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## **TRIESTE TWENTY YEARS AFTER: FROM THE CRITICISM OF PSYCHIATRIC INSTITUTIONS TO INSTITUTIONS OF MENTAL HEALTH**

### **Work within the Psychiatric Hospital.**

When Franco Basaglia was appointed Director of the Psychiatric Hospital in Trieste in August, 1971, he set about forming a team from the young doctors, psychologists, social workers, volunteers and students who had been drawn to Trieste by the previous experience in Gorizia and by the influence of the current critical hypotheses on Psychiatry and "total institutions" in politics, the media and public opinion.

Basaglia's point of departure was his often declared belief that the Psychiatric Hospital had absolutely no treatment value, that in order to provide truly "humane" care it was necessary to define new relationships, spaces and subjects, and that a therapeutical dimension was possible only through a total transformation of the institution.

For such a transformation to take place, it was necessary to utilise a group of young doctors "uncontaminated" by Psychiatry, and whose training would consist precisely in the daily effort to bring about that transformation process rather than rely on professionals formed in the static and archaic atmosphere of the Italian universities.

The already innovative Therapeutic Community developed by Basaglia in Gorizia in the preceding decade was superseded by the progressive opening up and transformation of the hospital in Trieste, leading to its eventual replacement by a network of alternative community services. (Fig. 1)

On December 31, 1970, there were 1,260 patients in the Trieste Psychiatric Hospital (serving a population of 3 10,000) with an annual turnover of about 2,500. Of these, more than 90% were compulsory hospitalisation (law of 1904), meaning that only a very small minority had been able to benefit from the voluntary hospitalisation stipulated by a more recent law (art. 4: 431/1968). In fact, in this period, the issue of voluntary hospitalisation, and all the norms of a new reform law (431/1968), became a major discriminant between renewal and resistance to change in both Psychiatry and psychiatrists. In Trieste, voluntary hospitalisation was greatly emphasised. For the patient, this meant an increase in the possibilities of movement both within and outside of the hospitalisation a progressive improvement in the quality of life and treatment, and a partial recovery of civil rights (Fig. 2).

During the first four years, maximum attention was given to changing and restructuring internal spaces (wards - bar - social areas) and to the systems of communication and exchange both within the staff hierarchy, and between staff and patients. Daily meetings were initiated in each department, as well as periodic general assemblies for all patients and frequent meetings of the entire staff. Specific attention was given to the participation and training of nurses, who gradually abandoned their traditional role as guardians.

Doors were opened in every department, and shock therapy and all forms of physical constraint were abolished.

Patients were encouraged to move freely about the city, provoking an often-negative attention and interest by the general public towards the idea of an open hospital.

In this first phase, the medical staff had to divert its efforts away from "psychiatric illness" and diagnosis and instead focus, through the deconstruction of Asylum relations, on an appreciation of individual stories and patient needs, and the rebuilding of relations with the community.

The first living groups were set up within the hospital. These went on to become the first group homes within the city.

During the patient assemblies, work therapy was criticised as being "objectifying", "repetitive" and without therapeutical value. Patients especially complained that they received only token rewards for real work. It was during these meetings that the first patient group was organised to establish the first co-operative in February, 1973. Working for the first time under a regular union contract, 60 patients were hired to clean the wards, kitchen and grounds.

These initial achievements (coop and living groups) made clear that the real obstacle to any true transformation and rehabilitation process was the legal and administrative status of the patient (i.e. inmate) and not the illness-related disability. Consequently, negotiations were begun with the Hospital Administration to extend the right to treatment and hospitality to those patients who, while no longer in need of hospitalisation, were still resident in hospital living groups because no external accommodation was available and/or because they still needed rehabilitation, though without specific psychiatric treatment.

The gates to the Hospital grounds were opened; concerts and parties were organised by local political and cultural associations attracting numerous students and young people, as well as the general public.

Emblematic of this period were the animation activities carried out between January and March, 1973, by a group of actors, painters and artists. For three months, and with the active participation

of patients, students and the general public, the first empty ward was transformed into a laboratory for painting, sculpture, theatre and writing.

The (by now) legendary Marco the Horse was built. Made of wood and paper-mache and with its belly full of the wishes of the hospitalised patients, this large blue descendent of the Trojan Horse was carried out of the Hospital at the head of a huge procession on the last Sunday in March, 1973: a symbolic "going out" to prelude the real "going out" which would occur shortly thereafter.

In this way, an intense and sometimes chaotic circulation of different cultures and behaviour was encouraged within the hospital grounds.

Holidays in tourist locales and recreational activities in town (movies, theatre, circus, etc.) were organised with increasing regularity.

The internal organisation of the hospital was also changed. Instead of a hierarchy based on a criterion of nosographical severity, patients were regrouped according to which part of the city they came from. In this way, both hospital and city were divided into five zones.

The staff was likewise divided into five groups, with each group responsible for a specific area.

This was the beginning of community work. It aimed at the release of hospitalised patients and their support at home, the handling of new cases, and the creation of positive working relations with the institutions and residents of each specific area.

It was by means of this "external work" - its obstacles, conflicts and successes - that the first meaningful changes were introduced into therapeutical practice, the institutional hierarchy and administrative schemes. It became, in fact, the true period of internship for doctors and nurses alike. By the beginning of 1975 the number of hospitalised patients had decreased to 800. About 1/3 of the original number had returned to their families, or was living in small apartments, council houses, or group homes. No one had been transferred to other institutions.

The first community structures began functioning between 1975-77. Their initial purpose was to provide support for released patients and, subsequently, crisis intervention. Functioning as day hospitals, they favoured a further substantial decrease in the hospital population, reducing the duration of hospitalisation for acute crises, and admissions in general

During this period, while the network of community services was taking shape, the Psychiatric Hospital was still fully operational

### **Construction of the new network.**

We consider this the most delicate phase in the entire transformation process. Not only did two different organisational systems have to function simultaneously, but the investment of human and material resources was much more intense. Doctors and staff had to keep the Hospital functioning while at the same time trying to change it and create a network of community services. Also, resistance to change within the hospital organisation and concern for the presence of psychiatric services in the community had become more acute. It soon became clear to the entire staff that a choice had to be made. It was decided to give maximum effort to shutting down the hospital and responding to all demands through the network of community services.

The community work and the presence of operators in the city had made especially clear the fundamental role of bureaucratic and administrative mechanisms in the definition of crisis and

psychiatric (especially compulsory) hospitalisation. As further evidence of this mentality even though the hospital population continued to decrease, the wards for acute and compulsory admissions were still operational. Thus, and pending the creation of the Psychiatric Emergency Unit in the General Hospital a 24hr on-call service was activated in conjunction with the Hospital Emergency Room. Its aims were to "filter" the demand, to provide a more adequate and less administrative response to crisis, and to oppose bureaucratic recourse to compulsory hospitalisation.

The first community services were soon operating as Mental Health Centres (NMC) open 24 hours and with the structure and characteristics they still have today. The catchment area for each Centre was limited to the capabilities of the staff, or to a population of about 50,000, thereby completing the territorial division begun earlier. A further division brought the number of Centres to seven, for a population of 40,000. This community network of services was already functioning in 1978, when the psychiatric reform act was passed in Italy.

Upon the request of the Ministry of Justice, a psychiatric counselling service was created for work in prisons. The counselling was carried out by NMC operators and aimed at providing therapeutic continuity for inmates and avoiding the creation of heavy institutional barriers. As a result of this initiative, it was possible to assist mentally disturbed individuals after their release, to provide alternatives to detention and to substantially reduce the number of admissions to Forensic Psychiatric Hospitals.

Each MIHC is open 24 hrs, is furnished with 8 beds (1 per 5,000 residents), and serves meals for both hospitalised and outpatients. It also provides walk-in and domiciliary treatment and has a social assistance service. Thus, the MHC's are not only alternative to, but have assumed all Hospital functions.

Each MHC has activated group homes within its community, initially to provide housing for released patients, and subsequently to give adequate support for those patients coming directly from home, without any previous hospitalisation experience.

The Psychiatric Hospital was shut down completely in 1980. A 24 hr Psychiatric Emergency Unit (officially known as the Psychiatric Diagnostic and Treatment Station), equipped with 8 beds and staffed by a psychiatrist and two psychiatric nurses, was set up within the General Hospital. Its purpose is to provide psychiatric first aid, counselling within the hospital and evaluation and referral to the MHC'S. About 1/3 of those coming to the Unit resolve their problems (conflicts, behaviour, and anxiety) during the initial contact and are sent home with a recommendation to see their family physician. Another third show a definite need for psychiatric assistance, but are able to go alone or with family members to their local MHC, to which they are referred. The remainders manifest acute psychiatric suffering, impaired social functioning or relational difficulties and are therefore referred, after initial diagnosis and treatment, to their local MHC. In this case, if the contact occurs at night, the individual is given overnight accommodation and is referred to an MHC the following day. Compulsory treatment can be handled either by the MEC or the Emergency Unit.

The Diagnostic Station is co-ordinated by a single psychiatrist, on a rotation basis among those working in the MHC'S. Thus, no one doctor is assigned to this service, while the nurses form a permanent group of 14.

In the last ten years, many activities have been developed in the field of rehabilitation, job training and placement, and which are open to all patients. There are training and recreational facilities, creative workshops (theatre, painting, etc.), literacy and educational courses (in Cupertino with the local school administrations) and coops for job training and placement.

To the first coop, formed in 1973 in opposition to work therapy, four more have been added. They employ nearly 200 workers (60% of which "disadvantaged") and pay union scale salaries.

These coops create jobs and enterprises that can compete on the open market. They seek to involve primarily young people with psychiatric problems, or problems of addiction and marginalization.

The coops provide training for at least 100 young people (in addition to 200 workers) working part time (20 hours per week) with salaries financed by a special grant from the Regional Government. Currently, there are 5 coops involved in 30 areas of productive activity, including a small hotel a restaurant, a bar, a bookbinders, a construction crew, a movers, a tailors, a shop selling handbags, a carpentry shop producing design objects and furniture, a workshop for video production, a commercial radio station, a theatre laboratory, a painting laboratory, greenhouses, a greengrocers, groundskeeping and maintenance crews.

### **Some indicators for the work of transformation.**

By 1981, the new network of Psychiatric Services had taken shape. The administrative structure of the Psychiatric Hospital was replaced by the Department of Mental Health, guaranteeing a single centre for the planning and administration of the service network and its related activities (FIG. 4).

At present (1994), the hospital is host to slightly less than 100 individuals, 70 of whom live in group homes of about 10 each, and 18 in a single geriatric ward for patients over 65 with serious physical illnesses. No one has been hospitalised for 15 years.

Of the 22 structures that made up the hospital only a few are used by the Service as classes, coop offices and workshops. The others have been acquired by public and private agencies for use as school and university facilities, and workshops.

The hospital grounds are crossed by moderate road traffic, and the entire complex is gradually being integrated into the surrounding area.

The Service network is made up of 5 MHC's serving a population of 258,000 (there has been a steady demographic decline in the last 20 years). The reduction in the number of community work groups and their respective areas occurred in 1992, and was due to the decrease in population and personnel as well as a better organisation of resources and structures and a more precise definition and differentiation of therapeutic processes and rehabilitation programs.

Currently, the staff consists of 25 medical psychiatrists (10 in 1971), 180 nurses (460 in 1971), 10 psychologists, and 9 social workers (2 in the old hospital).

To this figure must be added the nearly 50 young operators (assistants, educators, etc) provided by a social coop which was developed during the course of the transformation process. This coop operates under a service contract with the Health Administration, and is responsible for the management and maintenance of the group homes, and related rehabilitation programs.

The Service has an annual cost of 21 billion lire (1993) as opposed to 5 billion in 1971 (the cost of the lire has increased 400% since 1971).

For more than 10 years, there has been no Psychiatric Hospital in Trieste. The number of persons using the Service averages 10 per thousand annually. Recourse to private structures is minimal, as commercial Psychiatry is undeveloped. The phenomenon of transinstitutionalization is absent, if one excludes the recourse to general medical and geriatric services by elderly patients with organic illnesses and concomitant mental disturbances.

A substance abuse service (SER.T) has been under development since the early '80's, with programs designed for individuals with problems of alcohol or drug addiction. Many of these programs are developed in collaboration with the Mental Health Services (coops, workshops, leisure time activities, sport).

In the past, the hospital represented the last recourse and "dumping ground" for these problems.

It is important to remember that Trieste has undergone a significant demographic decline in the last twenty years, resulting in an increase in the percentage of the elderly (around 20% of the population is over 65).

The MHC's have responded to psycho-geriatric problems by counselling and assistance in hospital wards, nursing homes and other institutions for the elderly.

In a retrospective (15 year) evaluation, certain (for us) significant indicators have stabilised on very encouraging values.

The number of compulsory treatments, which in 1977 reached the peak figure of 117, has fallen drastically to an average of 11 (about 4.5 per 100,000) annually (1978-94). This extremely low figure, which paradoxically could signify abandonment, under-utilisation of the Service or its detachment from the conflicts and problems present in the area, in our case represents the most impressive result of the active and integrated presence of the Service in the community. In fact, the turnover has increased since 1971 (2700 annually, 2500 in 1971, and this in a context of drastic demographic decline) and patients no longer come almost exclusively from the "underprivileged" classes, as was the case with the old hospital (around 97%) but from across the whole social spectrum.

Equally encouraging is the sharp decrease in the number of persons sent to Forensic Psychiatric Hospitals after a court ordered psychiatric examination: 15 in 1977 alone, 25 for all of the next 16 years.

Great significance is generally attached to the number of suicides when evaluating the functioning of a mental health service. We disagree with this method, and consider suicide to be much more commonly an epiphenomenon of other dysfunction and areas of suffering within the social fabric.

Nonetheless, numerous researches have been undertaken in our city to measure and analyse this phenomenon, partly because Trieste is of epidemiological interest due to its, in terms of suicide, "middle European" rather than Italian characteristics, and partly because of the total absence of a Psychiatric Hospital. The number of suicides, which is higher than the national average, has remained nearly constant (around 25 per 100,000 annually) in the last two decades (1971-94).

Recent studies show an almost constant level throughout the century.

No increase in crime related to mental illness has been verified since the hospital was opened up, despite what the collective image of mental illness might lead one to suppose. Isolated episodes unduly emphasised by the media are statistically insignificant when confronted with the previous 20 years, or with other urban areas in Europe or America where psychiatric hospitals continue to exist.

The quota of chronicity, a constant by-product of the processes of internment and the routine use of hospitalisation, has seen a notable decline since the therapeutic intervention shifted from the

hospital to the community. The numerous studies conducted on this question show a clear difference in the courses and outcomes, especially for serious illness (Schizophrenia), of patients who fell ill before 1970 and underwent extended hospitalisation, and those who came in contact with the Service after that time.

Hospitalisations and relapses, and their duration have also decreased. Therapeutic possibilities have increased and diversified, in terms of locations, time, individualisation of programs, the activation and involvement of family and social networks, job training and accessing (in 1971 there was a single location, the hospital; today, in 1994, between the MHC's and the Emergency Unit, the coops and group homes, workshops etc there are 62).

There are no longer any requests for internment on the part of family members.

If we attempt to draw a profile of a patient currently receiving long-term assistance from the Service, we find a subject who is prevalently male, between 25 and 45 years of age, with serious psychiatric disorders (schizophrenic psychosis), but who has maintained his social abilities and has a network of family and/or social relationships only slightly below the norm. He is a high user of the MHC's and utilises, for varying periods of time, the opportunities they offer, and is sufficiently compliant, maintaining a non-conflictual therapeutic relationship with the Service.

As stated, shock therapy and all forma of restraint have been abolished and the expenditure for psycho-pharmaceutical drugs has been cut in half in respect to the peak levels of 1971.

But perhaps the most positive indicator in favour of a community service is crisis intervention and evolution (FIG 5).

Numerous epidemiological studies have shown that a non-bureaucratic, non-administrative approach to crisis, which is not strictly based on any medical model tends to reduce or render hospitalisation unnecessary, encouraging a more rapid return to conditions of equilibrium and reducing potential relapses. The crisis remains an event in the individual's personal history and the ties and resources, which it is the crisis itself to reveal, can be activated and reinforced. We refer here to the attitudes and operating style typical of a community service that is socially and not clinically oriented. In concrete terms, this means reaching out to the patient without rigid schemes of time or place, competence or selection. It means emphasising the network of social relations and the patient's qualities and abilities rather than his symptoms. It means operating without rigid protocols or hospitalisation periods, and giving maximum attention to therapeutic planning and environmental quality (furnishings, cleanliness, food, etc).

In the last 5 years, three user-directed programs have been established:

- self-help groups run by an association of young people with their own centre outside of the mental health department, emblematically called "FUORI C'ENTRO" ('out of centre')
- an information and organisational program for the family and relative of patients.
- a Women's Mental Health Centre, with programs and activities that seek to enhance a specifically female reality. The Women's Centre has become a fixed point of reference for the therapy, rehabilitation and liberation of women within the network of services, as well as providing a meeting place for all women, with a variety of cultural, social, political and entertainment functions.

These programs, together with the remarkable development of the social co-operatives (social enterprises), give a sense of the participation and protagonism on the part of Service users.

These three scenarios: social enterprise, self-help and family involvement, show better than any other indicator the efforts made by the Service and operators to create a truly new mental health institution (FIG. 6).

**Evaluating desinstitutionalization. Brief outline of a work in progress.**

These results are due not only to the structural changes deriving from a decentralisation of the hospital into the community, that is, only to an operation of institutional engineering, but also to a non-linear process of cultural transformation which entailed, among other things, a criticism of roles and hierarchies, of our psychiatric training and of the very function of Psychiatry itself.

The word '**desinstitutionalisation**' has been so consistently misused in recent years that we consider it an indispensable premise to define exactly what we mean when we use this term.

Desinstitutionalization does not refer to programs of dehospitalization or transinstitutionalization, nor is it the transfer of the culture, knowledge and practice once used (and still used today) within the hospital into the community.

The cultural changes connected to the processes of desinstitutionalisation above all define the tendency to reverse the centuries-old relationship between Psychiatry and its institutions, and their object.

For many, this remains a merely theoretical postulate, and as such is easily accepted. But the effort to realise these transformations in practice is much more difficult. In the first place, the "patient" must be recognised as having full social citizenship, which means access to full rights (and not just civil and legal rights but also the right of work, decent housing, a quality of life, etc.) and therefore a constant attention to guaranteeing the realisation and practicability of these rights.

The processes of transformation tend to highlight and attach great value to diversity. This means concentrating on the individual and his history, and not the history of the illness and the institutions which held him. It means recognising his needs and not the institutional need to reproduce itself and putting the emphasis on his capabilities, feelings and emotions and not the disability and limits connected with the illness. Only in this way can a service begin to create a reciprocal relationship with the public and with the patient. Only in this way can it negotiate a therapeutic relationship on the basis of equality, and to finally reduce the vertical hierarchy and distance between subject and institution.

Based on these premises, it is possible to establish some criteria, or better, some simple indicators with which to evaluate and discuss the work of transformation and research in the context of desinstitutionalisation.

**The community dimension** in psychiatric work seems to be widely practised and generally accepted.

However, working in the community instead of the psychiatric hospital is not of itself an indicator of desinstitutionalisation. The current reality shows that this presence in the community is often theoretical, bureaucratic and administrative. Many services theorise methods for filtering the demand and protecting the patient to such an extent that the service virtually disappears.

Community work can acquire a transformative value which is scientific ethical and political in a number of ways: by learning as much as possible about the mechanisms of the construction of psychiatric demand and monitoring these mechanisms; by recognising the institutional breeding of

crisis, illness and chronicity; by an attitude of curiosity and research towards the culture and history of the community in which it works; by participating in the conflicts and problems which cause the greatest social alarm; and finally by intervening in administrative and policy planning for changes in mental health.

The Service's presence in the community aims at impacting on the psychiatric demand at the moment it forms, before it is rigidified and complicated by contact with the numerous institutional stops. It seeks to refine the ability to intervene and control the formative processes of the demand itself thereby strengthening its capacity to prevent, modulate or, in any case, interact with the mechanisms that determine, construct and breed illness, crisis and chronicity. In this way, the demand will no longer overwhelm the Service with the characteristics of inertia, urgency, alarm and danger, while the risk of abandonment and the growth of hidden "horrors" within the community will be reduced.

For psychiatrists working in closed institutions, responsibility is inherent to the situation (for example, the behaviour in compulsory hospitalisation and in the organisation of the Emergency Station). Institutional responsibility takes shape in the psychiatric hospital as psychiatry's response to the mandate for social control. For this control to work, it needs to objectify the patient. There is no doubt that psychiatrists have learned to assume this responsibility.

In the community, this responsibility has undergone a sort of "wild" desinstitutionalisation, to the point of refusing to recognise the mandate for social control as a fundamental principle in Psychiatry.

In the last two decades, psychiatrists seem to have discovered their therapeutic vocation solely in their work, neglecting or ignoring, with dramatic consequences, the aspects of responsibility connected to this work, or rejecting outright the mandate for social control.

Re-elaborating the exercise of responsibility in daily practice can enable the Service to fulfil a role both of social control and therapeutic function. The Service's presence in the community tends, of itself to establish a sort of objective responsibility that arises out of the interaction/ presence with users, their life stories and the conflicts within the community.

In this way, it is possible to form attitudes and refine methodologies for recognising and intervening in the more difficult institutional nodes: public order, sanctions, the courts, prison, the forensic psychiatric hospital.

Instead, many services continue to automatically refer problems of anti-social behaviour, disorder and disturbance to others. It is thus easy to understand the exasperation and resentment many families and individuals continue to express towards the new law and as a result the image of mental illness which the community service was meant to modify is reconfirmed.

A responsible presence in the community means not only more knowledgeable and effective interventions and an improved quality of treatment, but also working directly with the formation/growth process of crisis and illness, and their often fearful projection in the collective imagination; in effect, it becomes a work of primary prevention.

Clearly, a limited number of cases of extreme suffering in individuals or social groups will increase the idea of danger or serious social risk connected with mental illness and therefore call into question the responsibility of Psychiatry (and the Service). And yet these cases are indicative of conditions of real distress, of increasingly serious social imbalances whose causes (and the

interventions to deal with them) cannot be referred only to Psychiatry (and the Services). Other social institutions (welfare, health, **police**) must also do their part.

In any case, the Service will continue to actively pursue the patient's interest in ensuring that other institutions fulfil their obligations.

### **A total care Service**

When we began to take total care of the patient and his unique problems, we came to realise how the question of time and place had to be completely reconsidered. The times and places of clinical Psychiatry had to become progressively something else, something within the contemporary modifications in the relationship between the patient's demand and the Mental Health Service.

It became clear that a "place" could no longer be limited only to those by definition: the Emergency Unit, the group home, the MHC. Any location was potentially therapeutic and could determine a unique definition of the relationship.

The redefinition and enrichment of place, of the therapeutic location, requires completely new abilities on the part of the therapeutic operator in order to use locations which can be specific or diversified, extended or imaginary.

Such a location is often a place to imagine, construct, and define. It can be a **waiting** place, a place present in the relationship with the service, the therapeutic team and the patient, his relatives, his neighbours.

The same applies to time. If assuming responsibility means operating in real time, for example, by dealing with a crisis immediately, as it were "live and direct", the dimension **of time** becomes a variable which tends to determine farther changes.

Thus, the operator must not only learn to be flexible in the definition and **limitation of time within the therapeutic relationship**, but also to use and imagine a time which is endless, a therapeutic relationship which is lifelong, which never ends.

The psychiatric hospital also determined a time which was "endless" (as does psychoanalysis), but we mean a dimension of time which avoids the inertia of institutional reproduction and instead develops the therapeutic group's ability to resist in the time, against the long-term risks of boredom, closure, repetition, thereby transforming the organisational relationships and structures of the group and Service.

Furthermore, if "taking care of" is no longer synonymous with hospitalisation, then the question of resources, tools, and personnel acquires, as with time and place, a central importance in the transformation process. The lack of resources in a service must be judged in relation to a lack or total absence of projects, and the inability to criticise clinical and psychological models which, having as their object illness and the body which is a only perpetuate the emptiness and insufficiencies (material and relational) around the individual.

Caring for the individual and not the illness, means appreciating resources which are diverse, multiple and unique: friends, social workers, volunteers, operators who put their own subjectivity into play, the family, the social network taken as a whole; but also objects, small skills, locations which are well cared for, small enterprises which result continually from the recognition of the subjective and unique abilities of individuals.

The richness and quality of resources is therefore not to be taken as a premise (" ... if only I had the right resources and structures ... !") but is strictly connected to the production of change and the ability to recognise ever wider quotas of liberty, capacity, initiative and identity. Other indicators we can identify to evaluate the desinstitutionalisation processes.

In a short referring: **listening**. By this we mean an attention to the individual life-stories and narratives which leads to the discovery of their meaning and value, making comprehensible even the most extreme experiences. By bridging oppositions such as **simplification-complexity, totalization-subjectification, professional operator and new subjects** (natural operators, family members) **individual work and group work, rehabilitation** and **liberation** we attempt daily to bring about change. But we believe that change does not occur once and for all. The tension created by the choice to attach value to different subjects and identities is the element upon which we base our hope that Psychiatry and its centuries- long reductionism can one day be overcome.