# Implications of Interior Transformation

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*"The asistencialist culture, still practiced in the country, generally based on restrictive practices, in the systematic suppression and in institutionalization, more than in the respect and the guarantee of rights".*
*Cohen & Natella*

**Abstract**

This article deals with questions related with the insertion of a health professional in a manicomial context, with the objective of working from the deinstitutialization (desmanicomialization) logic. This is a challenge that gives a glimpse of the implementation of the Healthy Habits Program in one of the wards of a psychiatric hospital. This approach is centered in the user, whose objective is to work "from within towards the outside" and demands a listening of all the voices: that of the user, of her family and those of the teams of the professionals. At the same time, it requires an interdisciplinary commintment with the same mission: the integral attention of the person who suffers his/her mental health. This mode of working turns into a *work alive in action* which produces intersectorial relations which reflect different intentions. Given these interactions, health work is done in a field of sand where tension reigns as a consequence of struggle in micropolitics. At the same time, there is an awareness of the efforts in creating and sustaining health programs with the perspective of the users´ inclusion in society.

**Keywords:** Health Care, healthy programs

**Concerning a place in the world: the psychiatric hospital.**

I am a mental health professional, with years of academic formation and also of professional practice, with years of formation in the School of Life lived in different socio-cultural contexts, with an ever present desire to work in an interdisciplinary ambience, with objectives centered in the person from the perspective of the rights of who enters a hospital as a patient and later returns to his community.

Inserted, ocupationally in a giant and many times a very inhuman manicomial structure, where these dreams clash with very strong stands of professionals anchored in paradygms (Kuhn, T.S.)[i] which has nothing to do with these desires…

From reading the clinical histories, the place where the histories of persons with different kinds of problems are recorded or removed, but such histories say little or almost nothing, besides a positive or negative symptom. It is there where the professional consideration is given, what he was taught and from this authority of the acquired knowledge, called scientific.

But it is also written from fear. Yes, from the fear that the written words become his judge and this is a risk for him.

One of the first lessons is to learn to write what must be written!

The clinical histories do not speak of the "patients!" They speak of the "clinical" look of the professional who observes one or the other "thing", called symptoms in these persons.

Persons whose conducts are "read" from this world of knowledge which developed and are confirmed behind the walls of the asylum structure. These women locked up in their craziness and those of their companions who travel in this tragic path. Lives which end up being carried[ii] away in various senses.

Life lived together behind these walls[iii], becomes "as if" (Deutsch, H.)[iv] like an attempt to answer the life of society, having a spacious park where it is easy to find religious places where to pray, paths-streets to take a walk, benches with tables where to sit and take "*mate*" with others, which does not always mean sharing. And the inevitable shop! A place that has everything! They have clothes to wear, shoes to put on, make-up to make one beautiful and perfumes to become "fragrant"… It is a monopoly! There is no competitor in this category. It is possible to find a canteen where to order "coffee with milk" or a "*milanesa* with fried potatoes", if one wishes and has money or if a relative or a therapeutic companion has paid it previously. Everything is foreseen in this place! Everything responds to the similar stereotype in this community. They are spaces thought of and created for the "patients" from a cultural model known as assitencialism, according to Cohen y Natella[v].

If we widen the view and place in context this manicomial space within the community setting, we encounter that it reveals another deep reality. The community does not tolerate to see these persons with mental sufferings in their streets, in their public transportation, in their general hospitals…

Society is afraid of these persons, they lock them up. It is enough to see the uses and abuses of mass media when a person with mental difficulty gets out of himself being in his house, where generally he lives alone, because he is alone in this world or because his family has abandoned him. In the daily language the phrase " for a sample, a button is enough" is often heard. For this as an example I bring this cut-out newspaper article taken

from the web which shows a mental health situation in the community. “*The terror of Mataderos:”insane” frightens neighbors”* in big letters, dated October 27, 2012 and the hour it occurred, 5:45 p.m.. Then in small letters, *“This is the history of the insane Hector”, a man of 34 years in complete abandoned situation who harass his neighbors with knives, among other things. Do you know him?”* [vi] These “categories” reduce the whole person at this critical moment and classify him in a sensational manner which distorts the information and induce the reader of the news or the television screen, with incredible efficiency, sustain a social stigmatization and its consequent discrimination and close up persons with mental suffering[vii].

From this same view in the context of life in community and considering the geographic location of psychiatric hospitals, it appears that they were founded in the middle of the 1800. They are geopolitically situated at the Riachuelo edges, the boundary of the city of Buenos Aires, then and at present, away from the central zone of the city.

Actually, in the presence of compulsive inminate closing and without strategic planification of these asylums, the creation of places for persons with mental difficulties was thought of based on the same logic, houses near the grand peripherall belt of the Autonomous City of Buenos Aires, the General Paz Avenue. The mentioned project did not prosper. There are some new waves with changes. The intention is to form small groups of persons living together, however the internal dynamics of some of these houses (places) seem to be copies of the manicominal ones.

It is difficult and complex to des-culturize the assistentialist culture that reigns in our times in the hospitals with specific pathological cases: restrictive practices, systematic suppression and institutionalization.

It is important, as Stevens points out to assume a gestaltic view, “become aware” [viii] of that which occurs. And what occurs? Something happens in society that fears the overflow of its citizens, therefore they are shut up. A serene, anesthetized, blinded society. The same can be said of the professionals who write about their “patients” with fear, therefore they only mention briefly on their conduct and prescribe medicine. Medical action finalized. Trimmed reality.

And the so called “patients”? They too, learn.

These tutorial institutions are schools where one learns to obey, to wait, not to question so as not to be molested. One learns to be silent, to listen without reacting and to silence the impulses to know why she is there.

The professionals also learn, there are those who learn to shout and others to be silent. A superior who shouts, a follower who shuts up interiorly raging. One learns to have “X…” a global view… Look at the forest and not see the tree, leave it to die in reclusion and in nonsense, which means empty

their lives of their right to decide, to chose, to intimacy, to be an active part of society.

The world of interned persons in the psychiatrics are also with them. We must empty our prejudices and conceptual distances in order to receive them and detect the real deficiencies that brought them to such enclosure.

An interdisciplinary approach is necessary. Interdiscipline is the great "Need"-"Looked for"- "Wanted"- "Desired"

Further than the described framework or background as an introduction till here, I want to rescue and prove that there are indices of changes and of challenges in the interior of this grand structure as signs of interdiscipline.

**Transform from within, like the yeast in the dough…**

To work from the concept of the person, as the subject with rights and rights to a life lived in community as a challenge where the Program of Healthy Habits is implemented in one of the services of this nosocome.

Be part of the necessity to rescue the interns from the concept of her person as a being who occupies a place in the institution, that one works in something and is someone in relation with another. This other could be a situation or a person…

From the logic of desmanicomialization (Cohen& Natella, 2013)[ix] approaches are done centralized in the users which generates adverse reactions in some radical professionals in their knowledge of what to do from the hegemonic model with consequences that exclude the subjects who are considered only as objects of their know-how and not subjects with the possibility of change.

The objective is to work "from the inside towards the outside", for the inclusion. This implies the attentive listening to the voice, custom and culture of the user. We do not lose sight of her symptoms, but we do not center in them. This approach has a psychosocial view. It tries to see and evaluate/think of the user within her family circle and the social context of society.

This approach require the overcoming of internal problems in the service improving the functioning itself, exact response to the demands of the users, brings with it the interdisciplinary obligation in one and the same mission.

The first task is to define how to call this population. Patients? Users? For name and family name?... the last two have been tried but to say the truth, the first reappears so many times that one is almost unaware that they return to name in an impersonalized manner: patient.

It was tried to work from the paradygm that the national law of Mental health Nº 26.657[x], but we discover many times that we are "outside this law".

To think of the users as a subject with proper name and as such with rights does not mean lack of knowledge of the reality of psychosocial vulnerability. On account of this, to begin to therapeutically treat them thinking on "from outside", one tries to professionally intervene from the remaining capacities searching the autonomy in her daily activities´ abilities, improving his quality of life, focalizing strategies in order to attain abilities to reach social integration, developing abilities in order to manage herself in society and to accede to the right to be assisted.

This is how a course (or path) of "deconstruct in order to construct" [xi] a new clinical intervention, the interdiscipline intervention. Deconstruct what we are accustomed to in order to construct together interdisciplinarily to the limit of transdiscipline.

This type of approach will allow the incorporation of different central ideas of reading (understanding) of the needs through which these persons mentally alienated are going through. The vital needs emerge for them to include and be included in society like needs to count on plans of action from the habitual, from the educational… to name some.

For this with the Healthy Habits´ Program[xii], one works in pursue of the recuperation of mental health respecting the dignity of these persons, beginning from the following objectives:

1. Promote recuperation and/or acquisition of basic habits: personal order, hygiene, health care, care of personal space, adequate conduct and others.
2. Explore and identify interests and activities that permit the users sustain their achievement in time.
3. Stimulate attitudes of self governance and an active role in caring for his person and the satisfaction of her basic needs.

For which specific modes of working together are made that breaks away with the institutional logic of confinement, like the group approach with individual and group interventions. Interventions on the environment and Interdisciplinary work with a service treatment team. The activities that were finally done were: Evaluation and intervention on the physical atmosphere; Evaluation of the population; Meetings with the professional team service. Participation in community assemblies; group approach; administrative activities of negotiation and planning together with the users, evaluation of the results. Also and in parallel form different meetings were held, like:

- *With the Executive Direction of the service*: The project is presented, a request to have meetings with the whole establishment is made: the

professional team, and their participation at the community assemblies. The request for the petition was the suggestion that in case of the need to communicate or realize an interconsultation with a professional, that it be made directly or a special meeting be called since the team meetings are spontaneous. The same happens in community assemblies, those that are done and the professionals who can come at that moment participate. In general not all the professionals participate at the community assemblies. Those who come most of the time are those from the occupational therapy, psychology and the infirmary chief.

- *With the infirmary group*: Works on the needs of the service, considers the perception that has the service dynamics from the infirmary area. One seeks to improve such dynamics and the quality of life of the users. This group suggests to work with the users the adhesion or pledge of a special nutritional treatment, for example like the case of the users with diabetes or hypertension. It calls for other meetings in order to continue to deepen and search how to solve specific problems.
- *With the group of professionals*: a meeting is called spontaneously other more formal ones but only with the members of the psychologists team and also interconsultations with social workers where they establish the modality of working, days and schedule assigned to work with the users.

The meeting is done with the users: with them the groups of reflection and work are implemented according to the chronogram of activities.

After 4 months of the application of this program we arrived with the following results:

**Users**

It is observed that at first they are surprised when they are asked how they feel, what they need to be better, what problems they see in the pavilion and in their dynamics, among others. Besides it is not only difficult for them to recognize their discomfort but also to express the possibility of change.

It would seem that they are accostumed that things are what they are, and it is alright that they be that way, like unbelieving that they voice will be listened to. It becomes natural that there are no solutions to the problems, what is lacking and the discomfort.

In the measure that they were given the space and the time to reflect, work and modify some of these things, they are seen to be more demanding of the things that they need, achieving to recognize themselves as persons with rights, desires, interests, and personal history. In relation with the established objectives it can be indicated that during this period the participants showed signs of improvement in the performance taken in some

occupational areas and a major inclination for the inclusion in groups of reflection.

The users attain to verbalize some problems for example they say that in the bathroom and showers some elements are lacking (knob of the showers and faucets, without doors in the bathroom, broken lavatory). Everyone agrees that is “horrible, without privacy”. The absence of a door or curtain in the showers: some say that they are not bothered with the lack of intimacy, “we are accustomed”, it does not bother me, I don´t believe that they look at me in a special way”. Others express with certain modesty “I choose the shower which is most hidden”, “ I feel uncomfortable, but there is no other”, “some patients are aware and they go away when I dry and am seen”. When the area of the nourishment and utilization of common spaces are considered (dining room, kitchen, living room), they say that there is very little variation in menu (food and dessert) and excessive repetition of a certain food (for example, rice). Food without flavor. In some occasions the food is raw, particularly when there chicken. They emphasize that there is no problem regarding the temperature of the food, they receive them hot or well refrigerated accordingly. They also bring out the fact that they do not use tablecloth, except on feast days. Neither do they like the individuals, because for them, it is a complication for them to take care of (maintenance and cleanliness). Sometimes silverwares are lacking, meaning spoons are lost. They don´t consider other silverwares. They fear the possibility of the use of fork and knives… they say “there are patients who can cut you”, ”there are aggressive patients”, “it´s a dining room of a psychiatric hospital” “disposable ones are useless”. They do not have napkins.

**Infirmary Team**

As far as the step to resolve the problems presented for the users: The meeting with the Infirmary was maintained and the problems presented were communicated. The way to complain to the management in charge of the nourishment was organized, so as to improve the quality of the service (food, schedules, necessary elements like napkins, trays or disposable individuals). The same things are in the charts as services which must be lent. With the possibility to send complaints to the management, the infirmary chief said that “never was it done, that whatever complain that they make are exact at the moment, that it would be convenient to do the same with the other pavilions, to avoid vengeance. On the other hand, the personnel of the infirmary, showed discomfort from a particular view: “ this happens because they are mentally ill, in other hospitals, like those of acute cases, the stewards (waiters) bring an individual tray to each patient with everything that is necessary”, “ we know that they should be served and wash the dishes, but it is not done, when we do not have personnel for serving, I call them,

and they have to come without complaining", "one tries to solve what is urgent and they get accustomed", "these things are taken up in the assembly, but later nobody does anything" (referring to the professionals)". "there are many things that must be done and adjusted and they are not done" (regarding the management), " the trays are left at night, till the following day, filled with insects".

**Professionals**

It is observed that the professionals have taken as natural some specific questions, some kind of institutionalization of the treating team as it shown from the multidisciplinary approach. As an example what is said during the assemblies which finish for being responsible to bring the information and complaints are not taken up again with the team to be given solutions, they are only transmitted to the infirmary. The slowness or the lack of replies that indicate whatever request or complaints to the different sectors of the hospital are accepted or taken as normal, for being a public institution. In questions related to nutrition and the complaints related to the chart, are considered that a joint action with other services or group of Habits will be better. With the use of silverwares, the team in general all agree, they have a negative reaction to the possibility of the use of knives. After a long discussion, they agreed to the use of plastic ones and it is important to mention that up to the present, this has not been implemented.

With regard to the interventions in a disciplinary way with the users, it can be said that, except in specific cases, the problematic approach do not generate genuine interest among the professionals.

To work from an interdisciplinary way allows us to say that it is a living work (Merhy, 2006), with the implementation of a type of manager attention as opposed to the hegemonic model centered in medicine. It searches to take care of health where the key social actors are not only health professionals, but also the users themselves. Everyone takes the responsibility of a change in the alienation situation to a healthy life.

Following Emerson Merhy[xiii], these changes, from a conduct centered in the users, imply processes that bring with them healthy actions, thus imprint new modes to generate them. The promotion of the recognition of the users as subjects of rights, moving them away of the place of subjects to the complaint or of not being subjects to certain situations that excludes them as subjects.

On the other hand, the forces that push in contrary forms is a sample of the existence of micropolitics different with those who live daily with them in the hospital atmosphere.

## Conclusion

The present article is inserted in the movement of the demanicomialization that is developed from the interior of a psychiatric hospital. This concept is conceived as the *transformation of a mental health system* (Cohen & Natella, 2013) so that the persons with mental sufferings live in the communities of origen and not in psychiatric hospitals where the logic of enclosure reigns, away from all types of community life, as social beings and active citizens in the measure that they are possible for them.

In this way, the rights of each person which is mentioned in article 7 of law 26.657[xiv] is also fulfilled.

In these hospitals tutors and over viewers seem contradictory to think of working from the paradym of the rights of the users, however, it seems very necessary to develop programs of intervention where they be the focus of what are implemented therapeutically, where they return to experience their rights to be considered in the first place as persons subjects of rights.

Merhy in his book "*Health: Cartography of Living Work*", presents a series of thesis that in some way express the interventions mentioned in this work. For example, the thesis that says "Health work is centered in the work alive in action". This work alive in action is constructed in every decision and in every effort that is imposed upon thinking of an approach from the view centered in the user and not in the professional. Be centered in the know-how of the professional means be centered in a dead work, because it does not generate health. Health understood as the state of general well being, the dead work does not generate well being and participation in the users as subjects of rights. On the contrary, they are placed in passive roles of those who cannot come out because they are categorized with the title of "Psychotics" and as they are unable to modify abilities and healthy conducts.

Work alive in action bring about the encounter of the subjectiveness, it is possible to verify this when at the group meetings the users can name and be aware of their needs and they search together modes to modify them. Therefore, they are not simply "psychotic patients" who only obey instructions of others.

The implementation of programs from the perspective of work alive in action in health produce effectively, a plus, this consists in the production of intersector relationship where the different intentions are reflected.

Because if all seek "health (or the cure?)", the modes to obtain it is put at stake to get ahead with micro politics.

It is possible to see that efforts to create and sustain programs that are not institutionalized exist centered in the rights of all persons to be and to live in a context of respect to his personal dignity. It is hoped that these programs do not depend in the oscillation of the will of party governments but in social politics and politics of mental health coherent with these

perspectives of health as a right of every human being as is pronounced in article 25 of the Universal Declaration of Human Rights[xv].

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Derecho a no ser identificado ni discriminado por un padecimiento mental actual o pasado. j) Derecho a ser informado de manera adecuada y comprensible de los derechos que lo asisten, y de todo lo inherente a su salud y tratamiento, según las normas del consentimiento informado, incluyendo las alternativas para su atención, que en el caso de no ser comprendidas por el paciente se comunicarán a los familiares, tutores o representantes legales. k) Derecho a poder tomar decisiones relacionadas con su atención y su tratamiento dentro de sus posibilidades. l) Derecho a recibir un tratamiento personalizado en un ambiente apto con resguardo de su intimidad, siendo reconocido siempre como sujeto de derecho, con el pleno respeto de su vida privada y libertad de comunicación. m) Derecho a no ser objeto de investigaciones clínicas ni tratamientos experimentales sin un consentimiento fehaciente. n) Derecho a que el padecimiento mental no sea considerado un estado inmodificable. o) Derecho a no ser sometido a trabajos forzados. p) Derecho a recibir una justa compensación por su tarea en caso de participar de actividades encuadradas como laborterapia o trabajos comunitarios, que impliquen producción de objetos, obras o servicios que luego sean comercializados.

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