Rehabilitating rehabilitation
Franco Rotelli

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"*The fact that today man, as man, is considered entitled to rights, such that a human being is something superior to his status, should be seen as something of major importance; now, universal principles are in force as a source of rights and the world has thereby entered into a new era*" (Friedrich Hegel)

Along with civil and political rights, social rights have also made their appearance, and laws are often provided with compensatory functions in favour of the disadvantaged. Unequal rights for unequal persons. In effect, what is recognised is that equal rights are not just a matter of abstract law. The ability and possibility of access in order to use these rights has been differentiated and justice becomes, quite rightly, a complex matter.

Differentiated advantages and possibilities in the access to rights must be guaranteed. The person who has (or is) less, must have something more in order to gain access to rights. The ethical foundation of public health must guarantee more to whoever has a greater need (in clear contrast with the ethics of free-market health care which tends to guarantee a great deal of protection and support to those who are normal or not very ill for purely mercantile reasons).

Meanwhile, every day we see people who have lost their driver's license because some doctor has made a psychiatric diagnosis (though no one has ever proven that psychotics cause more accidents than others). Complex justice always has two sides to it, which are in conflict with each other, and it is there that the problem lies.
At the same time, in three quarters of the world, rights (of any kind whatsoever) are only fully realised in the documents of the WHO and on TV. Yet even this is better than nothing.
The task of the new psychiatry ought to consist in empowering and rehabilitating (emancipating).
Instead, too often in the past (and still today) it has been a matter of in-abilitating.
What does rehabilitation mean? "To construct (reconstruct) real access to the rights of citizenship and the progressive exercise of these rights, to create the possibility of having them recognised and of activating them, and the ability to practice them". The right to citizenship is a political, legal and social right.
Understood in this way, (re)habilitation is a process for acting on three levels. If practised together, these levels validate one another, but if practised separately they will pervert one another.

1. Legal reform (with regards to care, obligatory treatment, places for care, user's rights, work, social interventions, etc.) is an essential aspect of rehabilitation strategies. It can render any other kind of intervention useless or, on the contrary, support and promote such interventions. On the one hand, political and legal rights and the laws which sustain, recognise and implement them are essential, while on the other, social rights are the chosen, practical terrain for carrying out rehabilitation practices (access to education, housing, schools,

work, an acceptable income, sexual freedom, freedom of opinion, self-promotion, quality of life, etc.). Specific legislation will be required in this area, the rehabilitative value of which is evident. The rehabilitation process must seek to be an active one in which the legal realisation of these rights for the individual is vigorously pursued.

2. If social citizenship is concerned primarily with obstacles and resources, empowerment must, above all, impact on these obstacles and free up these resources.
   The second level of this issue is constituted, on the one hand, by the actual availability of the resources to be obtained (housing, work, money, places for real training, possible social relationships, etc.) and, on the other, by the recognised right to have access to them.
   With respect to these first two aspects of the strategies for social citizenship, it should be emphasised that these actions, which are essential to rehabilitation processes, must be an integral part of whatever actions are taken and constitute a goal, in the full sense, for the professionalism of the services and operators. Even though these objectives can quite rightly be viewed as political, they must still be considered as an area where operators should intervene. The operators must dedicate energy, ability and time to the realisation of these goals. And regardless of whether one wishes to recycle such terminology or not, it is understandable why "therapeutic vocation" and "class struggle" were inseparable terms in one of Basaglia's texts.
   The attitude that "a right is something that should be deserved" or that "a right should only be given to those who know how to use it" finds us in total disagreement.
   On the contrary, we believe that a right is a universal good which belongs to all regardless of class, rank, sex, race, age or health conditions, and that no one can be denied a right considered universal and essential to full citizenship, which should, in any case, be recognised *a priori*. The action of empowerment cannot be aimed at "deserving a right" or at obtaining a right through the ability to use it. The right must be given *a priori.* Empowerment must consist in endowing a person with the ability to fully exercise this right if they are not yet able to, or if they have lost this ability, and to render realistic and feasible the exercise of a right which has been arbitrarily denied or which is still not sustained by existing, real conditions.
   In actual practice, one seems justified in saying that, in a democratic society which "in principle" allows for the universal acceptation of rights, the concrete goals of empowerment find themselves encountering the effective limits of this universal principle of the exercise of rights, which is generally accepted in the abstract but is still far from being fully realised in reality.
3. The strategies on the legal side (first level) and the strategies for the availability of resources (second level) are essential to a third level which consists in producing the capacity for access to value. The rehabilitation project can realistically contribute towards creating this capacity primarily through training and information, and by providing opportunities and collective practices.
   Too often, one speaks of rehabilitation only with respect to this third level, thereby ignoring the fundamental importance of the other two. This is both the fruit and the source of many of the perversions of the rehabilitation process which render the process itself unlikely and ineffective. In any case, let us now consider this third level.
   The quality of training and information, the creation of opportunities, human development and collective health practices for the benefit of the *whole* user (the designated user, family members and their collateral circuits, operators and services) is marked by indicators for process and outcome which in fact evaluate the expression and development of the capacity for access (to the rights of

citizenship). Personal autonomy, education, professional training, social ability, the need for power and the ability to express one's own point of view in a comprehensible manner are all essential training goals to be pursued (though what remains *rehabilitative* is always and only this: the process by which these rights are – along with others – pursued, rather than the rare instances in which they are fully achieved).

In the reality of everyday practice, the following can be considered as examples of (re)habilitative actions:

- the use of goods and services not normally used;
- the not acritical support of an act of rebellion, even if incongruous, and the searching together for the meaning of particular acts;
- the appreciation of any useful act whatsoever performed by an individual, after having made it possible for him to perform that act;
- the identification of what a person is capable of doing, whatever it may be, and the attention given to him which is directed towards the realisation of his abilities;
- the acquisition of an ability not previously possessed (and its development);
- improving one's environment;
- having, possessing, private property;
- the sense of belonging to something, and making that belonging possible;
- the participation in micro-collectives which are composed of peers and directed towards certain goals;
- collective action for satisfying a commonly recognised need;
- the quality of the products, environment, relationships, image, the setting and methods/style of training and/or production in any given training/work activity;
- whatever is done to help one feel that his own diversity is respectable;
- the recognition and practice of a sexual identity and of feelings;

Rehabilitation will also be the actions of social networks, the nurturing of interests, the real access to networks of communication and, above all, the sense of worth and that someone expects something of you. In short, housing, work and socialisation, and thus something which is a bit reductive. And even more reductive is identifying the rehabilitation and re-acquisition of abilities by a single individual.

Activities which perhaps serve to "pass the time" during a stay in hospital or in other health facilities are often indicated as "rehabilitative". This "passing the time" (for example, by producing useless objects) does not seem to have anything to do with the rehabilitation process.

Strategies for the distribution of resources which the individual does not then know how to use in social exchange, or even as an active consumer, seem to be equally irrelevant. Nor do exclusively protective or assistance actions seem appropriate, unless they result in a capacity on the part of the individual to learn or achieve certain goals or perform certain activities on their own.

Activities which only develop a consumer role or activities intended to stimulate new and unexpressed needs can also probably be considered as a form of empowerment, while behaviours and strategies which result in passivity or in the mere execution of commands or delegating to others instead of doing things on one's own are most certainly not so. Strategies which exchange work for freedom seem very risky with respect to a good outcome. The ability to "work" which is obtained in certain closed communities, even when it is real work (production of real goods for a real market), when exchanged "for" freedom can often lead to a distancing from the right to full citizenship instead of providing real rehabilitation. Thus, behind the appearance of a "rehabilitation" which is identified in a one-dimensional and reductive way with the ability to work and access to a job, a

regressive and invalidating mechanism is created which makes achieving the proper goal of rehabilitation - that of exercising the right to full citizenship – unlikely.
The "identification of rehabilitation with obtaining a good living standard" seems to be both valid and invalid. Invalid because to us it seems as desirable as it is not strictly necessary. What is essential is the process for obtaining this standard, rather than the standard itself. On the other hand, if one is poor, rehabilitation is only a myth.
Already in 1990, the WHO, in classifying the invalidating consequences of illness, made the following distinctions:

- *impairment* (functional diminishment or alteration due to an illness or trauma)
- *disability* (disability, or the result of this diminishment with respect to the individual's ability to perform physical or mental functions)
- *handicap* (the disadvantage experienced by the individual in his environment as a consequence of this diminishment and disability).

This classification has been criticised for the limits implicit in a medical conception of handicap which is based on a linear causality, proceeding by cause and effect from the physical (biological or bio-chemical) to the functional and, finally, to the social. This type of causality is in contrast to the circular causality currently accredited by science and is even less applicable in psychiatry where the physical damage, the original lesion has never been ascertained.
What is certain, however, is that the disadvantage deriving from the role of being ill and from the status of being assisted impacts in a decisive manner, and from the very outset, on the causation of disability.
Castelfranchi emphasises that this epistemological error is used by psychiatry in order to separate care from rehabilitation, thereby maintaining a secondary, residual disciplinary role for the latter which intervenes at the last moment in order to recover a social disadvantage and reduce a disability already seen as serious and difficult to remove. Instead, in psychiatry one must "deal with what appear to be the effects of the illness from the very start, in order to retro-act effectively and modify the very causes of the problem".
Living, as he does, in Jerusalem, it is perhaps understandable that for Mark Spivak (who, however, generally writes intelligently) rehabilitation means "intervening exclusively on the individual, readjusting him as much and in as many ways as possible to the expectations of the contexts of reference", which are not minimally placed in question.
One must cite Luc Ciompi and his studies in order to establish the fact that the prerequisite for a favourable intervention with seriously ill patients has very little to do with the diagnosis, while it has a great deal to do with the combination of expectations and motivations for getting well present in both the person and the context - and in the operators in particular.
Giovanna Gallio cites the three fundamentals of rehabilitation:

1. practices aimed at the material construction of the exercise of rights
2. practices aimed at the development of exchanges (interpersonal and social)
3. practices aimed at co-operation (towards social enterprise).

These are the three fundamental indicators for evaluating the quality of any rehabilitation process.
The importance of strategies such as self-help, social network projects and the involvement of non-professional psychiatric workers and, especially, of non-psychiatric professionals, is obvious (with regard to the last two: the former as non-specific volunteers, the latter as intelligence from other areas – architects, teachers, carpenters, plumbers, artists, graphic artists, computer experts and skippers. Experience shows that in this way, little by little, even psychiatrists begin to rehabilitate themselves).

Indeed, how is it possible to rehabilitate patients without first rehabilitating psychiatrists? Do their pharmacological and psychotherapeutic abilities, in the classic sense, have even the slightest hope of developing the abilities of their patients? Is not the complex-ification of psychiatry preliminary to any other discourse? Is not the real problem to be found in the *dis/ability* of psychiatrists? In the reductionism of their practices?

I have never thought that in the micro-institutional dimension it was possible to rehabilitate anything without a strong mediation of the object of such work. The decisive impact of interpersonal relationships makes sense and works only within a concrete modification of reality, which cannot live by interpersonal relationships alone but needs work, activities, materials and very real changes in both the cultural and natural environment. That the "real world" is by its nature connected in a circular fashion with initiative, undertaking and doing is both obvious and often forgotten, and equally obvious is the value, in cognitive terms, of a practice of transformation. Madness tends to be both the passive and active negation of all these things.

Today, work has transformed its prerogatives far beyond the strictly economic sense as the key to gaining access to rights and to structuring human and social existence.

Exclusion from work, which remains directly or indirectly the sole source of income, results in a radical loss of social meaning.

If this is so, how can rehabilitation or empowerment take place outside of the active, working, productive world and, above all, how is it possible to "cure" without work, if it is work which structures human and social existence?

Elsewhere, we have defined the action of empowerment which must be expressed in the real world with the, for us, very clear term of "social enterprise". That is, the action of empowerment in western society today seems to coincide with the necessity of a "social entrepreneurship" which should characterise whoever is involved in such activities, in order to realise these principles in a real, concrete manner.

The concept of social enterprise seems to us to be the one most suited for taking into account the total number of operational strategies required.

In fact, the term seems to contain a series of meanings to which we attribute great importance, and which is coherent with what we have said thus far. Above all, the term is based on the supposition that today it is increasingly evident that the central question of resources must be reformulated in new ways, as has in fact already been occurring for some time. That is, it is increasingly evident that the problem of the inadequacy of resources required to effectively realise the universal principle of rights, though still a problem, can no longer continue to be formulated as it was in the '60's. On the one hand, the problem is, or at least appears to be, the insufficiency of the absolute resources. On the other hand, it is perhaps and primarily (or perhaps even exclusively) the use of these resources as well as those resources which are available but not used. It is certainly possible to have legitimate doubts concerning the insufficiency of resources given that, up until now, they have been poorly used. Discussing social enterprise means immediately raising the familiar issue of the inefficiency and ineffectiveness (and much more besides) of the current health/social welfare system and the current institutions of the "welfare state", the functioning of which is often contrary to any sort of rationality. It is now clear to many people that these institutions often exist more for purposes of social control (including those based on violence – prisons, psychiatric hospitals, juvenile institutions, etc.) than for "rehabilitative" or "emancipatory" purposes. The costs/benefits ratio with respect to the system's rehabilitative and emancipatory goals appears to be enormously negative.

Very often the costs are not only too high with respect to the benefits obtained, but are, in fact, costs incurred for purposes which are the opposite of rehabilitation-

emancipation (once again prisons, psychiatric hospitals, but also a high percentage of hospital-based health care as practice and culture, the illogical use of drugs, etc.).
Assuming as always that the goal is the full right to citizenship, we can thus probably conclude that many extremely costly interventions by the State are instead designed to deny or reduce rights instead of realising their practicability. But even where one can assume that the effective aim is to broaden the real exercise of rights, this almost always takes place with procedures, institutions, norms, bodies and actions which are, at the least, irrational, if analysed in terms of costs-benefits.
We can thus say that the first task for a sensible strategy might be "rehabilitating the institution of rehabilitation". And thus the clarity of the term "social enterprise" and the enormous need to emphasis the centrality of its theme, a task which is endless and which cannot be eliminated even when goals are partially achieved, due to the fact that, in any case, the rules and methods of organisation among human beings (institutions) continually produce inertia, distance, hierarchy, lack of responsibility and the deprivation of individuals: at minimum as a collateral effect, at maximum as a perversion of the original purpose.
We have spoken at length about institutional rehabilitation and we believe the term to be extremely relevant. One either rehabilitates (empowers) by working all together (doctors, nurses, users, families, society at large) or very little progress will be made and useful techniques which are not destined to disappear within the space of a morning, a trend or a book will be even less likely to be found.
On the continual capacity for the modification of institutions depends liberation, access, the practical-affective dimension of any action, and opportunities for the exchange and enhancement of the numerous vital elements present in individuals.
Freedom is therapeutic but we are still a long way from being able to make this a reality, nor does it seem that we are currently heading in the right direction. Every day false prophets appear who indicate roads that go nowhere.
Of the many roads to liberation, the most improbable is that deriving from the false idea that the dream of deciphering the genome can lead to a knowledge of the "causes" of illness and thus to their cures. As Lewontin warns: "When the sequencing project will finally be complete, the general public will be greatly disillusioned to discover that, despite the bold affirmations of molecular biologists, people will still die of cancer, heart disease and apoplectic strokes, that the psychiatric hospitals will still be full of schizophrenics and persons suffering from psychotic-depression, and that the war on drugs will still not be won".
The "mad" continue to constitute the most oppressed minority in the world. It hardly seems the case to entrust their fate to the future of molecular biology. Nor should it be left to the good intentions of WHO documents: mere pieces of the game, the game of "as if". Psychiatry is a master of "as if".
With respect to Law 180, Italy is divided into three camps: those who strive to fully realise the principles of the law, those who oppose it and those (and this is the "democratic" majority) who, though in compliance with it, distort it, deprive it of meaning, work and facts, and transform it into a fetish. The enemies of the Law are preferable to this last category. Someday, it might be best to forget about the Law and just work day by day in the real world.

It might therefore be worthwhile to remind ourselves what "working in the real world" means, and at the same recall the operative principles upon which the movement for the renewal of psychiatry in Italy is founded, in order to rehabilitate a memory capability as recent as it is easy to lose sight of. These principles involve placing an emphasis on:

- the person (his history, the unique individual) rather than the illness;
- a criticism of the psychiatric hospital as the paradigm of psychiatry which is unacceptable;
- the non-neutrality (as a class) of the psychiatric apparatuses;

- the need for the involvement of institutions, political parties, the general public, etc.;
- the real, manifest needs (to which it should be possible to respond) of patients;
- social stigma and the procedures and institutions of social exclusion which distort the illness in itself;
- the power conflicts inherent in psychosis, which then over-determine the psychotic's progress and outcome;
- freedom as a calculated risk, as the offer of the possibility to choose, as a space where it is possible to imagine an encounter beyond the "illness" within a sought-after reciprocity;
- the legitimate doubt that the "illness" is nothing other than a form of the institutionalisation of mental suffering which prevents reading its history, its evolution, its contents
- the non-linear causality of the illness;
- the inter-personal, collective, network or community style of care as capable of radically changing the patient's destiny, whatever the cause of his distress, and thus:
- the affective and collective dimension necessary in order to modify the "inertia" of regulated relationships and baseless rules;
- the practices of daily life, in a context which is widened to include the family, work, housing, friends, the neighbourhood, income, the quality of life, etc, as the setting of the "therapeutic" work;
- the need to respect diversity, in whatever form it manifests itself, which does not reduce or deny the need for a "cure" but confers necessary limits and caution, and provides "positive" points of reference in the person's individual resources
- the general emancipatory value inherent in a relationship with "madness" which is more aware, dialectical and refined, through a radical change of its institutions; a change which should be seen as a laboratory for more general policies (social, living, political).

One need only reread these principles to see clearly that the new psychiatry in Italy never was, and shall never be, anything other than a great rehabilitation effort. And this as opposed to the desire to separate "rehabilitation" from "treatment", which constituted a veritable cultural matrix in the battle waged by many against Law 180 and the new psychiatry. And, conversely, how can one speak about rehabilitation without implementing this law?

In the fifteen years since Law 180, there have been ineffectual proclamations by minister after minister (Altissimo, Degan, De Lorenzo, Garavaglia), dozens of ministerial commissions and an infinity of printed paper. For, against, but above all how? What to do about psychiatry?

Elementary the responses, obvious in their banality, and elementary the sensible things that should have been transformed into real accomplishments instead of becoming the sterile subjects of endless, useless controversies, debates, congresses and proclamations.

Televised debates which were moderated by journalists totally indifferent to the real issue being discussed, an indifference which became definitive when the game of for-and-against had finally exhausted the adversaries, as well as the long-manipulated family members when they finally began to see things a bit more clearly.

What does applying Law 180 mean? It means doing four things, which are both elementary and necessary:

- mental health centres which are open as much as possible (does 24hrs a day, 7 days a week seem like too much?);
- residential living groups which are as small and numerous as possible;
- social coops which are as diversified and numerous as possible;

- as few psychiatric hospitals as possible

(does this seem like too much, like nothing at all?).

Therefore: at least **5%** of the total health budget, permanent training, the social welfare and health sectors as indivisible, the sole responsibility of a single èquipe for a single, given area, and widening the involvement of non-professionals in as many ways as possible. Trieste has done this, and nothing further was required. Certainly not another debate. What is there really to getting the job done?

Perhaps what it is needed is finally confirming what still seems an impossibility to many, and that is: that madness is part of normalcy, it belongs to it and is not at all its negation.

But this will take place only if our abilities, and those of others, instead of being reduced, continue to grow and remain vital and multiply.