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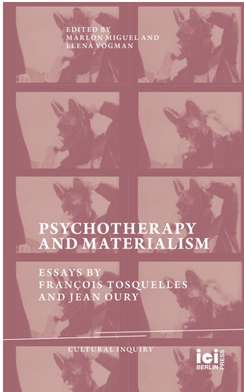

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JEAN OURY

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From Saint-Alban to La Borde

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Institutional Psychotherapy

From Saint-Alban to La Borde

JEAN OURY

INSTITUTIONAL PSYCHOTHERAPY

I am quite self-conscious about presenting 'institutional psychotherapy'; since its birth in France, it has undergone many variations — so many that its understanding is now, according to the region, according to the establishment, one of heterogeneity and full of contradictions. I will give a brief, wholly incomplete history based on my personal experience: according to the practice in which they are involved, everyone develops conceptions in their own way that become more or less theoretical after a certain number of years.

I came to the field of psychiatry in 1947 (because it is essentially a question of psychiatry when we speak of institutional psychotherapy, although its scope has been extended to other disciplines such as pedagogy or education). 1947 was still the post-war period — it is very

important to underline this: institutional psychotherapy in fact has deep roots in everything that happened during the occupation. I was in the psychiatric hospital of Saint-Alban: a hospital in Lozère, lost, isolated. Perhaps owing to this isolation, an experiment had been going on for several years: the structure of this hospital had changed in a way that was quite extraordinary for the time.

How to define, even provisionally, institutional psychotherapy? The term 'institutional therapy' was often used. It meant making the most of the existing structures in order to try to take advantage of everything that could be used to care for [*soigner*] the patients [*malades*] who lived there. 'Care'?[1] The very concept of psychiatric care [*soin*] will be challenged in the development of institutional psychiatry. This movement has developed around doctors and nurses. Hospitals generally maintained a car-

1 Translators' note: Oury uses the French verb *soigner*, which is slightly different from the English 'care' and derives from another tradition. The verb has different meanings including 'taking care', 'treating', and 'healing', but also connotes a strong attention towards something or someone. Furthermore, he and Tosquelles use the term 'sick' or 'ill people' (*les malades*), which we mostly chose to translate as 'patients'. Historically, in the French context, the two words are not interchangeable. *Patient*, sticking with its Latin origin, refers to the one who suffers and has a connotation of passivity. Also, the word implies a position in regards to the health system and professionals: a person taken in charge by the health apparatus. In contrast, *malade* refers rather to the subjective experience (and worldview implied by this state) of the suffering individual and is also someone who can have an active role in taking care of others. As Tosquelles emphasizes: 'Psychotic and neurotic ill persons [*les malades psychotiques et les névrosés*] cannot be reduced "by their illness" to human passivity, a passivity that is, moreover, quite relative, this bracketing or resting of activity and initiative that makes ill persons [*les malades*] in internal medicine and surgery be called "patients" [*patients*]' (François Tosquelles, *Le Travail thérapeutique à l'hôpital psychiatrique* (Paris: Éditions du Scarabée, 1967), p. 13; republished as *Le Travail thérapeutique en psychiatrie* (Toulouse: Érès, 2015)). Today, there is a transnational patients' rights movement that is ascribing more agency to our understanding of who a patient is.

ceral, concentrationary structure. Now, nurses had been prisoners during the war; some had been in concentration camps… When they returned, they had a different world view: their work milieu, the same as before the war, reminded them of the experience they had just gone through.

It is an event, in a person's life, to return to their prewar profession and find themselves in a similar atmosphere to that of the concentration camps! You also know that during the occupation, there was such misery in psychiatric hospitals in France that 40 percent of the patients died of starvation. All this created a fairly favourable ground for a raising of awareness not only individually, but collectively, implying the need to change something. I like to recall this origin of institutional psychotherapy: there is often too much of a tendency to dilute everything in rather abstract, supposedly theoretical things, and ultimately lose the essence of the issue. We could therefore define institutional psychotherapy, wherever it develops, as a set of methods designed to resist all that is concentrationary. 'Concentrationary' is perhaps an old word — nowadays we speak of 'segregation'.

These structures of segregation exist everywhere, in a more or less veiled way. Any build-up of people, be it patients or children, in any place, develops, if one is not careful, oppressive structures simply by being in a group with an old-fashioned architectural and conceptual framework. *Institutional psychotherapy is perhaps the act of setting up all kinds of mechanisms to fight, every day, against all that could turn the whole of the 'collective' toward a concentrationary or segregationist structure.*

The problem of the mentally ill is still burdened by a lot of prejudices (despite the progress of Mental Hygiene, which tries to present the mentally ill in a more humane way). One has only to open a newspaper to see how the

mentally ill are presented: as extremely dangerous people, as needing to be kept locked up. Yet, statistically, they are less dangerous than so-called normal people! Statistically, there is much more crime in so-called normal society. Yet newspaper headlines proclaim: 'The madman, who escaped from such an asylum, killed his mother-in-law, the police had to be called', and so on.

Also, even in the most modern healthcare structures, it is necessary to identify everything that can hinder the individuals from thriving within them: various elements developed out of this that later had to be theorized to maintain vigilance in the overall structure

I arrived at Saint-Alban's Hospital in 1947; I was an intern. The hospital had been 'humanized': cells had been abolished, and living spaces were acquired. At that time, in some other hospitals, the beds were adjoined: to get to your bed, you would have to climb over the beds of other patients; the only vital space was the dormitory corridor, there was no living room. People would stay there for years — they would meet at the foot of a staircase, or in the courtyard. So, the first thing to do is to organize a little bit of space, *a place where people can circulate a little bit more freely*.

But it's not just a question of letting them circulate 'freely' — because you quickly find that if no structure has been thought of, people start going round in circles, and it's a dead end. So, one has to create a place [*lieu*], but at the same time *devise occupations*, even the most rudimentary ones. The first effort of what was to become institutional psychotherapy was to tackle, in asylum structures, the most deprived areas; in particular, what are still called 'wards of agitated patients' [*quartiers des agités*] — there are also the 'wards of senile patients' [*quartiers des gâteux*].

It is now known that much of the senility [*gâtisme*] and agitation are actually effects, products of concentrationary life. One must have experienced it to see that agitated or senile people recover through the modification of their environment [*lieu*] and the activities they are given. The first major success of institutional psychotherapy involved modifying the wards for agitated patients, practically eliminating them.

When I came to this hospital, the wards of agitated patients had already ceased to exist. It was necessary to try to devise activities. This time saw the rise of active methods, especially in education. The reformatories were changing. There was a lot of talk about movements such as the C.E.M.É.A. (Centres d'entraînement aux méthodes d'éducation actives).[2]

Institutional psychotherapy always remained closely linked to these active education movements. This approach took psychiatric issues beyond the walls of the asylum, linking it to other fields, for example, summer camps, the I.M.P.,[3] and so on. All the doctors who later became part of this institutional psychotherapy movement did so in collaboration with the nurses. Training courses were organized to build awareness and know-how among the nurses (who had previously only been warders). In 1949, the first training course for psychiatric nurses took place as part of the C.E.M.É.A. on the initiative of various doctors (in particular Dr Le Guillant, Mrs Le Guillant, and Dr Daumézon).

2 Translators' note: Training Centres for Active Learning Methods. The C.E.M.É.A. were created during the Front Populaire period. They are a popular and modern education movement, and a training organization based on modern pedagogy principles and on the ideas of Célestin Freinet.

3 Translators' note: Institut médico-pédagogique (Medico-Pedagogical Institute).

These training courses took place several times a year, bringing together from fifty to one hundred nurses from all over France. In the long run, this led to a change, a raising of their critical awareness. The C.E.M.É.A. courses were something extraordinary. They lasted ten days. The nurses would come, for example, to a C.R.E.P.S.[4] Even if no particular technique was learned, the fact that people from about fifteen different hospitals would group together for ten days, the fact that each shared their own experiences in conversations, and that they understood that there were similar problems in hospitals other than their own, was enough to shake up habits. Some of them underwent something of a revelation, a crucial awareness that would change their lives. This does not mean that they could apply what they had learned! When they returned to their hospitals, they found themselves to be a minority that was bogged down in traditional structures — and sometimes this brought discouragement, depression. In the training courses, there were lectures, discussions, and learning of activity techniques — both group and ergotherapy.

Why am I recalling all of this? It may seem a little off topic. However, in talking about institutional psychotherapy, it seems to me important to think about all this, because we can do absolutely nothing in a hospital if we do not change something, not in the raw material of the architecture or the activities, but in the *consciousness* of the people who work there.

Now, this change does not happen in eight days, or in a year, or in ten years. It takes a very long time for nurses and doctors to become aware, and for that awareness to be *effective*. It should not be rushed. It's a bit like psychoanaly-

4 Translators' note: Centre de ressources, d'expertise et de performance sportive (Centre of Resources, Expertise and Sports Performance).

sis: you can't do psychoanalysis in eight days, it takes years — it works, or it doesn't work. As far as training courses are concerned, many have worked. But this has developed a kind of collective intra-hospital resistance to colleagues who went on these courses (even now, in some hospitals, one hears reflections such as: 'You went on holiday, you're going for a walk, you're a lazy bum, what does that mean, training course?', etc.).

But institutional psychotherapy can develop only if there is this progressive raising of awareness, attended by all kinds of difficulties, even at the level of the nurses themselves. This has brought significant benefits. It was also requested that the 'stewards', the 'heads of wards', 'administrators', and all the people who were involved in the status of the establishments participate in these meetings. The rigid structure of these establishments prevented the creation of places [*lieux*] where people could meet, talk, work.

This short introduction should not be forgotten, in order to give sufficient weight to what can be said about institutional psychotherapy. Ten years ago, I certainly would not have thought to mention all this. I might not have talked about the C.E.M.É.A., or the concentration camps, or the level of work of the nurses. But it's becoming a necessity, given everything that's been said and done under this term. To situate the issue better, I will mention a more localized experience: that of La Borde clinic in Cour-Cheverny.

FROM SAINT-ALBAN TO LA BORDE

I started this psychiatric clinic in 1953. At that time, there was no psychiatric hospital and practically no other clinics in the Loir-et-Cher department. We had to absorb everything related to psychiatry in the department. One clinic

with only a hundred beds was absolutely inadequate: the situation was very difficult and unfavourable, but at the same time also a very privileged one. Given the position of the patients (who were mostly refused by hospitals in neighbouring departments, such as Loiret, Eure-et-Loir, Indre-et-Loire, etc., which were overcrowded), we were forced to manage as best we could to try to hospitalize as few as possible.

Not having many available places makes things interesting: you have to make some up, be inventive! To try to treat patients without hospitalizing them, or if they are hospitalized, to invent techniques for very short or very differentiated stays. Forced by events, we are quite simply obliged to do it. Of course, because it was myself and a few comrades who created this clinic, we had a certain freedom. We were not tied up in what is called the 'administrative straitjacket', although certain difficulties, perhaps more camouflaged, reappeared — such as the problem (which we could talk about later) of hierarchy, individual specializations, and so on.

We lived with the patients who came there. It was a kind of common group. This point seems a very important one to me since, without having thought about it, one of the major obstacles had been removed: segregation. In a hospital, segregation always exists. Think about the problem of admission. Admission has nothing to do with welcoming [*accueil*]; it's often even an unwelcoming [*anti-accueil*]. In some hospitals, admission was limited to registering a sick person's name and curriculum vitae, and then undressing them and putting them into uniform clothing: a technique of depersonalization. There was no admission of this sort at La Borde because from the outset we were a more or less familial group. So there were problems such as: What are we going to do with fifty or

a hundred patients, nurses, and doctors? Of course, they have to be cured, that's what we're here for and they ought not to stay long: quite ordinary criteria… But what does it mean 'to care for' [*soigner*]? It was 1953, prior to the era of neuroleptics. You remember that, in France this era officially began with the introduction of Largactil around 1955. Institutional psychotherapy existed well before the era of neuroleptics.

Let's open a parenthesis to evoke again the wards of the agitated. Nowadays, when we talk about 'treating a ward of agitated patients', most people, most doctors, think of 'neuroleptics'. And the fact is that in many hospitals there is calm, sometimes even silence. But you have to check the doses — as if treatment of the agitated consisted solely in sprinkling them with all kinds of neuroleptics!

I'm not saying that institutional psychotherapy is against neuroleptics, quite the contrary — we even aim to develop quite original methods of prescription (both qualitative and quantitative). But taking care of people is not just about giving them medication. Even in ordinary medicine, this is clear: you don't have to be a psychiatrist to see that treating pneumonia requires a minimum of contact. Even the most physical of treatments work more or less well depending on the contact you have with the family and the patient. You have to be somewhat friendly to the people you are treating…

Thus, we asked ourselves the following question: 'What can we do with the people here, apart from giving them medication, apart from giving them treatments such as insulin therapy, electroshock therapy, and so on?' 'Leave them in peace, we ought not to bother them.' The intention is often good. However, if you limit yourself to saying, 'Don't bother them', then they will quickly bother you. Because when a patient is delusional, or

schizophrenic, or confused, or melancholic, you can't just say 'Don't bother them', otherwise incidents will occur, and you'll be forced to intervene. And if you don't think ahead, then in some weeks or months you will have to resort to the most oppressive structures (to prevent someone from committing suicide, for example).

One of the axioms we devised, then, was the following; that in whatever place [*lieu*] we are living for a certain period of time, a *maximum possibility of circulation* must be created. This axiom is often unrecognized in many modern architectural designs. When an official text states that a hospital 'with three hundred beds' should be built, can we be happy with this formulation? In surgery, this is expected, resting areas must be set up; but in psychiatry people do not stay in their beds! When someone stays in bed, one even starts to worry: staying in bed creates extraordinary isolation.

We ought therefore to insist on the need for social spaces! We are trying to introduce this axiom into architectural standards, together with teams of architects who are now familiar with institutional psychotherapy. The necessary number of square metres of surface area must be calculated and the necessary diversity of places planned… But this only makes sense if the patients are able to go to them! There are, we know, very good, very clean hospitals, with beautiful lawns, but where there is no live circulation: there are libraries, but one is not allowed to go in them, for example. We therefore have to *create places where people can go*.

This is the sense of the axiom of 'freedom of circulation'. But what does this mean in practice? There are basic facilities: a kitchen, administrative offices, a pharmacy, a library, a theatre, and so on. When we say 'freedom of circulation', we see barriers and resistances emerge. I often

use the most caricatured example of what happens at the level of the kitchen. There were dramas — many of the cooks did not cope. 'Freedom of circulation' means that patients can go to the kitchen, take care of it, and talk to the head cook. When the head cook is not prepared, hasn't done training at the C.E.M.É.A., comes simply to do the job of cooking, and then is sent 'crazy people' to... well, the cook will cry: 'They will touch the knobs, the gas, they will spill the soup on me…' The first tendency is to barricade oneself. It's normal for people to erect barricades: to close the door, to install a counter to pass dishes through, and then say 'leave me alone, I can't work', and so on. All this is for the cook.

Patients also go to the administrative office to see the guy doing the accounts, or to the pharmacy to shout at the person counting the pills. This can and does indeed create a lot of conflicts. But what is interesting, in this milieu of free circulation, is precisely the possibility of creating conflicts — not in order to annoy people, but to create life; for, without conflicts, there is no life. It's not a question of acting in a perverse way; but as soon as there is conflict, we have to take it as an occasion to try to talk about it to make relationships that are better adapted. It started out in a very simple way. We say, 'We have to let them circulate', and straightaway we notice that there is resistance. If we give in, the cook will barricade himself in the kitchen: it will snowball, and we will quickly return to the concentrationary system, the patients will have to be locked up in their rooms… We won't need to talk any longer about 'social square metres'! At the end of the day, there will be a regression.

Once we're committed, there's no going back. I remember a more or less heroic time: we had created what we called 'traps', for the cook, for example. For the cook

or for people who could not stand the intrusion of the patients into their territory. We devised something we saw as essential to adding a little bit of life to the collectivity: a sort of bar, a counter, where drinks, sweets, cakes, and tobacco were sold under the responsibility of a small group of patients. We knew that the cook would go to the bistro of the neighbouring village to play billiards or buy tobacco. We said to ourselves: 'If he has to go to the bar to buy his tobacco, it will force him to get to know the patients and not be afraid of them.' He found he was obliged to go there; we invited him to evening gatherings, to theatre and dance sessions, etc. Overcoming, eliminating fear, and dispelling this prejudice held by the layperson to enable him or her to enter into contact with the patients and accept this basic principle: freedom of circulation. Over time, this was achieved; now, it works very well... But many cooks quit!

As a result, people who work there, but who don't have an official position as a 'counsellor' [*moniteur*] or 'nurse', find themselves absorbed in a *relation* with the patient whether they like it or not, and how they respond may be of therapeutic importance. This point can be further elaborated upon by stating that *any function of any person working in a psychiatric centre is always indexed to a psychotherapeutic coefficient*. What we call the therapeutic coefficient, or rather the 'psychotherapeutic coefficient' in the broadest sense of the term, takes on a clearer meaning when we think that the way we greet a paranoid person can completely change the ambience of the day. If the counsellor, or cook, or secretary, talks to the patient in a normal way, it can change from top to bottom the person who feels persecuted, who is picking fights with everybody... It may be the cook who talks to him, the cook being neither doctor, counsellor, educator nor nurse. This factor is sometimes decisive on the psychotherapeutic level, of infinitely

greater importance than all the consultations that the patient may have in the doctor's office. It's hard to admit.

Simply sending the cook to the C.E.M.É.A. training course is not enough; there is a certain limit to these C.E.M.É.A. courses, because they are external to the establishment. You have to work the milieu, work on something that is there, on site, a kind of useless network that keeps breaking down. What I say as regards the cook, of course, has the same value for the rest of the staff. I'm thinking, for example, of cleaning ladies. I have often been criticized because when I was asked, 'Who does psychotherapy in your establishment?' in a somewhat provocative way, I answered, 'The cleaning ladies'. Group psychotherapists, in general, did not like that.

It's a good thing that there are no (or almost no) cleaning ladies anymore, so everyone has to do the cleaning. Cleaning is a noble activity. To clean a multi-bed room, you would have to be an exceptional psychotherapist to be able to talk to the people who are there, who are lying in bed. Saying to this or that patient: 'Here, we've come to make your bed' — it's not about just throwing him out of the bed! You have to be able to talk to him and say, 'Did you sleep well? What are you going to do today? Do you have to glue some paper back on there?' Or: 'We should go to the city, buy bedside lamps!' Doing the housework, which is to say, creating an ordinary everyday ambience. This does not go well with the usual standards of psychotherapy, but we have to work with what is there and this is what we have. Now, this is what there is, to be able to shape it, there are people there who are not trained, who have not obtained diplomas, but who are there all the same, and who have, whether they like it or not, a positive or negative impact on such and such a patient.

If we had the time to do a very detailed report on a patient from the day they were admitted to the hospital until their discharge, we would ask ourselves what played a role in their progression: was it because the doctor saw them so many times a week, was it because of this or that medication? Of course, all of this is important. But it may be that it was a conversation that this person had with their roommate or with the cleaning lady, or with whomever, on a certain day, at a certain moment of anxiety. It is elements like these, which might not be remembered, that matter immensely in practice. How can we turn it into an advantage?

That's when I realized that there is a bare minimum that has to be done, and this bare minimum is often very demanding: a minimum of briefings, as well as a minimum of training sessions with a very heterogeneous staff including doctors, cleaning ladies, cooks, educators, nurses, psychologists. These meetings only make sense if they are repeated; if there is a certain ritual that is part of the work. However, we know very well that, in all establishments, when people say, 'We're going to have a meeting', many people answer back, 'Another waste of time! We don't have time to clean up, or to work, or to give shots as it is!'... It's true, meetings are often an extraordinary waste of time... Because they are badly done! But we realize that by having these meetings, at ground level, by saying: 'What are we doing today? You saw such and such patient, what did he say? How was he? What did it make you think of?'; we can make use of all the exchanges that can happen in a meeting, provided there are no hierarchical barriers.

It is necessary to break down hierarchical barriers so people can express themselves; we then realize that we can save an extraordinary amount of time because the patients, who until then had remained completely passive, say things like: 'We're here to be cared for, not to work, we're here

to have our breakfast served to us in bed…'. All these arguments quickly disappear, so that we see that, based on discussions in meetings, we can create activity groups in which the patients themselves take everything in hand. We then see that among all these patients, there are people who are much more qualified than the psychologists, nurses, and so on, people who are simply asleep and just need to be woken up. These are people who one crushes if one confines them in traditional structures. They will wake up, and, at that moment, the staff (what we call the staff, meaning those who do not have the status of patients) will be able to have a slightly different function. Instead of being busy with tasks, instead of being physical staff, they will become staff who are able to think a little, they will have time to think, to organize things.

It's not a question either of going to extremes, of saying things like 'Oh, I don't work anymore, I observe, and I'm a psycho-sociologist!' That's a risk! The patients do the cleaning, and we come to see from time to time, once in the morning: 'How is it going?' That is not what it is about at all: you have to stay involved because otherwise it would have been better to do nothing. The risk of this kind of technique shifting is extremely common. For, without realizing it, you return to what goes on in regular asylums: there are the good workers. 'The good workers', you know what the good workers are. There is the ward for agitated patients, the ward for senile patients, the ward for I don't know what, and then there are the good workers. In a large asylum, there are many good workers; they do a peculiar kind of work, to the extent that if we removed the good workers, the hospital's finances would suffer greatly!

This work is very important: agricultural work, masonry, furniture making, which doesn't cost much… So, the goal is not to fall into that trap. It is tricky, it is

difficult. It is certain that if the people who are there do the work, even with the counsellors, the work will be effective. This problem must be honestly addressed. These people are hospitalized; there is no employment contract with them, and here they are working, cooking with the chefs. They can very well say, 'This is exploitation!' It is true, it is exploitation if we keep that perspective. And if we start paying them....

But we cannot pay them; we can't give someone who is hospitalized a salary. If they are paid a low wage, it will be said to be shameful! A somewhat proud person will say, 'Keep your money, I don't want to be paid a low wage for work as qualified as that of your counsellor, if not more.'

This is therefore another source of conflicts, but these conflicts are very interesting because they call into question something much deeper: the very status of the people who are there, but also their status when they were outside, when they were not ill. What did you do before — were you a cook, a driver, or did you work in a factory? So all of this will be questioned, and we will have to say we can't pay you, but still, there is something to do. We must not fall into this hypocrisy: 'Oh, but you are doing occupational therapy! It is healing you! You should even pay us to do this cooking or cleaning work in our place'... We can't go that far.

Obviously, in society as it is, there are contradictions; it is not easy. It is better to be occupied than to do nothing. It's true, it's true that by doing nothing, you become ill; you need to be occupied, but it's not mandatory. But there's everything in there, among the staff, and there are guys who still take advantage of the 'good patients'. For example, women who like to knit, make knits, skirts, whatever. They do it on the sly, like that, to such and such a counsellor, for example a thousand-Franc note is given for something one

would buy for twenty thousand. We have to watch out for that.

That's when we realize that *we can't do anything if, conjointly, we don't create a real internal society composed essentially of the patients themselves, a society which will manage itself.* This is, in my opinion, a second axiom: in collective living, it is always very harmful to live piled up. We cannot say it is not human, because it is as human as anything else, but living in a crowd creates toxins and conflicts that are sometimes entirely negative. Therefore, we must find a way to resist this. How do we solve, for example, this little problem of salary, of allowances, as it is called elsewhere?

It is not easy to create a society of patients within the hospital and for this society to manage itself, to be autonomous, because the patients are not going to create it themselves: it has to come from a certain framing or supervision [*encadrement*], from the team that is there, from the doctor. But if we do it directly, by bringing together all the patients who are willing to come and listen one fine day, and by saying: 'My friends, we are going to create a society, and you will be the ones running it, you will do parties, workshops, etc.', if we leave it there, it would have been better not to do anything at all, because very quickly that creates an extraordinarily corrupting ambience: indeed, we create a system of framing relations between the administration and the patients of a kind that is correctly called *paternalistic*. Now, you know that the paternalistic relationship is something very dangerous, something more or less reducible to: 'We're going to please daddy.'... The medical director is pleased that we get together, and then we have a bar, and we have a celebration every eight days, that we have a library, and so forth. We have to find something else. So, it seems that the cleverest thing that has been found so far is the creation within the establishments of what was

first called The Club, the therapeutic club. *The therapeutic club only makes sense if it is not connected directly to the doctor's demand or desire, it must have an autonomous existence, independent of any system of exploitation.*

Indeed, whether it is a clinic or a hospital, we are talking about a commercial undertaking: budget management and operational efficiency are necessary. How do you escape this pressure of exploitation? To try to solve this problem, societies have been set up that are part of one establishment, but depend on another organism. The most widespread or common ones right now are the Croix-Marine societies. Some people have heard of the Fédération des sociétés de Croix-Marine, a federation of Mental Hygiene societies that started in Saint-Alban in 1947, the centre of which was established in Clermont-Ferrand.

The purpose of these societies was initially to take over the work of doing 'good deeds' — it was part of charitable work, but it was to structure it better. In other words, 'What are we going to do with the poor patient who is leaving the hospital? We have to find him a job, a family placement.'… But quickly, we said: 'It's all very well to take care of people when they get out, when it happens that they do leave, but we should be able to get them out; we should therefore provide Mental Hygiene not only outside the asylums, but also inside.' There was, in fact, a paradox: Mental Hygiene was done outside the asylums, but the concentrationary structures were being preserved on the inside. So we had to try to do Mental Hygiene work on the inside.

This work faced many difficulties and resistances. During a general assembly of the Croix-Marine societies in 1953, a Spanish-born doctor at Saint-Alban at that time, François Tosquelles, officially advocated for the creation of what he called 'Hospital Committees' within hospitals.

These Hospital Committees have developed just about everywhere. But there are pitfalls here too. For example, a ministerial circular of February 1958 recommends that, in the organization within hospitals of sociotherapy, ergotherapy, and so on, Croix-Marine Hospital Committees be created. A Hospital Committee, because it is affiliated with the Croix-Marine Federation, does not depend at all on the hospital; its management is handled by the patients themselves through a democratic system of election — president, secretary, and so on. Nurses and hospital staff also participate in these committees; it is recommended to have nurses, to have administrators. They can help, but they should not have the majority.

For this to work, the Committee must therefore make a *contract,* a very specific contract, with the establishment. This contract can provide, for example, that the establishment cedes to the association (they are associations under the law of 1901, so they can make donations) this or that area of the establishment itself: a playground, a number of rooms, spaces to do workshops, and so on. But the important thing, which is often not respected, is that these Hospital Committees are able to take over the work of ergotherapy… That may seem like a small detail, but it is crucial — otherwise, it's a sleight of hand: they will say they've set up a Hospital Committee, but it's not true….

Indeed, by taking charge of all the hospital's ergotherapy, all the non-productive and productive workshops (carpentry, raphiatherapy,[5] etc.), we meet areas of conflict, bringing a certain 'ferment' into the hospital. In just a few years, the Hospital Committee went from having a small budget, i.e. a packet of cigarettes, given to the 'good

5 Translators' note: Oury probably refers to a therapy based on weaving of raffia palm.

workers' each month, to managing considerable sums. I remember that in 1947, the administration paid 8,000 francs a year for all the entertainment in a hospital with six hundred patients. And out of these 8,000 francs, 4,000 francs were needed to pay for a flag on 14 July. With the remaining 4,000 francs, we had to buy presents for Christmas — that was all we could do.

Well, ten or so years ago, the Hospital Committee raised 15 to 20 million [francs] a year — which is not bad! But it's easy to see where resistance can come from. When an entire administrative structure traditionally operates with workshops that are performance-based, it's clear that there has been some sabotage, and it's understandable that this Hospital Committee structure is not an easy thing to accept.

So, the contract had to be better elaborated. For example, it was important to acknowledge that in the accounting plan that donations were made to the hospital around 1956–57, specifically the figures related to ergotherapy could be managed by the Hospital Committee. Therefore, the Committee could officially manage the workshops, under the control of the administration.

It may be a little tedious to go over all this, but it is so important that I will do it anyway. Ignoring this connection risks degrading the undertaking, despite its advocates' good intentions. For example, in some modern hospitals we are seeing attempts at implementing institutional psychotherapy. Workshops are created, then a Club. Architects are building what have been called Social Centres. I find it better not to talk about it. I'm thinking of a hospital that has a social centre that costs half a billion… It's not bad. It's extraordinary, it's beautiful! But the patients don't go there. The people from the city are the ones who go there, famous people and others. This makes for a mixing of the

population, but it does not tally with anything; and what could we have done with half a billion… How many little Christmas presents could we have gotten with such a sum? In a word, this is a kind of degeneration of the spirit of the Hospital Committee.

And often today, when we talk to doctors, to interns, about the urgent need to create Croix-Marine style Hospital Committees, everyone laughs. They say 'the Croix-Marine, but what is the Croix-Marine?' So one doesn't dare talk about it any further. But all the same we must try to save it.

But I was getting to the point about the various conflicts that result from institutional reshuffle. *These conflicts can only be resolved if we set up an internal structure in the establishment that is constituted in a wholly different way to the structure of the establishment itself.* Most of the time, an establishment structure is vertical, let's say pyramidal: the director, the bursar, the warder, and so on, the doctor, and then at the bottom of the ladder, the good workers. It's very difficult to tackle such a structure directly, but, *if it is accepted that it is possible to create another structure, one that is not vertical but horizontal, and that does not have a sort of rigid axis, but will have many small axes, a structure I call polycentric* (centred on a secretariat, a general assembly, workshops, etc., so that people are able to take on responsibility) *we will find ourselves faced with the need to invent* workshops of all kinds, which may stay for a long time or which may disappear — that is, to invent *something very mobile, able to adapt to the demands of the patients who are there.*

We can't envisage anything when we're stuck in pyramid-like structures, not even with the best of intentions. On the other hand, the polycentric structure is the instrument for setting up a whole where opportunities

for exchanges and encounters can be multiplied, and systems of conflict can be settled. For example, at any given time, how can we respond to the demand for payment that seemed legitimate to some patients who were doing a job? 'We can't, because that would be hypocritical, we can't pay you a salary'? To pay someone and not have it be a salary, this always leaves things open to interpretation… On the other hand, we can estimate, despite accounting complications, the amount of work that all the patients carry out. It can be estimated quickly by substitution, by saying as follows: 'We would have to hire this many staff to do this; deducting Social Security costs, tax returns, etc., we can pay this sum to the Club and the Hospital Committee as a whole, which will become the Hospital Committee's treasury, fed by a collective effort.' The distribution of the money will be done in a completely different way than the individual payment of remuneration.

It's important to remember that people are there to be treated, to try to find a solution to their problems. We can thus try to set up a commission made up, for example, of nurses, doctors, and patients, for considering each case. For example, a guy has to get out, but he has no family, no job, no housing… It's a very common occurrence. We can rely on structures that we develop jointly, structures ranging from the Croix-Marine to the social service office in the town, sheltered workshops, etc. But these are only provisional measures, and they are quickly swamped. It can happen that someone needs to live for fifteen days outside to try their luck. The Hospital Committee, through this commission, can decide: 'We're going to give him or her 50,000 francs.' 'Go ahead, and in two weeks, come back and tell us what you've done.' With these 50,000 francs, he

must be able to find a place to live, food, and work. Often it works, and sometimes it doesn't.

Everyone accepts that this is a kind of solidarity fund, but the main advantage is that this solidarity fund is managed by the very group of people who are there, who know each other. This eliminates the somewhat dubious kind of charity that reappears every time someone says: 'We will help you'. The guy leaves in a much more reassured way, he knows that the money is being given to him by friends. They can also say to him: 'Just pay us back when you have the money' — depending on the case. But then the person feels far more connected when they make a commitment to their fellow human beings rather than if it's made through the administration. That's one of the advantages of Hospital Committees. But these Hospital Committee funds can also be used for a film club, such as to buy a device that improves the way of life inside the hospital, without it coming directly from the establishment management.

Why did I insist on these few examples? To try to introduce a difficult question, one underlying this formulation: *institutional psychotherapy is the act of setting up techniques of mediation.* 'Mediation' is not a felicitous choice of word, but it is the one used. It seems that the Hospital Committee is a solid example in which mediation is established between relationships that can develop from person to person, or from a collective to a person. These are direct relationships that, whether we like it or not, are often quite oppressive, permeated with prejudices. The intervention of a doctor, if only because of their role, their status, their place in society, will always be affected by a certain distortion.

We can see that we have to try to introduce something, another structure — what we call a 'structure of mediation'. If the Hospital Committee is one of them, we must not

forget that it is in everyday life, on a daily basis, that we must introduce structures of mediation. You meet someone, you don't really know what to say, you offer them a cigarette. We can say that cigarettes are a form of mediation that make engaging in dialogue possible. When we say that, in order to be able to work in a collective and to create a milieu of free circulation in which people can talk better with each other, a bar is required where newspapers and tobacco are sold, because it's true that the exchange will take place there, on the occasion of someone buying something. Even people not expecting it will find themselves caught in a certain 'relationship trap', because they came to buy something; they will engage in a minimum of dialogue, which can sometimes be of extraordinary importance. That's when people recognize each other: they knew each other well before they were hospitalized, they'll reunite there, a conversation will spark, they'll go for a walk together, and perhaps the other person he has met will find him a job, perhaps simply by saying, 'Look, I have connections, my family has a ...'. This, we can see, involves the creation of a system of mediation — but it is true also in the activities of theatre, cinema, newspapers, and so on. *It is not enough to say that something must be set up that is able to create an exchange. It is all well and good to make exchanges, but ultimately it is necessary to have some mediating structure* ['un support']*, and above all an occasion.*

If you would like, perhaps we could talk a bit, and pick up on this problem later. I've presented things more or less roughly, but a more theoretical explanation of this problematic would need to be tackled, which would enable us to see that the psychiatric example can very well be applied to other structures. I am thinking in particular of schools, active education methods and then the I.M.P., and so on. But I think that it is preferable to use what I have just

said, as a form of mediation, as it were in order to engage in a dialogue.

QUESTIONS AND ANSWERS

[Audience]: *There's a question I'm asking myself regarding institutional psychotherapy: I have the impression that I.P. [institutional psychotherapy] is tolerated by the country in which we live, at least within the political structures that we have at present. Because one of two things is true: either establishments that operate on the basis of institutional psychotherapy constitute a new form of segregation, or they run the risk of creating a new form of segregation, insofar as they are organized around themselves, but where the exchanges are perhaps organized within the establishment. This constitutes progress, because it didn't exist before; but what is exchanged with the outside? And doesn't the establishment then appear, in the eyes of the outside world, as a collectivity of the mad?*

Jean Oury: Presenting institutional psychotherapy in a very fragmented way, as I have done in this introduction, may lend itself to your criticism and make you think that, indeed, there is some kind of rather closed world being established, with a particular structure. We've also been accused of creating an intra-asylum neo-society; but this seems to be a misunderstanding. It was to avoid this that I insisted on pointing out (perhaps too quickly) something that seemed fundamental: that we were obliged, given the overload and growing demand for hospitalization, to find a way to heal as quickly as possible. It was, as it were, a guarantee that there would be no 'confinement', to use Foucault's term; it was to create an anti-confinement [*anti-renfermerie*].

This 'anti-confinement' dimension was totally guaranteed, because some people had to leave for others to enter!

It was also a guarantee against the formation of an enclosed universe, because it's simply a matter of letting some people in and pushing others out, without bothering with them anymore. Moreover, the tragedy with all these psychiatric problems is that when you take on someone who is ill, you take them on for life. You can't treat it like appendicitis or the flu. For example, there are people I came to know twenty years ago, I did not see them for two years, and then here they are again. For example, with the recent flu epidemics, we've seen an upsurge in asthenia, fatigue, and depression. People I hadn't seen in ten years came back with acute, suicidal depression, requiring urgent treatment. They'd been fine for ten years, but then they'd come back. I didn't even have to reacquaint myself with them, I recognized them. I had their file card, I knew their family, and so on. It was a kind of continuity.

This is to tell you that the hospital, the clinic, such as I presented it, is a kind of hub where people come back easily; but that doesn't mean they can't leave it! They are obliged to leave it, but precautions must be taken in order to let them go: you can't throw someone in the water; you have to follow their progress, make them come back… What is created from the fact that the experiment works, even if someone came for fifteen days, is the equivalent of what happens in the C.E.M.É.A. courses for nurses: a revelation. People who are in their little lives — go to the office in the morning, come home at night, 'we only have illnesses of the body'… It's easy to see how far these prejudices go. For example, traditionally trained nurses have a lot of difficulty adapting to this work. If you tell such a nurse, 'Enough with the injections, you need to go run a gardening or cooking workshop', it's an affront! 'What, me, a qualified nurse, you want me to dig or wash dishes? It cannot be!' Similarly (and this has become famous), when

a psychologist arrived at La Borde clinic, I would say to them: 'Do the dishes. A month of washing up!'. When you're a real psychologist, washing up is a fantastic job for observing; you can make extraordinary observations in such places.

I give these few examples to illustrate how we fight against this 'dualistic prejudice'. On the other hand, if the Hospital Committee is misunderstood, it will close in on itself — and it's to avoid this enclosure that what we called 'fairs' are organized. But fairs can also remain an activity of patronage, of good deeds: the poor sick people who are there, gathering funds, having fun… the 'tender charity' of fairs!

To avoid this, we organized open-air fairs, which became major events throughout the region. I remember, for example, that two or three years ago, this Hospital Committee organized what we called 'culture month' — which, by the way, went on for two months. That year's theme was 'La Sologne' (the clinic being located in the Sologne region). It was extraordinary! The patients themselves organized, for example, along with the enthusiastic help of the local population, evening gatherings in the villages, several a week; people volunteered both for folklore activities, and to organize conferences with historians, geographers, archaeologists, novelists, filmmakers, etc. All segments of the population were interested. At another fair, something extraordinary was organized by the Hospital Committee: all evening the Republican Guard played Vivaldi and Mozart at the Blois Cathedral… All that is to say that it's not at all 'confined'; it's well known that people circulate, and families often come on Sundays to spend a day there. So we need to open up these structures to the 'outside world'. Otherwise we remain in a chapel, in isolation…

Everything that's closed off becomes dangerous: it ferments! And whether we are talking about communist ideas or something else, the fact that they're inside a closed structure means what occurs is something other than communism, an idealism of who knows what sort — but it has nothing to do with communism, even if the money is shared. Besides, it's not about sharing the money. The people who are there are on Social Security; it's not the Club that feeds them.

Isn't the desire to live afterwards precisely… Maybe not exactly in the same way, because at the time they were ill, and in principle they got better… But isn't the desire to live afterwards precisely in that way, somewhere else?

I understand the question well; it's often asked. Never (despite having seen thousands of people over time...), never has it come up. It only comes up when it's asked! As in any hospital, there's what we call 'sedimentation' (which is a bit of a geological term), and 'chronicity'.

We can say that the chronically ill are not those who stay. The chronically ill can often work, stay at home, helped by psychotherapy, pharmacology… These techniques enable us to act with extraordinary flexibility, to discharge as many patients as possible, or to not even hospitalize them at all. By contrast, there is a category of patients we call the 'sediment'. This sediment is composed of patients who may be severely schizophrenic, but above all by patients whose social conditions are unsatisfactory. They are rejected, forgotten, even if they have friendly visits from time to time. These are people who are forgotten, and for whom nothing can be done in terms of the society as it currently stands — except when we are lucky enough to find a few family placements. We can't use this layer of sedi-

mentation as an excuse to say that they like staying there! Other patients just want to get out and work.

The problem you ask is the famous 'sector' problem, which is far from being solved. I don't think we can solve the problem of the sector by not wanting to see it, by turning a blind eye to the need for a specific living centre (at least at certain stages of mental illness) to treat people.

The sector is:

- Make this centre as open as possible, so that there is two-way circulation, so that people can come in, and so that patients can go out to take on responsibilities elsewhere.
- But at the same time, it means creating, for example, what I mentioned earlier: a social office in the neighbouring town, where people can look for work, housing, to have meeting places, small units — not necessarily of 'aftercare', as they say, but units that could just as easily be called 'pre-care', which often prevent hospitalization.
- It also means collaborating with schools; for example, we can link the work of dispensaries with the problem of special classes. In other words, [the educational and pedagogical work] has, at a certain level, the same theoretical aim of taking up what is at issue in mental illness: we can say that mental illness is an illness of relationality — that's very approximate. On the other hand, we can affirm that the institution, in the end, is everywhere. The first institution that exists in today's society, the institution that teaches you to talk and walk, is the family. You can't do institutional psychiatry without constant contact with the family, without 'working' the family milieu.

I don't know if I've answered exactly what you were asking?

It always depends on this question of 'tolerance', because this problem arises in psychiatry, but it also arises in maladjusted childhood. In my opinion, perhaps because I'm a psychiatrist, these problems are identical. A so-called 're-education' centre, in fact, has the same problems as a psychiatric service, as a psychiatric hospital. And I have to say, moreover, that educators sensed some of the pitfalls long before psychiatrists, and avoided some of them; there are others they didn't avoid, but all the same, whether it's psychiatry or maladjusted childhood, the big question for me is: 'How will a society like ours be able to tolerate for long such structures that bubble up, that try to ask questions, that try to understand and that try, in fact, to get people out a bit, as you were saying, of the TV, of the little car, of this or that?'

This certainly creates problems... But it's a more general question than that of psychiatry itself: we have to choose between what we might call a 'hyper-segregationist' universe, which is unfortunately becoming more and more pronounced — a whole system of compartmentalization, to lock up the mad or children.

You know, what I'm saying here, I could also say about high schools — but I won't, because that would be too violent. We can talk about hospitals, because they're still, let's say, an almost sacred domain: the mad, the mentally ill, we can talk about them. At a certain point, you could even do anything inside, even engage in total communism — no one cared at all: as long as it stayed in the asylum! They even said: 'You see, it's good for the insane, but not for the others...'. But there's no doubt that there can be a danger here: all these currents of institutional psychotherapy presenting themselves as subversive, risk triggering such a *reaction* that the practice of institutional psychotherapy

will be barred. To avoid this kind of 'reaction', I find it very beneficial to take advantage of existing official structures, such as those of the Croix-Marine societies: it is a guarantee after all.

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