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(a cura di)

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A Biopolitical Approach to Mental Disorders Through Three Literary Testimonies: Alda Merini, Lori Schiller and Diamela Eltit

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dedicated to Drosilla Spazzi

1. Introduction

The onset and spread of the social and political debate around mental healthcare policy originated last century, approximately between the 70s and the 90s. Such an intricate debate went on in many different civilised countries all over the world; it mainly concerned how a 'theoretically' developed country would take care of her citizens afflicted by mental disorders.

Undoubtedly, it is not the right place here, nor the aim of the current paper, to outline exactly where and when the debate occurred in detail, neither to analyse the terms of the socio-political confrontations on the subject. Suffice it to point out here that a relevant extensive change in diagnostic and therapeutic protocols took place around the same time in many psychiatric hospitals all over the world. The changing protocols led to an overall paradigm shift in the field of psychiatry, not just in a purely clinical sense, but also with a practical impact on mental health policy in several countries. Furthermore, such an extensive reorganisation encompassed varying radical linguistic implications by way of promoting a politically correct language use on the subject, in order to foster the overcoming of diffidence and suspicion to-

wards psychiatric patients in different societies. Regrettably, the long-awaited change in social attitudes has struggled to come to the fore, until today.

The aim of this study is to explore that linguistic and social revolution in the matter of psychiatric treatment protocols by analysing three diaries written by three female patients locked in three psychiatric hospitals between the 70s and the 90s. Undeniably, we cannot consider these diaries as proper reliable testimonies for the purpose of our analysis, since each narrative is a mere 'reconstruction' of intense human and psychic experiences. Thus, it would be quite an impossible challenge, for anyone who personally experienced such a tremendous circumstance, to give a trustworthy, lucid report. It concerns long-forced hospitalisations, compulsory isolations within a psychiatric hospital, time marked by psychotic attacks alternating with periods of strong sedation: a person who suffered from these kinds of deep traumas could not possibly describe them in an objective and emotionless way. In all three cases, in fact, the re-enactment of the traumatic experience relies on some external collaborations that contribute to putting lived experiences and upsetting memories into words. Nevertheless, the three diaries combine both literary and documentary materials whereby their narrative schemes, unquestionably co-written, teem with evidence, images, feelings and clues, altogether composing an internal point of view: the patient's perspective. However, let us address the issue case by case.

2. Three different gazes from elsewhere

The first book of memories we will consider in the present study is Alda Merini's diary, *L'altra verità. Diario di una diversa*, published in its first edition in 1986 thanks to the help of Alda Merini's publisher and friend Vanni Scheiwiller. Later, in 1997, a new enlarged and revised edition by Rizzoli appears, with an introduction written by her childhood friend, Giorgio Manganelli. The diary reports the author's experience within the psychiatric hospital *Paolo Pini* in Milan, which consisted in a long hos-

pitalization between 1964 and 1972, or, to be more precise, in a broader period of consecutive hospitalizations and discharges. Before this long traumatic suspended condition, she was an aspiring poet who had published her early few poems until the hospital reclusion silenced her. Later, Alda Merini returned to her poems, publishing the ones composed during her hospitalization, and soon became a refined and recognized poet. Although she was used to the process of writing, she admitted she could not write her memories from the hospital on her own. Both in the introduction and throughout the whole diary, Merini confirms several times that her memories re-emerged as incoherent and contradictory fragments. They were confused and sometimes unbound one from the other: «memories are not continuous, spaces of confusion and forgetfulness» (Merini 1997: 58, my translation), she wrote; and finally, trying to evaluate of her own diary: «the conclusion is not truthful and perhaps not even credible» (Merini 1997: 133, my translation). Merini clearly claimed she was unable to report facts and experiences, although precisely that sense of powerlessness was to lead to the creation of a book composed of varying and unique paintings, representing different scenes of her path through tragedy. Her writing is extremely natural, her gaze is innocent, her spirit is continuously astounded by little things.

The second book we will examine is Lori Schiller's diary, *The Quiet Room. A Journey out of the Torment of Madness*, published in 1994 by Warner Book and put into writing with the contribution of the journalist Amanda Bennett. In some chapters of the book, events are narrated in the first person, while in other chapters, different points of view relate some of her specific traumatic occurrences. Hence, friends, relatives or therapist's testimonies enrich the account by alienating pathos and completing the story's re-enactment. The first psychic and traumatic episode in Lora's life dates back to 1976, and then, from the same year until 1989, she was locked away and discharged consecutively form several psychiatric centres in New York and surrounding areas. Flashes of lucidity alternating with blackouts mark the time of her memories, and a vivid critical sense, together with a subtle irony, typifies Lora's writing.

The third testimony is Diamela Eltit and Paz Errázuriz's book *El infarto del alma* (1994). More exactly, this publication is an artistic project collected in a diary form that brings together photographs and accounts written in a diary-page style. Diamela Eltit is an interesting Chilean writer, recipient of numerous international literary awards, such as the last National Prize for Literature won in 2018. The idea behind the project grew out a series of visits and interviews that the writer did to the guests of the Putaendo Psychiatric Hospital in the Chilean region of Valparaíso, together with the photographer Paz Errázuriz, in 1992. In 1994, they published their incisive report in pictures and words in order to give feature and voice to some female patients they had met and interviewed during their visits. For the purpose of this paper, we will focus on the case of a nameless woman, or n.n. (*nescio nomen*).

There is a wide range of important themes that link the three diaries which might be worth considering and reflecting on. Such as, for instance, the topic of what beauty or ugliness is, or even the self-perception of the body. In Merini's words:

> Patients' faces, to say the least, were monstrous. They had lost all feminine features; looking at them (little by little I got used to it) the witches from *Macbeth* came to my mind. […] And I, I don't know but I have often wondered how mentally ill women have such inconceivably ugly faces, and whether or not drugs produce these features, though I'm almost sure of it (Merini 1997: 32-33, my translation).

In Diamela Eltit's book, the theme of beauty and ugliness is modulated with the main leitmotif of romantic relationships inside the hospital. What kind of aesthetics leads the patients to their love affairs?

> Couples become confused to me. There is a great number of lovers. Are there lovers? Margarita and Antonio, Claudia and Bartolomé, Sonia and Pedro, Isabel and Ricardo, and so on, and on, and on. Which is the language of this love? I wonder while I am watching them […] what kind of romantic aesthetic moves them? I can see before me the stuff of disparity when they break with established patterns, I witness beauty allied with ugliness, senility attached to

> youth, the paradoxical relationship between the cripple and the squinter, the learned and the illiterate. And there, in such a lack of composure, I find the core of love. I understand, in an exemplary manner, that the beloved object is always an invention, the biggest unplanning of reality and, at that very moment, I must accept that lovers have another vision, a mysterious and subjective vision. Afterall, human beings fall in love madly. Like mad people (Eltit, Errázuriz 1994: 18, my translation).

In Lori Schiller's diary, a distressing sensation of emotive isolation permeates all her memories, as well as the long and endless days she spends within different hospitals, lost in the compliance of an imposed daily discipline. Indeed, another important theme that connects the three books is represented by the self-perception and conception of their real condition. The strong sensation of being imprisoned in an alienating everyday routine spurs them to reflect on the sense of the 'inside' and the 'outside', or even on the goal of recovery. According to Lori Schiller's ironical point of view:

> The next day was exactly like the one before, including all the same feelings, Voices and overpowering fears. The only difference was that at lunch they served spinach quiche. [...] I was a captive (Schiller 1994: 129).

That physical and emotive isolation, together with an intimate alienation within a repetitive daily routine, causes a complete loss of contact with one's own body and thoughts, the loss of the sense of being a person and not only a patient.

3. Terms of a Widespread Discontinuity in Mental Care Approach

In such a context, there is another theme that connects the three diaries and features some interesting bio-political implications we would like to address in this article. Throughout their pages,

it is possible to trace signs of how patients perceive therapeutic protocols, clinic treatments and medical approach towards mental disorders. Particularly, we will focus on their testimonials as to an evident transition that occurs between an initial therapeutic period, marked by physical containment and strong drugs, and the following renewed approach to their personal disruption. Thus, the diaries are genuine testimony from the patient's point of view of the widespread changes in the public psychiatric health policy previously mentioned. We will clearly detect a discontinuity between an ancient psychiatric approach, consisting in practices such as strong sedations, bodily constrictions or strong electroconvulsive therapies, among others, and a new method, at the very least more human, the «terapia della non violenza» in Alda Merini's words.

In order to better understand the core and extent of such a relevant therapeutic discontinuity, it is necessary to go back to retrace those signature episodes that supported the process of change. An important revolution in the psychiatric field takes origin from the publication of the results of an experimentation conducted by the American psychologist David Rosenhan. The so-called 'Rosenhan experiment' was published in 1973 on a prestigious scientific magazine and soon broadcast all over the world. The experiment consisted of testing the validity of psychiatric diagnosis in several hospitals across the US. A group of researchers was instructed to claim to be hearing voices and other typical psychotic symptoms, while acting normally, attempting to gain admission into different psychiatric hospitals. In a significative number of cases, these 'pseudopatients' were diagnosed with schizophrenia or manic-depressive psychosis. The experiment posed a challenge to psychiatric approach on the theme of mental disease and originated wide political debates in order to renew legislations in this regard.

In the same vein, in Italy dates the 13th of May 1978 the final legislative text regarding the policy on public psychiatric health, the final step of a long and intense debate, involving politics and society. The issue outbreaks from a series of photographs, taken by a French photographer, Raymond Depardon, within the San Clemente Psychiatric Hospital, situated on a little island near

Venice. The project promoter was Franco Basaglia, an Italian psychiatry reformer, with the purpose of denouncing the state of degradation in which usually were constrained psychiatric patients by means of a series of photos. A sequence of cruel, harsh pictures shocked public opinion and forced politics and the entire medical establishment to address the issue of mental patients' rights.

In various Latin-American countries, the psychiatric reform process arose from the so-called Caracas Declaration of 1990, a basic policy statement published at the conclusion of an important summit around mental health laws and policy, organized by the World Health Organization and the Pan American Health Organization. The document fixed some major principles draft as guidelines in the matter of mental health policy. In Chile, from the end of 1960s, the debate regarding the policy on public psychiatric health was particularly lively, even if the reformist movement was devoid of any political and financial support. Unfortunately, in 1973 the military coup interrupts any aspiration and hope for civil progress. The return to democracy after the Military Dictatorship in March of 1990 coincides with the year of the mental health summit and the Caracas Declaration, both contributing factors to the development of the Chilean care system and of national mental health reform.

4. The Returning Gaze

Such a discontinuity between an ancient medical approach to mental distress and the new one, echoes in the three considered diaries. The narrative of a constrictive therapeutic method experience from the patients' point of view could represent a key element to reach a more complete vision of the issue, as well as its limits and criteria. Alda Merini's memories about her internment into the Paolo Pini psychiatric hospital of Milan are dominated by a sombre atmosphere. The hospital governance violates any patient's private space, as well as restraining and repressing any forms of social life, communication and interrelation between

them. A programmatic isolation aims at keeping control on any potential disturbance of the quiet atmosphere and on the regular course of a daily healthy routine, although, theoretically, a correct human interaction was considered an essential skill to guarantee recovery and normality. During five long years locked up into the hospital, until about 1970, Merini's experience consists of a continuous violation of privacy and personal dignity, too. For instance, during the procedure for personal hygiene:

> They lined us up in front of a communal sink, barefooted on the ground immobile in puddles of water. Then they ripped off the few clothes we had (the rough linen hospital gown, the same for everyone, with two thin strings on either side that let the air totally filter through it). Later, nurses moved to soap us up even in our most private parts, drying all of us off with the same filthy sheet. The oldest ones fell to the ground for the incompetent way they treat us. Some people slipped, others hit their head badly. Every morning, faced with that sink and the horrible smell, I fainted and was forced to regain consciousness with harsh words, under the flow of ice-cold water. [...] Later, they lined us up on certain sordid benches, closed to some huge windows, and there we stood, looking down at the ground as if we were guilty of something, killed by indifference, without one word, a smile, or just an ordinary conversation (Merini 1997: 37, my translation).

All the hospital institutional attitudes and acts toward patients were similar in their deepest essence, both during the daily routine and during the official therapies' administration. Everything they did was aimed at raising a continuous stir of guilt inside patients; therefore, guilt and blame acts as moral super-structure accompanying and justifying physical constrictions. As Merini argues: «we were filled with guilt, every day; our instincts were guilt; our visions were guilt; our desires, our senses were blamed. So diminished, we only had to play, play monsters or saints, which is practically the same thing» (Merini 1997: 106, my translation).

Concerning clinical protocols and treatments, her diary is filled with references to a widespread and undifferentiated administration of electroconvulsive therapy. The treatment, consisting in passing an electric discharge through the brain to induce seda-

tion or convulsions, as known, was applied in the central pavilion of the psychiatric hospital, a place converted into a true hell in patients' imagination. Furthermore, it was indistinctly administrated for serious mental disruptions, as severe depressive disorders, but also to persons only disturbing the quietness of the place. Since disturbing was understood as insomnia or any nocturnal nightmare, for example, or even certainly patients' yells and any sort of outburst, but also groans and shrieks of fear or pain, in one exemplary case, due to a patient who had just given birth to a child, and and immediately removed from his/her mother and taken to an unknown location.

The hospital governance was used to administrate only a few kinds of therapy for all sort of disruptions: they used to strap patients to the bed, initially with «iron contraptions, tied to their wrist and ankles» (Merini 1997: 75, my translation), iron-bound then evolved in clamps, and generally to keep them tied up for days to take out or release their anger. Experimental treatments consisting of drugs which could leave a person in a state of unconsciousness for days, or, for example:

> ...the treatment of Debren, ten injections a day, I could not sit, I could not rest even for a moment. [...] There were wobbly puppets all around, desperately trying to lie down, but they couldn't, just as Tantalus was tortured (Merini 1997: 99, my translation).

A hospital ward crossed by ghostly figures, wobbly puppets, indistinguishable one from the other, moving relentlessly as in a holy mythical condemnation, in Merini's eyes. Electroconvulsive therapy (ECT) features prominently in the diary. Now, modern ECT is very different, while patients are under general anaesthesia, electrodes deliver a series of mild electrical pulses to the brain, causing a brief, controlled seizure. But ECT in psychiatric treatments was used for the first time in 1938 and consisted in a strong electrical current administrated to the brain, causing a whole-body seizure during which patients might bite their tongues or even break bones. In Merini's book, there is a very intense and vivid description of the overwhelming feeling of dread in front of the man in charge of taking patients to the central pavilion, compared to an ogre. And then, the sense of hopelessness

in the waiting room, women wetting themselves, or fainting… But once, Alda Merini was taken away from that waiting room by her new doctor, doctor G. (Enzo Gabrici, she reveals his name only at the end of her diary), who will mark a turning point in her life.

> Doctor G. really helped me a lot; thanks to his non-violence therapy, gave the patient the feeling that they might still be alive, or that perhaps they might gain access to some sort of authenticity of living, to which the patient usually aspires (Merini 1997: 69, my translation).

In her life, Doctor G. will represent a great change, a possibility to return to an authentic way of life, a totally new approach to her troubles. For example, it was doctor G. who gifts her with a typewriter and invites her to go on writing poems. The sense of violence and annihilation that had dominated her until then, gives way now to a new feeling of care and identification. According to the new approach, not all patients are the same, but each one has their own fears, troubles, worries… Each disruption is now interpreted in relation to a specific history, personality, lived experiences, it means, each patient becomes a person in doctor G. 's approach, and each treatment needs the patient's collaboration. Compared to the previous pervasive feeling of guilt and inappropriateness, there is now a new sense of warm care and comfort:

> As well as in the Trial by Kafka, every day we used to put ourselves on trial, and the sharper and more intrusive our indictment became, the more we learned to be ruthless in there. But I have been trained in psychoanalysis, with its gentleness, its childhood secrets. And it helped me, in my spare time, to analyse myself, to recover and to save myself (Merini 1997: 114, my translation).

Alda Merini's writing is lucid and poetic at the same time. Her diary is formed by a sequence of pictures, like paintings hanging in certain museum galleries. For each scene, words are carefully chosen, sounding heavy and precisely evoking the actual and mental atmosphere she was immersed in. Representations are both realistic and interpretative, cruel and poetic. And between one picture and the other, there is no continuity, only empty spaces of confusion and forgetfulness, as she says, holes that a

dazed mind is unable to fill. If space and time are the logic coordinates we need, in her diary, time is rarefied, not sequential: it possesses no value. Therefore, space remains the only means to connect memories, but it is an enclosed one.

Lori Schiller's diary, *The Quiet Room. A Journey out of the Torment of Madness,* gathers voices and testimonies of friends, relatives and therapists accompanying Lori's tale related to her illness. Lori's narrative tone is often ironical, a sign of an intelligent, lively personality. The variety of the points of view serves to underline the evidence that a mental disorder is an event involving not merely the patient herself but also the entire family and environment. Here, the mental malaise is seen as a chemical imbalance affecting body and thoughts. Lori Schiller's life split between two different realities: elation and depression, always tormented by Voices commanding or blaming her. The initial therapeutic experiences in Schiller's tale echo Merini's dramatic memories. For instance, Schiller's recounting of her experience is quite similar the experience of staff people running to hold patients and contain them, and the fear and sense of real terror that grows within them.

> The big men were coming running. I could hear their footfalls pounding the stairs and halls. I could hear the thumping and grunting as equipment was being dragged into place. I could hear ice cubes rattling in a cooler. It was going to happen again. I was going to be cold-wet-packed. Cold-wet-packing was a form of restraint that was only used to calm the most violent and out-of-control patients. Most people quieted down under the influence of other methods. [...] And then came the real horror. They hoisted me onto the elevated bed that had been set up for me in [...] the hall itself, or wherever they could get set up fast before I totaled the place or hurt someone or myself. With strong hands holding me flat, others began wrapping me securely in sheets that had been soaking in ice water. They wrapped me tight as a mummy, arms and hands at my side. [...] After the two hours were up, I had usually recovered enough of myself to be selfconscious about what had transpired, and modest about my nakedness. So two female staffers would have the honors of demummifying me. I'd be freezing, wet and cramped, and feeling embarrassed, degraded and demeaned by the whole process (Schiller 1994: 139-141).

The lucid tone of Schiller's words discloses the terror she felt. A part of her mind is aware during the violent constriction she suffers; she feels pain, humiliation, shame, growing anger. And a sense of total incomprehension of her malaise. Once again, illness is guilt. Throughout the entire book, experiences of degradation, constriction and containment follow one another repeatedly:

> ...the cycle continued. Crises. Quiet Room. Threats. Calm. Then another explosion, more time in the Quiet Room, more wet-packing, more talks with the psychiatrist, more threats of the state hospital (Schiller 1994: 146).

The rhetorical recourse to enumeration, by way of sentences made of one or few words, is useful in order to reflect on the linguistic plane the repetitiveness of her daily life under the hospital control.

Many pages in Schiller's diary are also dedicated to the use of experimental drugs, strong anti-hallucinogens, together with physical restrictions, over patients reduced to a state of pure puppets, like in Merini's experience:

> Everything they did to me in the hospital was a form of control. Medicine helped contain me, but not my thoughts. Sodium amytal helped mellow my behavior, but did not tame my brain. Cold wet packs restrained my impulsive and explosive behaviors, but did not muffle all the clamor and upheaval going on inside (Schiller 1994: 147).

In Schiller's experience, we often perceive that therapies are direct to the body, to block it physically with bounds, or chemically with sedatives. But her mind is still aware, conscious that the very same nightmare is still tormenting her while nurses are blocking her body. She suffers from a continuum of constrictions and abuses, that show how the hospital governance used to acts on patients' bodies, indistinctly, but never touches what there's inside their brains, precisely the place in which troubles coexist with lucid intelligence. Once again, we have got a narration that distinguishes the body trauma and the inside one. According to the ancient clinic treatment, a patient is merely a disturbing

body to be controlled. In Schiller's clinical pathway, after many downfall and troubles, in and out of several hospitals, she finally found a doctor who proposed a new approach and therapy. Paired with certain specific drugs that influence her brain chemistry, contributing to extreme mood swings, she receives a cognitive behavioural therapy, too. The psychotherapy treatment represents an act of personalization, the way to acknowledge the patient's dignity and uniqueness. It is a training to perceive symptoms and to ask for help.

Diamela Eltit and Paz Errázuriz's book, *El infarto del alma*, is a different kind of testimony. Its writing comes from a series of visits, meetings and interviews, dating back to 1992 in Putaendo Psychiatric Hospital, near Valparaíso, in Chile. The hospital structure itself reflects the evolution of the psychiatric policy during almost a century. When it was built in 1940, it was a sanatorium, in 1968 converted in a sanatorium for psychiatric patients, and then a real asylum in 1980. Isolated and away from urban centres, since the Chilean legislative reform that marks the protocols' shift, the hospital also changes its name, and now is called Psychiatric hospital Dr Philippe Pinel, from the name of a French psychiatrist of the end of the eighteenth century.

The central theme of their project focuses on couples, on romantic affairs, on love and sex among these forgotten actors of the society. The idea of the book is a political project oriented to raise awareness about the state of the hospital residents, located in the margins of the civilised world, two hours outside of Santiago in the countryside. The book is an accurate report by two artists living outside the institution, and not, like in Merini and Schiller' books, born from the patients' own voices. Paz Errázuriz's photos capture couples of lovers as it seems they chose to present themselves in front of the camera. Sometimes in a formal attitude, some others in a rigid posture, or more natural. Photos are accompanied by a text, written by Diamela Eltit, who tries to give a different voice to each of those portrayed, framing their various personalities. Although the aim of the project is a public act of denunciation of these patients' ghostly existences, as rejected and socially excluded, the book points out some interest-

ing implications in order to analyse the shift in Chilean public health policy regarding psychiatric protocols.

Guests seem free to roam the hospital structure and the fenced yard, and free to build relationships, love affairs or affective ones. Inside that enclose the decrepit building, within the empty, arid paddock, their figures move without following a particular order. Eltit's words, accompanying photos, give shape to a willingly fragmented narrative, a patchwork composed by multiples female voices speaking about love. Eltit's attempt consists in giving a voice to those who do not have one, a different one to each guest she interviewed or with whom she talked. Almost all of them have a name, but never a surname and maybe the name indicated may be not the real one. That suggests they exist without a civil identification, outside of any legal recognition by the state. In this sense, particularly interesting is the case of a woman without a name, indicated as n.n. at the hospital administration archives. Just the fact that she has no name reveals how the hospital governance used to work before the reform started in 1990: locked up throughout many years, she lost her dignity and her right to a name. Eltit meets n.n. together with her boyfriend and listens their relationship tale through her voice. During n.n.'s interview, something peculiar happens. She starts taking her clothes off to show a scar on her body:

> …she shows us her scar, what she really shows us is the trace of her sterility, of the ancient operation that cut off her reproductive capacity forever, without her consent. Because of her insanity, her children only paced through her mind when she affirms, encouraged and contradicting her own anatomy, that recently she has been pregnant: "fatty", she says, "with two, eight months". She says it with her trousers unbuttoned and a wistful look (Eltit, Errázuriz 1994: 18, my translation).

N.n. shows a scar on her skin left from a surgical operation, the evidence of an intrusive intervention on her body. She says she has been eight months pregnant recently, with two babies. It is not clear if she has had an induced abortion or maybe, as she suggests, she gave birth in an unconscious state and then the hospital governance picked the babies up and took them away.

Her memories are confused. But then, she was sterilised without being previously consulted, because surely that woman is not able to give her consent. What rights has she to her body? What rights can person deprived even of her name have?

The ancient therapeutic policy has made her a woman with no name and no rights. They deem it necessary to sterilise her, to stop her biological reproductivity. Since all patients are considered non-productive numbers of society, say the authors, they need to be contained, spaced by civil society, controlled and, better, forgotten. Once again, the core theme is about subjectivity, the declaration of one own individuality by means of human rights and citizen rights. Until patients go on living their segregated existences as rejected subjects non-recognized by the law, their bodies too can be treated as objects. Like Merini's and Schiller's diaries, the ancient protocols are merely oriented to contain bodies, outbursts, but not to lead patients to create a subjectivity with an acceptable balance.

5. Some considerations on benchmark values and biopolitical issues

The three diaries offer us a privileged point of view, that is, the perspective from inside the hospitals of whom is receiving psychiatric treatments. Through their testimonies, as seen, it is possible to detect that in the three cases, a deep change in therapeutic and diagnostic protocols actually occurred. Slowly, maybe, by steps of transition, through periods of coexistence between the previous approach and the new one, however, the three voices tell us that something really happens during those years. What follows is a certain discontinuity from an undifferentiated approach to mental disorder, distinguishing only between stronger and milder outbursts and regardless of the medical and personal history of each patient, toward an attempt at providing a diagnosis that takes account of specific individual traits, traumas and environment. A transition from depersonalisation to personalisation.

Thus, let us analyse the terms defining this discontinuity, the criteria on which the ancient therapeutic approach was based, and the guidelines which lead the new one. Before any further consideration, it is important to remember Michel Foucault's conception of biopolitics (1976), as the whole public policy related with the field of human biology, it means, how politics intends to administrate human beings, citizens, in the matter of to ensure their lives. Biopolitics theory in Foucault's thinking is based on the concept of the Norm and Normalization, or social normalization, and involved the setting of an idealised norm of conduct from which it is possible to administrate society toward the common good through the best route, that is what Foucault calls 'disciplinary power'. The concept came to be used extensively in military field, health and education policies, among other aspects of social structure in modern societies and was reconsidered and revised later by Gilles Deleuze (1990), Antonio Negri and Michael Hardt (2001), Roberto Esposito (2004).

The concept of Normalization refers to the mathematic category of normal distribution in Probability Theory, defined as a type of continuous probability distribution for a real-valued random variable. The concept soon becomes transversal, passing from mathematics to statistic, through Adolphe Quetelet's social physics and Francis Galton's biometric studies, until the social sciences field. In Statistics, the normal matrix distribution, called Gaussian matrix distribution too, refers to a matrix-valued parameter of probability distribution as a generalization that considers the multivariate normal distribution. In its graphic representation, it consists in a symmetrical bell-shaped curve, whose mean refers to the average and the standard deviations from the mean quantifies the variability tolerated, in a set of given values around the mean. Thus, the Normal is the standard value in a continuous probability distribution and in the field of social sciences, its principle hinges on the concept of an average person, a benchmark for every deviation from the normal line.

The 'normalizing societies', according to Foucault, describe and register the average person normality range and assume it as a criterium for political activity and society administration: «the normal comes first, and the norm is deduced from it» (Foucault

2005: 63). Indeed, the average is a kind of theoretical concept, graphically represented by an area or range that, starting from the normal perpendicular line, includes the minimal symmetrical distancing zones from the reference axes. Average, or the normal standard, origins from the assembly of all those standard features, or what is technically 'normal', of the human being within a certain society. This model, or type, becomes a frame of reference for all those deviant behaviours that live on the fringe of a normalised society. Depending on the system of values of each society, deviant can mean criminal and pervert, but even in some cases, disabled people, or people affected by mental disorders.

As we saw in the three diaries, the idea of a psychiatric hospital locked up and placed far from residential areas or towns corresponds to the logic of a normalizing perspective. According to this principle, normality is located outside the hospital, and abnormality inside. In Eltit's words, the psychiatric hospital is the triumph of reason:

> The Putaendo psychiatric hospital is the result of the triumph of reason, of rational economy, whose greater commitment is to define boundaries of the property. The guests, having been already dispossessed, deliver themselves to the adventure of the other, to the unlimited amorous fascination, from the trenches of the confinement offered by the hospital circumstances (Eltit, Errázuriz 1994: 44, my translation).

Regarding abnormality, the only distinction applied among patients is between those who provoke the greater disturbance to the hospital community and who the lesser. If it is normal to sleep during the night, therefore insomnia, just like restlessness, outbursts of anger, physical or soul pains, are considered validated disturbance and treated with heavy sedations or electroconvulsive therapies to restore patients within that normality range.

Between that inside and outside, there is a non-continuous fault, an invisible and non-permeable barrier keeping the two spaces separated. Inside, existences do not need civil identification nor legal recognition; inside, people are called by their name, if they have got one, but never by their surname. Inside,

people do not have rights; they are not recognised as subjects but rather treated as objects. Inside, existence flows subjected to an everyday routine to be respected. Outside, functional societies, composed by productive members enjoying rights and duties, carry on with their normal lives according to the standard of Normality.

> I hated being locked up. Most of all, though, I hated the hospital because everyone there thought I was sick. Well, naturally they thought I was sick! If you are in a mental hospital you must be sick. That was why I wanted to get out. I wanted to get out to be normal again. There was nothing wrong with me (Schiller 1994: 80).

The normalizing approach to mental disorders was based on an aprioristic theoretical, normative classification, that distinguished between average persons, or normal types, and deviant ones. The effect of such a simplistic differentiation coincides with social marginalisation and the stigma of abnormality. In Alda Merini's words:

> The insane asylum never ends. It is a long and heavy chain that you get rid of, strapped to your feet. You will never unravel it. And I keep pacing around Milan, with this sort of weight at my feet and within my soul. Anything but the Holy Land! That one was definitively a land cursed by the Lord (Merini 1997: 97, my translation).

In such a context, how is it possible to interpret the widespread discontinuity marked by Rosenhan experiment of 1973 in the US, or Basaglia's reform of 1978 in Italy, or even the Caracas Declaration of 1990 for many Latin American countries? As we mentioned, they represent a shift in perspective, a renewed approach, more careful to performances and behaviours, that replaces the concept of Normalization, or Normality. Once again, mathematics will help us to reflect on the criterion that lays behind the new attitude, providing with the applied category of the Optimum. The Optimum value (minimum or maximus) concerns objective function and consists in finding the best available values, given a defined domain, that is, some specific input

condition or limitations. For example, in the matter of flights scheduling, the domain – the input conditions- is represented by certain variables as the number of aircrafts, flight crews, airspaces and routes available. The objective is maximum profit at a minimum cost of energies and money. In this sense, Optimum is an operative concept, connected to action, to performance, not to subjects, nor to the essence of human beings or their personality.

In the field of mental healthcare, the focus shifts now from a classification by individuals or, better to say, their stereotyped profiles, to the observation and evaluation of their behaviours, seen as performances in specific situations. This change of focus corresponds to the transition from a Normative regime, governed by the logic of Normality, to a new ethical-political approach, governed by the Optimum logic, as to say, the efficiency one. The fundamental juxtaposition does no longer consist in a distinction between normal or deviant types, but between efficient or deficient behaviours, without implying any effective and substantial reference to the category of Normality. The aim is to make efficient, or more efficient, human behaviours. And to do that, it is necessary to become free from any theoretical classification and to refocus on operational definitions of mental disturb. Once left behind all abstract and theoretical models regarding normality and abnormality, the focus shifts now to deviant behaviours, seen as deficient from a performative point of view, it means on these behavioural segments that can weaken human performances. Thus, the subject is never implicated in his totality or essence. As Davide Tarizzo explains,

> if we offer [about mental disorders] only operative definitions rather than theoretical ones, we can avoid discussing the very nature of mental disorder, and consequently developing theoretical and abstract models of normality and abnormality (Tarizzo 2013: 50).

Mental disorder is no longer seen as a symptom of an illness that concerns the very person, and the therapy is now oriented – by means of drugs or a cognitive behavioural therapy retraining –

to a behavioural optimization. Therefore, for example, the new therapy orientation does not involve any restrictions on the freedoms, that means, a higher permeability of the hospital spaces and the creation of delocalised mental health centres, in accordance with the recent healthcare reforms.

In conclusion, the three diaries offer us a special gaze on psychiatry development in recent years: as we saw, they reflect the passage from a normalizing approach, which distinguished between normal psychic type and deviant one, to an optimising one, focused on the behavioural observation through the categories of efficient or deficient performance.

6. A *politically correct language for a new ethic*

The new therapeutic trend is no longer interested in labeling people starting from a pre-established array of psychical illness or deviances but only in focus behaviours, as we said, from a performative point of view. Thence, a performative approach according to the Optimum logic does not mean that a person has to behave or perform perfectly and in the best way, but rather leads people to become more efficient in their everyday behaviours. The new performative approach implies to becoming autonomous and responsible in carrying on their lives and upgrade their skills and talents. In the meanwhile, it is essential to be fully aware of the onset of psychotic symptoms, conscious of peculiar signalling of loss of control, and ready to reach help.

Such a radical shift in a medical reference system must also affect other cultural fields. Certainly, it involved the use of language not just in specialised areas but also implementing a renovation in everyday common speech toward a politically correct way to speak, based on a more polite and proper vocabulary. For example, there is now a tendency to avoid all references to the concept of illness or disease regarding psychosis, preferably replaced with expressions like ‘mental disorder’, or ‘mental disturb’. Something similar occurred in Italian (‘malattia mentale’ vs ‘disturbo/disagio mentale’), and in Spanish too (‘enfermedad

mental' vs 'desorden/trastorno'). Furthermore, rather than 'insanity' (in Italian, 'pazzia' and in Spanish, 'locura') it is preferable to use other expressions like 'outburst', 'attack' or even 'episode' (in Italian: 'accesso', 'attacco' or 'evento psichico'; in Spanish: 'ataque', 'brote' or 'episodio psicótico'), in order to relativize and not categorize. Moreover, as to the common practice to label clinically patients depending on their illness, psychiatry tends to avoid the ancient use of words like schizophrenia, depression, neurasthenia, bipolarity, and consider them all 'personality disorders', and distinguishing among them depressive-neurotic tendencies, obsessive-compulsive disorders etc. The same happens in Italian and Spanish: instead of 'schizophrenia', 'depressione', 'nevrastenie', 'bipolarismo', the preference is to speak about 'disturbi della personalità', like 'tendenze maniaco-depressive' or 'disturbo ossessivo-compulsivo'. Finally, in Spanish, rather than 'esquizofrenia', 'depresión', 'neurastenia', 'bipolarismo', the correct lexicon prefers to select expressions likes 'trastornos de la personalidad', therefore 'tendencia maniaco-depresiva', or 'trastorno obsesivo-compulsivo'.

This brief exemplification is useful to remark that a huge paradigm shift in the field of psychiatry took place in many different countries almost at the same time, depending on a scientific evolution more than a political one. Furthermore, as mentioned, such an important reorganization involves some linguistic implications related to a politically correct use of language on the subject. The purpose was to lead society to temper diffidence and suspicion towards psychiatric patients, although we must consider the trial is still an ongoing experimentation. Tendencies to stigmatize remain entrenched and common in our modern and supposedly evolved societies. Because the problem lies in the essence of the human being, according to Alda Merini:

> Human beings are socially evil, a bad sort. And when they find a turtledove, someone speaking too softly, someone crying, they thrust upon him their own faults, and in this way insane people came into the world. Because insanity, my friends, does not exist. It exists only in some dreamlike reflections of sleep and in the ancestral fear we all have to lose our minds (Merini 1997: 123, my translation).

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