new institution adhering to the norm, this might also indicate a new form of protest (compared to the system) linked to a therapeutic community, if this is able to assume an attitude of negation in terms of the functionality of the psychiatric institution, as a place of the abnormal within a norm. This also means that the presence, within other institutions (family, school, factory) of elements of disturbance discharged from a psychiatric institution that no longer acts as a dumping ground for external contradictions could serve to highlight the true contradictions in the realm of the so-called "norm," just as the "norm" is contradictory in the place of abnormality. A "discharged" person can play a role as a reintegrated person in society through a reinvented institution, but they can also fulfill a function of disruption, in the sense that their mere presence in the external world negates that idea of a one-dimensional world as desired by the system and, at the same time, underlines the practice within an institution that refuses to exist solely as a noncontradictory dumping ground for contradictions.

This could be a possible way forward for the future. For now, we can say that the mentally ill person, upon entering a specific institution, begins a career, just as any other professional career begins within any specific institution. In the eyes of the system there is no difference, as long as everyone remains within their own boundaries and sphere of competence. At most there can be a reversal of roles, but the relationship with the system does not change. There will always be an ideology linked to science, as a supposed resolution in terms internal contradictions, that will impose sanctions and define everyone's role, so as not to disturb the production and balance of the system.

At this point, the problem shifts to the terrain of scientific ideology, which simultaneously establishes a norm and the necessary punishments in order to enforce it in defense of this equi-

librium. Norm, sanctions, and the ideology of science are always indispensable to each other.

Now, if it is the ideology of science that determines the norm and establishes the most suitable punishments that work for the system, it is scientific ideology that acts as the principal institution that determines *illness in the way that we understand it.* The fact that bourgeois psychiatry is now willing to recognize that mental illness can be closely linked to the contradictions of social reality, expanding a field for investigation and treatment from the individual to the family, school, and factory, means that it knows it can create new institutions (family therapy, factory psychologists, social workers) that will stifle conflict, without ever questioning the foundations on which that ideology is based: *the definition of the norm as a boundary supporting the values of the ruling class and the division into roles as a subdivision within the acceptability of different forms of competence.*

Now, our problem is whether it is possible, within an institution, not only to break an institutional cycle but also to question the limit of acceptability and rules through the reversal of forms of science that are not explicitly class-based? This kind of question could have been, until some time ago, an intuition about the political meaning of the dangers that our anti-institutional practice might encounter, and on a practical level this is now a reality that presents itself in an urgent way as a countertransferential negation of institutional violence. We have reached a theoretical and practical impasse, which has nothing to do with the scientific theses to which we are accustomed. For us it is a question of understanding how an anti-institutional form of practice can concretely impact on structures; or whether this attempt to impact the system through the denial or reversal of an institution is merely a new utopia (which thus becomes a new ideology), which allows us to endure the type of life we are forced to live.

Institutional careers are what keep, at all levels, each person within the circle of their competence. Trying to escape from this can simply mean being *transferred* to another institution or being pushed back into one's own: the game is always the same.

Are we condemned to continue living and acting in ways that help the preservation of institutions and the system? Or does the political opening up of a problem offer us a way out?

Frantz Fanon's *career* seems to show a path which ended, in concrete terms, with his participation in the "African revolution." Fanon followed, in his short life, the entire institutional journey that the system allowed him: from a brilliant psychiatrist in Lyon, to a psychiatrist committed to work in Saint-Alban,[2] to a psychiatrist of color with colored patients in Algiers during the period of the liberation war. It was there that, evidently, Fanon clarified his position as a politicized psychiatrist, realizing that the relationship between doctor and patient (as well as that between white and Black people, and therefore between those with power and those without) *was always an institutional relationship in which roles were defined by the system.* The most his action could lead to was reformism and a technical perfectionism of an institution that offered, in exchange for confirming the patient's dependence on it, "healing" and social reintegration into a reality that Fanon defined as form of "systematic dehumanization." Therapeutic acts resulted in a silent acceptance of the system, and Fanon could then only choose revolution as the only place outside institutions where he could act.

His resignation letter from his role as chief physician of the Blida-Joinville psychiatric hospital in 1956 states this in explicit terms:

> Although the objective conditions under which psychiatry is practiced in Algeria constituted a challenge to common sense, it appeared to me that an effort should be made to attenuate the viciousness of a system of which the doctrinal foundations are a daily defiance of an authentically human outlook.

2 Asylum in France where many radical psychiatrists worked, including Francesc Tosquelles and Frantz Fanon.

For nearly three years I have placed myself wholly at the service of this country and of the men who inhabit it. I have spared neither my efforts nor my enthusiasm. There is not a parcel of my activity that has not had as its objective the unanimously hoped-for emergence of a better world.

But what can a man's enthusiasm and devotion achieve if everyday reality is a tissue of lies, of cowardice, of contempt for man? [...]

Madness is one of the means man has of losing his freedom. And I can say, on the basis of what I have been able to observe from this point of vantage, that the degree of alienation of the inhabitants of this country appears to me frightening.

If psychiatry is the medical technique that aims to enable man no longer to be a stranger to his environment, I owe it to myself to affirm that the Arab, permanently an alien in his own country, lives in a state of absolute depersonalization.

What is the status of Algeria? A systematized de-humanization.

It was an absurd gamble to undertake, at whatever cost, to bring into existence a certain number of values, when the lawlessness, the inequality, the multi-daily murder of man were raised to the status of legislative principles.

The social structure existing in Algeria was hostile to any attempt to put the individual back where he belonged. [...]

The function of a social structure is to set up institutions to serve man's needs. A society that drives its members to desperate solutions is a non-viable society, a society to be replaced.

It is the duty of the citizen to say this. No professional morality, no class solidarity, no desire to wash the family linen in private, can have a prior claim. [...]

The worker in the commonwealth must cooperate in the social scheme of things. But he must be convinced of the excellence of the society in which he lives. There comes a time when silence becomes dishonesty. [...]

> For many months my conscience has been the seat of unpardonable debates. And their conclusion is the determination not to despair of man, in other words, of myself.
>
> The decision I have reached is that I cannot continue to bear a responsibility at no matter what cost, on the false pretext that there is nothing else to be done.
>
> For all these reasons I have the honor, Monsieur le Ministre, to ask you to be good enough to accept my resignation and to put an end to my mission in Algeria.[3]

Fanon was able to choose the revolution. We, for obvious objective reasons, are prevented from doing so. Our reality is still to continue to live the contradictions of the system that determines us, managing an institution that we deny, performing a therapeutic act that we reject, denying that our institution, which has become an institution of subtle and hidden violence through our own practice, does not continue to be merely functional to the system. In attempting to resist the allure of ever new scientific ideologies through which contradictions tend to be stifled, it is our duty to make these ever more explicit, while aware that we are *engaging in an absurd wager in wanting to make values clear while the denial of rights, inequality, and the daily death of man are written into legislative principles.*

3 Frantz Fanon, "Letter to the Resident Minister (1956)," in *Toward the African Revolution: Political Essays* (Grove Press, 1967), 52–55. Emphasis by the author.

Consolidated Bibliography

A specific list of "works consulted" relating to the therapeutic community originally appeared at the end of the chapter by Lucio Schittar. It has been reformatted for this edition and integrated into the overall bibliography, with mistakes in the original corrected as far as possible. A further list of works by the Gorizian *équipe,* described as "related to the work of institutional psychiatry (1963–1967)," was included at the back of the original 1968 edition, with numbering for each publication. This list has been integrated as well, although some of these did not eventually appear as promised in specific publications, but were given as conference papers. It has not always been possible to locate the final place of publication or other publication details (page numbers, author names) for each reference listed in the original 1968 publication. The remainder of the bibliography below relates to texts cited in the introduction or in the editorial notes.

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