Subjectivity and institutions: from Franco Basaglia to recovery

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1 Foreword

Today, the recovery movement seems to be almost as important for some as it was, a few years ago, the anti-institutional movement, although players, methods and philosophies, even the powers involved, appear to be different and completely new. If that were the case, we would really be in the presence of a historical phenomenon and not just a passing trend, or, worse, a fashion. To quote Basaglia, it would not be a mere "change of ideology" from old psychiatric knowledge and powers (Basaglia, 1980), but a true paradigm shift in the field of health and mental health. On the other hand, if what happened in Italy could be seen as an anticipation of these issues – so dramatically topical today -, it would be an important test of the topicality of Basaglia's theoretical-practical action and of the anti-institutional movement over forty years later.
The "recovery" construct was itself a challenge to medical-biological reductionism in psychiatry, since it appeared possible, through it, to oppose the active role of the person, the importance of factors associated with his/her concrete existence, his/her empirical givenness, such to influence the course of his/her psychopathological condition not in a mechanistic and extrinsic, hetero-determined way, but through the significance of said factors within the world of an individual subject. Precisely because they are identified with this world, they must be contextualized, and so become founding elements of a reconstruction of subjectivity.
The emphasis on factors and determinants that are internal and external to the person, subjective and social, versus naturalistic factors related to the "disease", is combined with the need to obtain answers to a whole set of needs and, simultaneously, to demand rights, in a process that sees the "sick person" as an individual and collective subject, protagonist of change in services, culture and knowledge.

> The task of today's psychiatry would therefore seem to be that of refusing to seek a solution to mental illness as a "disease", but working to approach and consider this particular type of patient as a problem that – only because existing in our social reality – may represent one of the contradictory aspects to resolve which new approaches and treatment facilities should be set up and invented. (Basaglia, 1967, p. 420)

Basaglia's statement, therefore, calls into question the issue of the interpretative models of psychiatry and the very concept of disease, which has never been, and clearly is not yet so today, protected from criticism.
The issue of paradigms was again revived strongly in the recent international reflection (Bracken, Thomas, Timimi et al. 2012; Priebe, Burns, Craig, 2013; Mezzina, 2005; 2012a). The reductionist neurobiological, "technological", paradigm which is connected to the medicalization of daily life

and to the various forms of "biopower" (see Foucault), has re-proposed invariances as founding principles of the scientific knowledge within a framework exclusively centered on the positivist vision of the sciences of nature, without taking due account of the crisis of scientific models inspired by the knowledge of complexity (as in the works of Von Forster, Prigogyne, Morin). Psychosocial aspects such as relationships, values and systems of beliefs, different practices are, in this logic, an afterthought if not openly disavowed. The wider definition of bio-psycho-socio-cultural approach seems to line up these different fields, but while recognizing the interaction, it does not return a meaning to us, in any case.

From a theoretical perspective, the criticism of disease models, and particularly of the construct of schizophrenia and its heterogeneity, has now pushed the reliability of this, as well as of psychiatric diagnoses in general, to a critical limit (Bentall, 1990; Boyle, 1994; Buchanan , Carpenter, 1994), and similarly there has been a normalization of experiences such as hearing voices (Romme, Escher, 1989; Coleman, 2011), up to the attempt at reconstructing a meaning in the experience of madness (Geekie, Read, 2009; Read, Mosher, Bentall, 2004; Bentall, 2003); while there has been considerable advancement in the reflection on the limitations of the biomedical model (Rose, 2006; Whitaker, 2010) affected by the creation of a system of expectations, and related economic interests around pharmacological treatments.

2 The disease and its double: the recovery from the institution

As regards recovery, the known follow-ups of schizophrenia, starting from the early studies of the World Health Organization (Sartorius, Jablensky, Shapiro, 1977; World Health Organization, 1973; 1979) and the debate on chronicity as a "social artifact"(Ciompi, 1984; Harding, Zubin, Strauss, 1987) have shown that, among multiple factors, those institutional in nature are undoubtedly of paramount importance: the way how the disease is treated and how the patient recovers his/her social life are the preconditions for clinical recovery and social processes. According to Basaglia, the criticism of the disease that overlaps madness and the person who lives it, as dictated by psychiatry when it imposes itself as an objectifying medical science, is the heart of the matter.

> Just as medicine has been built on a dead body, so psychiatry was built on a dead mind. By analogy, we could define psychiatry as 'mental anatomy'. So, psychiatry has entered the same field of medicine: the behavioural disorder has been included among the disorders of the body, body and behaviour have become the same thing, and similarly body disorders and mind disorders have become the same thing, both within the positivist logic of the cause-effect relationship. (Basaglia, 2000, p. 61)

He continues: "The disease has been made to coincide with the behavioural disorder, organic body and social body have been homologated. Both the sick organic body and the sick social body cannot express their sick subjectivity. Instead, they express their objectivity of sick things" (ibid, p. 173).

This disease is not only shaped by the institution, as sociological and psychiatric studies have described (Wing, 1962; Goffman, 1961), but even its institutional double emerges as the effect of the reduction of the human within the imposition of rules and powers.

> The double disease is the transformation of reality (experience) into an ideological reality, that is to say practical-ideological parameters used to destroy the experience and take it to the level of a common behaviour that is, in fact, only its double. (Basaglia Ongaro Basaglia, 1971, p. 178)
> It is through this process of rationalization and organization of needs that the individual is deprived of the opportunity to possess himself (his own reality, his own body, his own disease) [...], but lives his place in the world as a sick entity; which means that he lives the passive role that is imposed on him and that confirms the rift between himself and his own experience. The disease becomes ill behaviour, false relationship that replaces a non-existent relationship: occasion and confirmation of domination. (ibid, p. 180)

Today we wonder if, outside the totalization of the asylum, a theme still exists that pushes us to think of an institutional disease, a double to be unveiled; or if the acceptance of the medical ideology of illness is an indisputable fact, from which then we may define critical practices.
While the scenario of the asylum was about to be liquidated by law 180, referring to the new medicalization of psychiatry, Basaglia wrote:

> Keeping this connotation of sick person, the individual who suffers from mental disorders is included in the positivist framework of medicine, so that behaviour is homologated to a body, and therefore the notion of disease is confirmed in a new way, recycled." (Basaglia , 1980, p . 480)

There is an extremely deep point here, that Basaglia and the anti-institutional movement had already identified then. While the individual fights to get rid of the double institutional identity in all its implications - psychological and of deprivation of power -, there must be a radical repositioning of psychiatry and medicine with respect to him: a de-institutionalization of practices, knowledge, roles, players, institutions and healthcare, legal and social circuits. Similarly, the recovery does not look at the disease, but departs from it; it only incidentally has something to do with an "awareness", and even less with a "consciousness of disease", and instead has still to start from a sort of internship within the various forms of institutional relationship that are posed today in the world of psychiatry.

3 Movements of subjectivity and limits of personal recovery

In order for any possible healing to be true, we can first of all agree with Basaglia that we must abandon the notion of total delegation of the body and mind to the technicians and the institute that treat the disease together. This coincides with the re-emergence of a "subjectivity issue" that undermines the model of disease and its coded treatment. Namely, the change of the caregiver, its loss of identity, its impossibility to be identified with the old psychiatric asylums and with the social control they ensured, becomes the possibility that the treated individual sets himself free from the uncertainty of the dominating relationship (Basaglia, 1979, p. 470).

> We want to change the pattern that makes the patient a dead body and strive to transform the dead mental patient in the asylum into a living person, responsible for his own health. (Basaglia,

> 2000, p. 74)
> Certainly one of the most important therapies to fight madness is freedom. When a man is free, possessed himself and his life, it will be easier for him to fight madness. (ibid, p. 89)

Here the idea, that will belong to the notion of recovery, of recovering a responsibility for one's own health within the globality of life, is combined with the goal of emancipation and recovery of power, that Basaglia, even with limitations and cautions, posed. "It is obvious that a schizophrenic is a schizophrenic, but above all he is a man who needs love, money and work; he is a total man, and we must not respond to his schizophrenia, but his social political being" (ibid, p.115). The contradiction "between what we are and what we would like to be", between a denied individual and his objectification in the positivist and reductionist vision of disease, re-interpreted within the semantic horizon of recovery, can be the engine of that struggle for the affirmation of a subjectivity towards the objectivity of the medical condition, ratified by the institution mentioned by Basaglia (ibid, p. 22).

Since it is subjected to a process of nullification, within that objectification, the expression of subjectivity is in itself a manifestation of resistance against the institution.

In these multiple senses, the deinstitutionalization has produced the visibility of the suffering subjects, inside and beyond the disease. They finally appear as concrete individuals who take part in social relationships, seeking to thwart fates of exclusion. We believe that only starting from this therapeutic and care practices can be organized, based on the entirety and integrity of the person and his/her body, in real life (whole life).

The notion of recovery is based on the recognition of the importance of elements and factors associated with one's subjectivity in repositioning his/her relationship not only with the disease, but with life. Therefore, it is primarily a construct of the individual, a personal fact, and, as such, it is a non-linear and multidimensional process or path (Mezzina, 2012a).

In "personal recovery", as opposed to "clinical recovery" (Slade, 2011; Unger, 2010), the person *himself/herself* remains a determinant of the process through his/her capacity of self-determination, resilience and coping of the disease, but also through personal change and the simultaneous acceptance of responsibility.

However, recovery, or healing, cannot be seen only as an individual path, as this would again underlie an ethic of individual redemption from a condition, the disease, still seen as a guilt - not unlike how rehabilitation can simply be re-education in the language of power.

We can state and maintain, apart from the correct emphasis on singularity and subjectivity, that recovery is also and above all an interpersonal and social fact. Precisely because it regards the individual, it lies in the globality of the living experience within a given social and cultural context.

4 The issue of factors extrinsic to the individual

The question of the significance of social factors immediately arises. These have often been described as "determinants" by the epidemiological-statistical term (Marmot, 2005). Basaglia wrote: "Recoverability has a price, often very high, and is therefore an economic and social rather than a technical and scientific fact" (Basaglia, 1969, p. 76).

In this sense, he viewed healing as a class fact: there is a number of personal, family, environmental factors that allow for healing and recovery, if the prognosis is favourable.
This does not happen if basic needs are not met: "We cannot understand what disease as long as the primary needs of men are not met" (Basaglia, 1975, p. 369). Even outside the realm of mere survival, material resources and tools for inclusion are obviously necessary, but not sufficient in themselves in the path towards autonomy and improvement of the most objective components of the quality of life (Borg, Sells , Topor et al., 2005). Money, a home, a job are essential vehicles for recovery, because they represent opportunities for the reconstruction of one's identity and social bargaining capacity. "He who does not have, is not" – recalled Basaglia. To confirm this link, we should at least mention the association recognised between employment and healing rates, and the consequent discharge from psychiatric institutions in the course of the twentieth century (Warner, 1985).
However, the question of the subjectification of social factors arises immediately afterwards, of how they affect a subjectivity that is recovering, that is to say, how extrinsic factors relate to intrinsic factors, although the theories of recovery divide them in somehow mechanistic manners sometimes (Jacobson, Greenley, 2001).
In defining how social factors prove subjectively useful one must, on one hand, work around the probabilistic-statistical construct of "determinants" and, on the other hand, bypass the sociological and controversial construct of need. The recovery process should find answers to needs, but – as Basaglia recalls – these needs are always mediated by the social organization. People do not express their needs, but that which they introject as a need (Basaglia, 1980, p. 482). This, however, contains the contradiction between the individual and the constructed nature of the need, and its political and collective dimension.
Considering the process of deinstitutionalization organised in individual paths, Franco Basaglia wondered how he could differentiate between the tools and resources made available after disassembling the asylums in their individual situations. It was precisely the subjectivity of people that gave them a meaning that was from time to time specific, identified in life projects, through the things they could implement in terms of opportunities and alternatives, starting from the example of the economic aid (cf. Basaglia quoted in Gallio, Giannichedda, De Leonardis et al., 1983, p. 39). This raises the importance of the subjective factor or of subjectivity itself; i.e. how aid factors are subjectivized or become subjectively relevant factors (Davidson, Strauss, 1992).

5 The dialectic between health and disease in everyday life

In this discussion, beginning from the emphasis placed on obtainable and accessible resources, it should be recognized that the dimension of daily experience stands out as central, in spite of the poor attention received by the services when compared with the attention paid to symptomatic behaviours, as happens in the field of research. Here, it is a matter of recognizing the scope of life's practical issues: how individuals experience situations, face obstacles and challenges, and adapt their goals and ideas along the way, in a creative way. Not unlike what happened and still happens in total institutions in the terms described by Goffman (1961), the crucial requirements to be met for a recovery of the material conditions of life outside the institutions are: a job and an

income, a house, social life, daily life and its routines; and we must also consider the role of chance and events as opportunities for change, for new interests and new emerging meanings (Borg, Davidson, 2008).

It is exactly in the everyday life dimension that we should search the probable essential contradiction of the recovery process, which is Franco Basaglia's greatest challenge to the thought and practice of medicine: "healing" must not exclude or cancel suffering, but recognize it as part of the human experience, within a process of recovery and reprocessing.

Reciprocally, if we look at the disease, healing will be included in it, to dig the space of life out of it. That provides ground for the option not only of healing "from" the disease, which is inherent in the medical discourse, but also to recover "in" the disease (Davidson, Roe, 2007).

On the other hand, "a life despite symptoms" was one of the great teachings of the school of deinstitutionalization. People, even within a disease or a ratified diversity, could live in the community, long for a normal life, be entitled to receive a response to primary needs and relationships.

According to Basaglia, the peculiar aspect of human beings is that health and disease are in a constant dialectical relationship with one another. These constructs - health and disease - certainly relate to each other within a framework defined by a "rule", which is explicitly expressed in terms of participation in productive life.

In this sense, Basaglia took us back to that constitutive component of healing from a social perspective, which is repossessing one's life:

> That which is commonly intended as healing is therefore together the expression of the patient's acceptance of his condition of being defrauded and dispossessed of the possibility of living the disease dialectically, and consequently one's body as experience. The medical ideology and practice contributes to deepen the fracture, support the alienation of the self as a value, and technically confirm them as the main condition beyond which lies health. (Basaglia, 1975, p. 377)

6 Recovery as participation and citizenship: the passage from needs to rights

This re-appropriation of health cannot really take place as an individual fact, but is something that belongs to social and political processes and changes. The entire deinstitutionalization movement highlighted the need to cross the participatory dimension of the transformation process. Similarly, reconstructing, understanding, enabling the connection between the Self and collectivity, between own and shared, is also one of the most fascinating aspects of the question of recovery.

In this sense, the same participatory dimension, when posed with evidence, indicates that the person is emerging from isolation, from the rupture of meaning and language that results in de-socialization.

For many who have experienced suffering, socialization remains a difficult and precarious balance to reach with independence and sometimes with solitude as a choice. What is then the meaning of recovering a social life? Some mentioned a "lived citizenship", as the unveiling of the intimate

social nature of even the most personal recovery (De Leonardis, 1990; Mezzina, Borg, Marin et al., 2006).

Social integration, intended as adaptation to reality, seems rather linked to a sort of pedagogy of the social game, where it is essential to learn the ability to decode it and grasp the complexity of its multiple levels. We should, in fact, understand what is the relationship between recovery and unlivable conditions or oppression, which are the prerequisites of any "coming out" of madness. Healing often takes place within antinomic pairs: either to accept society in terms of values and prevalent ruler or antagonize it, to opt for an individual change or pretend the change of micro-contexts, such as the family, to favour the evolution of existence or counteract the course of the disorder.

Another issue is which contribution individuals can give to changing the rules and dominant ideas precisely on the contradiction between health and disease, for example by breaking the disability (disease)-stigma nexus. This, on the side of those who suffer, means a work of dis-introjection of deviance, in abandoning the role of the sick person.

Similarly, a post-reform stage was necessary, a reformulation of the theme of the needs and the response to them, as it was laid out by Basaglia, in terms of citizenship rights (Dahrendorf, 1989). The conceptual frameworks most frequently used in guidance documents on the topic of recovery (Le Boutiller, Leamy, Bird et al. 2011) include, as a background, exactly the promotion of citizenship, intended as support the reintegration of people in the society as citizens – i.e. rights, inclusion, employment – but not separated from a change in the services, globally (“whole system change”).

This is why it is important to grasp the link between alternative psychiatry criticism practices and the new leadership, empowerment, the entrance of the users of the services as collective subjects, on the policy scene.

Even in official documents (World Health Organization, 2010b), empowerment is depicted as a multidimensional social process that determines changes in the lives of individuals and in the circumstances of their health.

That is why we prefer mentioning recovery *and* "emancipation", because we want to emphasize the aspect of non-freedom that is related to the disease condition as personal and social misery, to the loss of rights or prevention of the access to socially usable resources, and therefore to the effort that must be made to "reassemble".

Today all this remains confined within the specific field of psychiatry and within the research for sectorial rights, although it represents one of the different forms of social exclusion, something still experienced by individuals who belong to an "oppressed minority" (Rotelli, 1992, p. 94). For this reason, society, starting from its dimension of community, must be mobilized and crossed with transformation with a strategy that includes a two-way movement, a dialectical movement (Davidson, Mezzina, Rowe et al., 2010).

7 Services as catalysts of opportunities and resources: deinstitutionalizing the therapeutic relationship

> Any type of organization that does not take into account the patient in his free personal way of inhabiting the world will fail its purpose, because it will act on that subject as a negative force, even though seemingly aimed at his healing. (Basaglia, 1965c, pp. 289-290)

Crucial questions arise here: if it is true that recovery as a personal fact (if not even strictly individual for some) may occur outside the codified systems of care, what is its relationship with micro and macro social contexts? What is the role of the services in this regard, if they are usually organized around the disease?
In contrasting the damage produced by the institutions and all the iatrogenic effects related to the "therapeutic" sphere of action, what should we ask from the services so that they may facilitate recovery - the re-acquisition and recovery of the self? Apart from a mere technical role, can they play as mediators and act as agents for that emancipation of the subject?
So we may talk about, in this sense, a "de-institutionalization of the therapeutic relationship" connected with the recovery of the decision-making power of the person on his/her own life, as we said. Through a passage from the domination/control relationship to care and the therapeutic relationship we have not only seen a change in the balance of power, but a possible relationship was defined in the place of the diagnostic objectification that excludes it, while the globality of the person was rediscovered beyond exclusively technical reading operations (Mezzina, 2012a). Once again, this corresponded to treating the other equally and with reciprocity, "as if" he or she were totally capable of living according to the rules of the relationship, even though a limit is often placed that prevents this operation of "breaking the rules or the roles" from being completed (Topor, 2001).

8 From the institution as a meeting ground to the "outside": the challenge of recognition and power

Basaglia insisted, as we have said, on giving the patient the opportunity to speak: "It is the content of experience that should be transmitted" (Basaglia, 1980, p. 484). The power of the narrative of recovery is, as has been said, an "I say", where the word is back in the mouth of the subject who lives the experience, who looks at it again and defines it by himself in terms that differ from psychiatric categorizations.
A central theme of Basaglia's reflection has been putting the disease in brackets, a Husserlian epoché that may perhaps pave the way to that contact with the suffering subject that, in the final stage of this reflection, becomes an event outside institutions (Basaglia, 1967, p. 411).

> It is only in this direct contact, without the mediation of the disease and its interpretation, that the subjectivity of those who suffer from mental disorders may emerge: a subjectivity that may only emerge in a relationship that, eventually out of the objectifying categories of positivist psychiatry, whose most concrete result has been the mental hospital, manages not to lock the abnormal experience in a further objectification and preserve it linked and closely connected to the individual and social history". (Basaglia 1980, p. 472)

And here we are again in front of the almost obsessive question whether that contact advocated by Basaglia since its earliest writings is really made possible in the de-institutionalization or if it only remains an idealized contact, as he feared: "In order to cope with the disease, we should be enabled to deal with it outside the institutions, not only outside psychiatric institution but outside any other institution that has the function of labelling, codifying and establishing. But does an 'outside' where we can act before institutions destroy us exist? The face of the disease that we know is always 'institutional'"(Basaglia, 1968, p. 516).
As a pre-condition, we should ask: "Who listens? What is his/her power position with respect to the individual who speaks and to what extent does this power determine the meaning of the word?" (Ongaro Basaglia, Basaglia, 1979, p. 433). There must be a mutual recognition with somebody who takes the risk and makes his/her power available. According to Basaglia, this reciprocity implies that the therapist is challenged by the patient, as well as the patient is challenged by the therapist, so that each one is recognizable by the other: "Therapy makes sense when there is a reciprocity between the patient and the doctor "(Basaglia, 2000, p. 41).
Even in the invention of new institutions and new situations, we cannot escape the contradiction between suffering subjectivity and institution only by denying it or transforming it, and even reinventing it (Rotelli, 1993).
We should conceive of a service where a complex interaction is created to mix the suffering, or the disease itself, with life, through situations and contexts of experience, examples of which can be the services opened twenty-four hours a day, to the extent that a Mental Health Center proposes - as someone poignantly defined it, a "healing-oriented unstructured environment" or a social habitat (Rotelli), but also art workshops, cooperatives and all the transitional spaces that move towards a wider social field - an "outside". There is therefore a need to act and transform things, spaces, places, in addition to relationships. "The decisive force of interpersonal relationships is meaningful and effective only within the modification of a reality that cannot live only on interpersonal relationships, but needs work, activities, matters, concrete modification of culture or nature" (Rotelli, 1993, p. 109).
In other words, it seems essential to us that this process of redefinition of the demand for care, of decoding and therefore de-institutionalization of the disease itself (Rotelli, 1990, p. 73), takes place through experience and in the conditions posed by reality itself. Within them, the person can walk his/her path, if the service is capable of necessarily taking its share of positive risk on the person as a whole, on his/her abilities, on his/her health in the dialectic interface with the disease.

9 What can healing and recovery still say to us. Provisional conclusions

Control and social exclusion will still affect that field where both the caring and the healing process move. If exclusion predominates, freedom stands out as a priority requirement, as a precondition of recovery as full citizenship, which cannot be given otherwise. In itself, disease is described as non-freedom and non-choice, as the trap of subjectivity, and then recovery cannot but consist of a process of opening of a range of possibilities that enable the suffering subjects to see their hopes come true as a promise, or rather, as a right for everybody - including those who keep feeling bad - to a different management of their disease.

Perhaps, thanks to the research and experiences around the theme of recovery, we understood that this disease-object, today still revealed as a precarious construct, constantly changes over time and more than a course it is a process, an irregular and jerky process that occurs in parallel with life, with its facts and lived experiences, with changes and significant social transitions. In this longitudinal, irreversible vision of one's biography we already see a concept of historicity of the existing that refers to the recovery as a self-narrative that materializes for the first time, that is as a reflective awareness of one's path, collected by witnesses who are the peers, the significant others, the operators.
This is the reason why we must help the person interpret that meaning as a transformation project (Impagnatiello, Mezzina, 1992). The reconstruction of this flow of meaning is part of the process through which recovery takes place and manages to recover and even re-include the disease without "making it see reason". This brings us back to Basaglia's latest theoretical elaborations:

> Disease and abnormality, like any other human contradiction, can be used as a means of re-appropriation or alienation of one's self, therefore as an instrument of liberation or dominion. [...] The significance of each action is determined by the value we recognize to man and the use we want to make of it, hence we infer the we will make of his health and his disease, of his normality and his abnormality. [...] If the value is man, health and normality cannot be the norm, because the human condition is that of being healthy and ill together, normal and simultaneously abnormal. (Basaglia, 1975, p. 380)

In this framework - the notion of recovery/healing - the two aspects of the "clinical" and the "personal" seem to us to be amenable to a systemic reason, which is that of being operator and patient, respectively. Together, they actually confirm a dominant culture that sees the world of psychiatry, namely the institutional world, and the social world, i.e. the world of people and their communities, as separate and incommunicable, with the former trying to dominate, interpret and control the latter.
Rather, a vision of recovery - in the wake of Basaglia - should include both these poles in a dialectical process of transformation of the observer and of the observed, where the visions and proposals of both - the therapeutic and life - engage in a confrontation, a full contact match that will deeply transform both of them. And this will happen while considering and in the awareness that the definition of the institution as reality/ideology embraces both. Therefore it is not healing, but the transformation of this relationship that we still deal with today, as an opening of new balances of power and opportunities of existence for those who suffer and as a precondition of the care work.
The ultimate goal of our action will still be, although in ever new and different ways and through changes in the social and political world in which we live, trying to free one's subjectivity from the objectification performed by institutions, also intended as organizations, micro- and macro-social systems; or perhaps transforming the latter in the hope we may change the conditions that prevent us from being fully human.

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