Proceedings of the Eleventh International Conference

organized by
the Pontifical Council
for Pastoral Assistance
to Health Care Workers

"In the Image and Likeness of God: Always?"
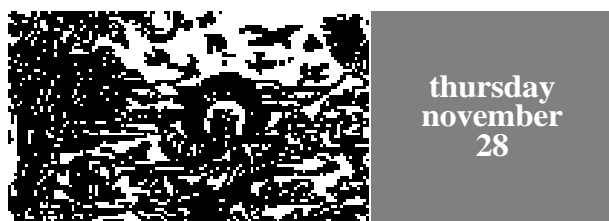## *Disturbances of the Human Mind*

November 28-29-30, 1996

Paul VI Hall Vatican City

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PREVENTION, TREATMENT,
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"I was sick and you visited me"
(Mt. 25:36)

CARDINAL ANGELINI'S GREETING TO THE HOLY FATHER

Holy Father:

This Eleventh International Conference organized and promoted by the Pontifical Council for Pastoral Assistance to Health Care Workers marks a new milestone on the road of research, analysis, reflection, and practical conclusions traveled by this Council from its inception in connection with the fundamental questions concerning the sanctity of life and the dignity of the human person.

Researchers, scientists, scholars in biomedicine, theologians, psychiatrists, sociologists, and moral theorists have here addressed themselves to the various questions concerning the structure of the human mind, the dramatic facts on the widespread presence of mental illness, its direct and indirect causes, the places where disturbance occurs, the large number of social reference models, the forms and the manifestations of its various kinds of pathology, and the criteria and the means of prevention, treatment, and rehabilitation.

With ethical and spiritual goals in mind, inquiry has been carried out into the tasks and methods of helping and caring for the mentally ill—both from a strictly clinical point of view and in terms of pastoral assistance—in line

with that humanized and humanizing dimension to which you, Holy Father, have so often called our attention so nobly.

The question which is contained in the title of our Eleventh International Conference does not express a doubt. On the contrary, it seeks to stimulate an ever deeper answer in the affirmative—in the knowledge that every living human being is a celebration of the glory of God.

This compelling and Christian answer does not aspire to be merely scientific, nor can it be a matter of a simple statement of principle. It seeks, instead, to shake consciences—especially those of health care workers, but also of all those who identify with the solicitude which has always animated the Church's approach to the mentally ill—so that these are never forgotten and certainly not excluded, but come to be considered our very real brothers and sisters.

The reception that this International Conference has met with this year, too, is a source of authentic hope that the ecclesial community in particular will become ever more sensitive to the questions and problems of the mentally ill, thereby giving rise in scientists, health professionals, and volunteers, to a growing spirit of service which is guided by the vocation and mission of the civilization of love.

To sum up, this meeting with Your Holiness seeks to be an opportunity and a witness to faith in the guidelines laid down by the magisterium of the Church, that demonstrates and confirms—above all, in her care and concern for the sick and the suffering—that she is a loving and attentive mother.

May your paternal and inspired words, which draw this international encounter for study and reflection to a close, accompany the hope that with enthusiasm and courage all of us here today will renew our commitment to serve those who suffer!

FIORENZO Cardinal ANGELINI
President of the Pontifical Council
for Pastoral Assistance to Health Care Workers

ADDRESS BY THE HOLY FATHER

The Mentally Ill Are Also Made in God's Image

1. I am pleased with this meeting, which allows me to offer you my greetings, distinguished participants in the international conference sponsored by the Pontifical Council for Pastoral Assistance to Health Care Workers on the problem of mental illness, with the significant title: *In the Image and Likeness of God: Always? Disturbances of the Human Mind.*

I affectionately greet Cardinal Fiorenzo Angelini, whom I thank for his cordial address. A particular word of appreciation is owed to him and to his co-workers, for their efforts in preparing this symposium, which has brought together specialists from all over the world.

2. Distinguished Ladies and Gentlemen, present among you are researchers, scientists, specialists in the field of the biomedical sciences, theologians, moralists, jurists, psychologists, sociologists, and healthcare workers. Together you represent a heritage of humanity and wisdom, of science and experience which can produce very useful advice for the understanding, treatment, and care of the mentally ill.

The Church looks on these persons with special concern, as she looks on any other human being affected by illness. Instructed by the divine Teacher's words, she believes that "man, made in the image of the Creator, redeemed by the blood of Christ, and made holy by the presence of the Holy Spirit, has as the ultimate purpose of his life, to live 'for praise of God's glory' (cf. Eph 1:12), striving to make each of his actions reflect the splendor of that glory" (Encyclical *Veritatis Splendor*, no. 10).

Man is created in God's image and likeness

The Church is deeply convinced of this truth, even when man's mental faculties — the noblest, because they testify to his spiritual nature—seem severely limited and even impeded by a pathological process. She therefore reminds the political community of its duty to recognize and celebrate the divine image in man with actions that support and serve all those who find themselves in a condition of serious mental illness. This is a task which science and faith, medicine and pastoral care, professional skill, and a sense of common brotherhood must help to carry out through an investment of adequate human, scientific, and socioeconomic resources.

3. The title of the congress invites us to further examine this line of reflection which has just been outlined. Indeed, while, on the one hand, it again offers an authoritative affirmation of the Bible, on the other, it raises a disturbing question.

The conviction that man has been created in the image and likeness of God is one of the pillars of Christian anthropology. This is what is written in the first chapter of Genesis (1:26). Philosophical and theological reflection has identified in man's mental faculties, that is, in his reason and in his will, a privileged sign of this affinity with God. These faculties, in fact, enable man to know the Lord and to establish a relationship of dialogue with him. In discussing this, St Thomas points out, "Person signifies what is most perfect in all nature, that is, a subsistent individual of a rational nature" (*Summa Theologiae* I, q. 29, a. 3).

It should be made clear, however, that the whole man, not just his spiritual soul, including his intelligence and free will, but also his body, shares in the dignity of "the image of God." In fact, the human body "is a human body, precisely because it is animated by a spiritual soul, and it is the whole human person that is intended to become, in the body of Christ, a temple of the Spirit" (*Catechism of the Catholic Church*, no. 364). "Do you not

know," the Apostle writes, "that your bodies are members of Christ? ...You are not your own... So glorify God in your body" (1 Cor 6:15; 19-20). Hence the need to respect one's own body, and also the body of every other person, especially the suffering (cf. *Catechism of the Catholic Church*, no. 10004).

By grace man becomes a child of God

4. Precisely because man is a person, his dignity is unique among all creatures. Every individual man is an end in himself and can never be used as a mere means for reaching other goals, not even in the name of the well-being and progress of the community as a whole. By creating man in his own image, God wished to make him share in his lordship and his glory. When he entrusted him with the task of caring for all creation, he took into account his creative intelligence and his responsible freedom.

The Second Vatican Council, delving into the mystery of man under the guidance of Christ's words (cf. Jn 17:21-22), opened up to us horizons inaccessible to human reason. In the Constitution *Gaudium et Spes*, "a certain parallel between the union existing among the divine persons and the union of the sons of God in truth and love" (n. 24) is explicitly mentioned. When God turns his gaze on man, the first thing he sees and loves in him is not the deeds he succeeds in doing, but his own image, an image that confers on man the ability to know and love his own Creator, to rule over all earthly creatures and to use them for God's glory (cf. ibid., n. 12). And this is why the Church recognizes the same dignity in all human beings and the same fundamental value, regardless of any other circumstantial consideration. Therefore, regardless, too—and this is most important—of the fact that this ability cannot be utilized because it is impeded by mental illness.

5. This conception of man as the image and likeness of God is not only confirmed by the New Testament Revelation, but supremely enriched by it. St Paul says: "But when the time had fully come, God sent forth his Son, born of woman, born under the law, to redeem those who were under the law, so that we might receive adoption as sons" (Gal 4:4-5). By grace, therefore, man truly shares in this divine sonship, becoming a child of God in the Son.

The Second Vatican Council teaches that Christ is "'the image of the invisible God' (Col 1:15). He is the perfect man who has restored in the children of Adam that likeness to God which had been disfigured ever since the first sin. Human nature, by the very fact that it was assumed, not absorbed, in him, has been raised in us also to a dignity beyond compare. For, by his Incarnation, the Son of God has in a certain way united himself to each man" (*Gaudium et Spes*, no. 22).

6. At this point we feel the whole weight of the disturbing question which appears in the topic: "Always?" This is a provocative question which is not only asked at the *ontological* level—here faith and reason converge in recognizing the full human dignity of the mentally ill—as much as at the *deontological* level: one can in fact ask whether the way a mentally ill person is treated by his peers in daily life corresponds fully and adequately to what he is in God's plan.

That question—"Always?"—must spur both the personal and the collective conscience to a sincere reflection on our behavior towards those persons who are suffering from mental illness. Is it not true that all too often these persons encounter indifference and neglect, when not also exploited and abused?

Through God's grace, there is also another side to the coin: I stressed this in the Encyclical *Evangelium Vitae*, recalling "all those daily gestures of openness, sacrifice, and unselfish care which countless people lovingly make in families, hospitals, orphanages, homes for the elderly, and other centers or communities which defend life" (no. 27). But we cannot close our eyes to certain forms of behavior which seem to ignore human dignity and to trample on man's inalienable rights.

The mentally ill always bear God's image and likeness

7. We Christians, especially, cannot do so. In this regard the Gospel speaks clearly. Christ not only took pity on the sick and healed many of them, restoring health to both their bodies and their minds; his compassion also led him to identify with them. He declares: "I was sick and you visited me" (Mt 25:36). The disciples of the Lord, precisely because they were able to see the image of the "suffering" Christ in all people marked by sickness, opened their hearts to them, spending themselves in various forms of assistance.

Christ took all human suffering on himself, even mental illness. Yes, even this affliction, which perhaps seems the most absurd and incomprehensible, conforms the sick person to Christ and gives him a share in his redeeming passion.

8. Thus the response to the theme's question is clear: whoever suffers from mental illness "always" bears God's image and likeness in himself, as does every human being. In addition, he "always" has the inalienable right not only to be considered as an image of God and therefore as a person, but also to be treated as such.

It is everyone's duty to *make an active response*: our actions must show that mental illness does not create insurmountable distances or prevent relations of true Christian charity with those who are its victims. Indeed, it should inspire a particularly attentive attitude towards these people, who are fully entitled to belong to the category of the poor to whom the kingdom of heaven belongs (cf. Mt. 5:3).

Distinguished ladies and gentlemen, I have recalled these fundamental and comforting truths, well aware that I am speaking to people who fully understand them. I gladly take this opportunity to express to you my full appreciation of your valuable work and to encourage you to continue a service with such lofty humanitarian importance.

May the Lord bless your therapeutic work and crown it with results that comfort your patients, to whom I offer my affectionate thoughts and the assurance of a special prayer.
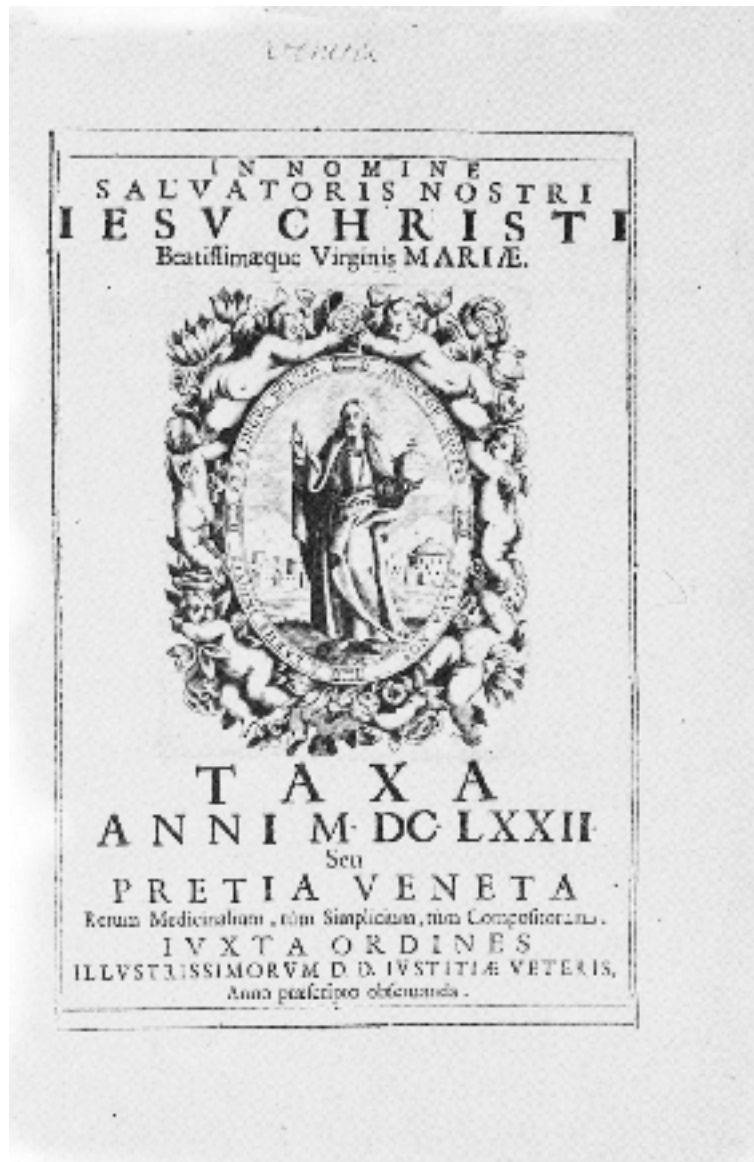
CARDINAL ANGELINI'S INTRODUCTORY REMARKS

A New Attitude Towards the Mentally Ill

The question expressed by the title of this international conference does not seek to raise a doubt about the truth that in every human person there is a reflection of the image and likeness of God. Its intention, rather, is to identify and explore through the paths of reason, science and experience itself—where all are illuminated by the faith—those traces of this mysterious reflection of God which are present in those who suffer from disturbance caused by mental illness in a variety of forms and in different degrees of intensity.

What is of utmost importance and seeks to be almost a provocation is not, however, a theoretical and abstract answer in the affirmative. This would not be enough. Because the divine image also shines within man when his faculties are compromised or limited in their use as a result of mental illness, the social community—and Christians in particular—must recognize and celebrate the divine image in man through service to those who suffer from such illness.

The refusal and inability to perform this duty become wrongdoing when they are expressed in indifference to the problem and in a total absence of practical commitment. This is a duty which science and faith, medicine, and both natural and Christian morality are called upon to perform through the use of the increasing advances in and demonstrated effectiveness of therapeutic methods and instruments.

The third international conference, held in 1989, was also dedicated to the "human mind." The subjects discussed by the conference this year represent from many points of view an updating of the work of its predecessor.

Researchers, scientists, experts in biomedicine, psychologists, theologians, and moral theorists—all of international fame—will address during the course of this conference the various questions and problems relating to the *structure* of the human mind, the facts and figures relating to the presence of mental illness, its direct and indirect *causes*, the *places of such disturbance*, the *various models* of social reference, *the forms and manifestations* of the different kinds of mental illness, and the criteria and *the means of prevention, treatment, and rehabilitation*. From an ethical and spiritual point of view, the tasks and methods of caring for the mentally ill will be examined in strictly medical terms and in terms of pastoral assistance.

Mental disturbance afflicts a fifth of mankind and should not only be studied from the point of view of its causes but in a very special fashion in terms of its consequences. We must do this if we want to face up to, treat, and cure such illness, and to do this we must have a conception and a vision of life which recognize its origin in God; we must perceive the inviolable sanctity and the noble dignity which are present in each and every human person.

We constantly hear that before closing psychiatric institutions we should provide alternative facilities and amenities in town and country, structures and amenities which in many regions do not exist or are inadequate.

This is true, but it is not the whole truth. The structures and amenities are not sufficient if in their use and management human and Christian principles and criteria are not applied elements which involve seeing those suffering from serious mental illness as brothers to love and to serve. We are also dealing here with a problem in the current *mentality,* which, unfortunately, is becoming ever more closed and selfish and tends to want to remove suffering and to marginalize it.

Now that science has achieved great steps forward in the treatment of mental illness, such forms of treatment are clearly totally insufficient if they are not infused with a renewed sense of social sensitivity. Experience shows that one of the most serious problems in the

treatment and care of the mentally ill lies in their presence in families, which on their own are not able to help their afflicted relatives without risk and in an adequate fashion. Even the most modern facilities end up being like the infamous lunatic asylums when the human *heart* is lacking.

In relation to the role of health care workers active in this area, all such workers should be psychologically, professionally, morally, and spiritually trained and prepared for this form of assistance and care.

This international conference will also dedicate itself to the study of the structural causes of mental illness within our society. The key point, however, remains that of the achievement and creation of a new sensitivity and

mentality. Indeed, there can be no doubt that at the root of many and new forms of mental disturbance there is a crisis in values and the dominance of anti-values which propel man into increasing loneliness. The step from this loneliness to mental disturbance is short—indeed, it can be very short. The alliance between scientific resources and spiritual resources is not a mere question of possibility—it is a question of duty. It is, therefore, the irreplaceable solution when we come to consider that an increasing number of pathological phenomena in the field of mental illness spring from a lack of access—in both preventive and therapeutic terms—to the support of spiritual resources.

FIORENZO Cardinal ANGELINI

HIROSHI NAKAJIMA

The Programs and Activity of WHO in the Field of Mental Health: A Response to the Challenges of Today's World

The charter of the World Health Organization states that "health is a state of complete physical, mental, and social well-being and is not a mere question of the absence of illness or infirmity." This definition gives the right weight to the mental and relational aspects of the health of human beings. Whatever may be the mental incapacities or disturbances which afflict an individual, he still has the right to receive medical care and attention and the social, psychological, and human support which will allow him to achieve the highest possible levels of independence and well-being.

Since its inception fifty years ago, the World Health Organization has developed programs and initiatives in the field of mental health. At the present time, and in order to respond to the challenges posed by our world and by the various cultures which inhabit it, these responses revolve around four principal axes.

1. *The first axis.* We strive to promote a healthy development of the child and in this endeavor we also seek to understand his cere-

bral functions. For this reason we are very conscious of the risks and consequences of nutritional deficiencies; we thus seek to help our member states to promote and implement programs which monitor and improve the diet of mothers and their children. We also place great emphasis on the fact that the child must be loved and protected if his full development is to be guaranteed. At the same time, however, we place major stress upon the importance of his receiving the means and instruments by which to construct and develop his own freedom within a framework of responsibility.

2. *The second axis.* We encourage community participation in the debate about the psychological origins of phenomena such as violence or suicide, the importance of the economic and social environment in the emergence of these forms of disturbance, and the possible role of this environment in prevention and treatment. Attention is also drawn towards the violence which society itself perpetrates or provokes, a process which acts to legitimate the law of the

strongest through the influence of the values of money and success.

3. *The third axis.* We seek to promote community participation in care and treatment. This is especially the case in relation to the elderly. Indeed, for elderly people loneliness is far too often a primary cause of fragility and vulnerability, and this acts to aggravate their economic precariousness. A shift to new approaches to mental health involves the introduction or the strengthening of public policies of social support which require substantial financial contributions. One thinks here of help in the provision of housing and a reform of the system of nursing care. It should also be pointed out that these approaches must increase their reliance upon voluntary associations and upon neighborhood support networks.

In all these different fields we place great emphasis upon the fundamental role which the family structures can and must play. This is very evident in the case of elderly people who are isolated and without financial resources. But it is children and adolescents who are most marked over time by failings in their family environment. Everybody agrees in theory that every child should have the right to grow up in his or her own home and in good conditions. But we well know that at the present time, in the situation as it is, the opposite often happens. The break-up of families, poverty, and war are other factors which impose the traumas of separation and violence on children.

The clinical studies carried out in war situations demonstrate the essential role played by the family in maintaining the psychological solidity and health of children even in extreme conditions. Equally, daily practice in the sphere of psychiatric treatment shows the benefits in therapeutic terms that a child can gain from the active participation of his family. Aggression, the fragmentation of personality, crime, escape into drug addiction, the search for identity and membership in violent groups, a lack of reference points, marginalization, and prostitution—these experiences are not a matter of mere chance, but are directly related in terms of risk to the absence or failings of the child's family and the emotional and educational role it plays in his life.

4. *The fourth axis* of the strategy of the World Health Organization. We are in favor of the development and integration of the services relating to mental health in all basic systems of health care. What we suggest in this area is that, on the one hand, experts in neuropsychiatry should always be available for consultation when necessary by those who are in need of such a service and, on the other, that essential psychotropic drugs and essential psychosocial help should always be available.

Mental illness must be dealt with both from a medical point of view and in psychological and social terms. This form of illness involves suffering which must be treated and reduced to such a point that the sick person can renew relationships, re-establish communication, and—where possible—engage in independent work. Material and social support is necessary, but it is not enough. We need to treat and care for the mentally ill person—that is, we must reduce his burden and help him to reconstruct a will and an ability to live and to engage in relationships with other people.

As other psychiatrists have emphasized, respect for the psychically disturbed requires both respect for their symptoms and a commitment not to abandon them to what would be a "chronic condition without hope, but which is tolerable in social terms." To these human beings, who in their differences from us reflect a part of the truth about ourselves, we must offer "health care facilities and not places of internment." It is in this relationship—which should be marked at one and the same time by respect and a suitable sense of responsibility—that the image of our shared humanity will be formed and shaped.

Your Eminence, it is with emotion that I take part in this eleventh international conference of the Pontifical Council for Pastoral Assistance to Health Care Workers. Over the years Your Eminence has confirmed your friendship towards me by inviting me to participate in your work and thought. I am infinitely grateful to you for what you have done for health in the world and in particular for the health of the poor. Your Eminence has consecrated all your energies to this field and has mobilized the network of institutions and health care workers under the supervision of the Church to this end. You were awarded the Sasakawa Foundation Prize, and I myself had the pleasure and the honor to award the "Health For All Medal" to you in the name of the World Health Organization. In a little while you will embark upon the path of retirement, which I hope will be long, happy, and sufficiently active to allow me once again to have the opportunity to meet you and to work with you in the cause of improving the health of all the peoples of the world.

Dr. HIROSHI NAKAJIMA
Director General of the World Health Organization

The Experience of Music Therapy

During each session of the international conference a symphony orchestra conducted by Professor Adolfo Petiziol (President of the Italian Society for Music Therapy) played a number of musical pieces. A semiotic analysis of each piece was carried out to detect which relevant symbolic elements represent and express the affective-intuitive, relational, emotional and at the same time cognitive dimensions of the music of that piece. These elements, which express the meaning of that music, constitute the theoretical and practical basis for treatment involving music therapy. We are dealing here with archetypical or elementary images which correspond to the inner depths of human beings, their emotions, their suffering and their joy. The following pieces were played during the international conference.

1. Wolfgang Amadeus Mozart:
The Marriage of Figaro—Overture

In the progressive construction of his reality as an individual, man needs regularity, and because of this he is predisposed to the perception and recognition of rhythms which are themselves necessary to the creation of a nucleus of stability. Certain qualities which are present in the interaction between the mother and her child such as intensity, length, synchronization and form are high-level characteristics which produce an *affective syntonization*. This spontaneous form of behavior, which on the whole reflects the character of the shared emotions of the relationship, is of fundamental importance in the emotional and cognitive growth of the child because it imparts subjective meaning and form to his inner world.

The structure of the music which we will now hear—namely the *Marriage of Figaro* by Mozart, which is melodically ordered, clear, and comprehensible, but also has one or two joyous surprises—is well sustained by a regular rhythm. For this reason the experience it provokes provides reward and pleasure similar to that of an encouraging relationship with somebody who is meaningful for us—a relationship where we feel reassured and supported, free to play and to explore our universe.

Thus we encounter the innocence of the spirit of the artist, which is like that of a child, a spirit moved to create but at the same time to ask fascinating questions about the nature of things. Music and science have the divine right to respond to these questions because reality is many-faceted and holistic. Similarly, the route to its understanding involves a large number of levels and offshoots. In a female patient who had psychic disorders the rejection of music, with its symbolic function of union between the interior subjective world and the external and relational world, represented a mechanism by which to remove and banish the suffering caused by rejection at the hands of a mother who loved music.

2. Franz Schubert:
The Unfinished Symphony—First Movement

Music—and in particular this piece by Schubert: *The Unfinished Symphony*—may be seen as an ally and a support in the process of individualization, a metaphor by which to represent and express the movements of the spirit and to give sound to what is not expressed and without form. Music stimulates the imagination in a situation where all the senses can be used and be amplified in altered states of consciousness. This scenario follows an idiosyncratic and symbolic logic and can be seen as the language of the self, of our inner world. Aristotle thought that music "not only imitates objects but expresses the character of the passions themselves" because it lives out a relationship with reality which goes beyond verbal language to embrace the emotions, joy, pain, fear and tranquillity which are immediate experiences rather than mere concepts. Music is as complex as the self. Music can thus be considered as being—or favoring—a projection of the individual psyche which is made up of sounds, themes, harmonies and timbres which are in conflict or which are complementary, integrated, consonant or dissonant. This also arises from the fact that listening to music favors a regression through the emergence of states of less structured consciousness which allow the overcoming of defenses and a coming into contact with the organization of the individual's own inner universe.

In this composition by Schubert we can detect two levels of consciousness: one is made up of timbres and low sounds, the other consists of a melody which takes place at a higher level. There is the use of violins and the creation of an intense and striking emotional space which takes place in the search for integration and mutual support. The timbre of the instruments together with the tonality set in a minor key and a melodic line which proceeds without ups and downs evokes intense emotional responses which are nonetheless linked to and filtered by the character of each individual self. All this takes place with a sensation of darkness and sadness which through a movement which is at times directed upwards, and a change of approach, produce a temporary opening to hope and light. The harmony proceeds slowly and gives a greater sense of intensity and reflection to the melody—something which deepens its emo-

tional meaning and significance. This piece, with its features of weaving and color, can favor an experience of alteration in terms of time and/or regression towards the past in addition to reduced distances from childhood stages. In the process of individualization we should also put ourselves into contact with, and become aware of, the dark sides, the shadows which are within each and every one of us. The vibrant atmosphere of the sound of this piece enables us to experience the intensely dramatic character of the mystery of our psyche.

3. Ludwig van Beethoven:
Symphony No. 7—First Movement

The force and the practical energy which are developed in this seventh symphony by Beethoven can be associated with the development of the voice of the human spirit, which, through the evocativeness of the sound, strives to give a meaning and a form to the experience of pain, doubt, will and subjective passions. The search for a transcendent dimension above the terrestrial experience seems to express itself in the momentary stopping of the flowing of ordinary time in the composition, an ecstatic silence of celestial spheres: "In excelsis, in silentio" declared St. Augustine. This is interposed with the vigorous rhythmic and melodic elements of the piece which produce its internal cohesion. The essential feature of Beethoven's music and of this composition as well is the constant and decisive search for expressive methods which are coherent expressions of his personal and tempestuous spiritual and mental attitudes. Thus it is that in the ear of the listener the dynamic variation of intensity and of timbres produce an emotional reaction through the increase or decrease of energy which activates and motivates the emotions and at times leads to the release of aggression.

Even though the melodic line is accompanied by the same movement of the base notes and sustained by a binary rhythmic structure which is regular and thus predictable, these features of violent timbre and dynamic contrasts can disquiet and upset a psychically weak individual who may experience a sense of anxiety-inducing imbalance because of the force and the diversity of emotions which are provoked. Indeed, intensity is very marked in the musical expression of schizophrenic patient. It does not, however, involve variations which conform to his different states of mind—almost as if these people were no longer able to control the ways and means of representing and recognizing affective states in other people whether at a behavioral or a symbolic level.

4. Gioacchino Rossini:
L'Italiana in Algeri—Symphony

The happy tempo, the magic of the rhythm, and the electrifying exaltation of the contrasts are elements which we find in this symphony—*L'Italiana in Algeri* by Rossini. The sound and the rhythm of this piece are natural phenomena which are contained in the human body and which the human being experiences from the time of his being in the maternal womb. For this reason when he is born he is already impregnated with a special sound context, shaped by the heartbeat of his mother, and made sensitive to frequencies which are like those of the voice of his mother. These early, sensorial, pre-

verbal experiences are at the base of certain emotional responses which are provoked by listening to music. This is because in the perception of music subcortical (limbic) structures and functions are involved which are linked to cortical modulation and changes in emotions, which are themselves caused by associative responses and the emergence of memories. The form of this piece involves a sequential relationship between themes and structural unities, as is the case in the use of the instruments. It can produce the notion of "when something happens" in the imagination. The alternation of a melody which has sweet and striking characteristics with a melody which is festive in tone—which is followed by a more tranquil melody and then by a stormy and agitated one—conveys a representation of life which is flexible and dynamic in character. Every motif—even if short—presents a kind of feeling, but how this is perceived depends not only upon the enigmatic language of the music and the technical methods which are employed, but also upon the individual self—something which is developed during infancy and which supplies each and every stimulus which has a personal meaning.

5. Helmut Laberer:
Los Andes and Carretera Panamericana

The purified freedom of intuition and the emotion of a victorious light of the spirit are here able to produce a symbolic representation of a monotonous, repetitive and oppressive reality which is experienced without that creative liberty which is necessary to the bringing of emotional variations to daily life—variations which bestow subjective meaning on every experience. The rhythms are percussional and obsessive. They are similar to those which are produced by patients suffering from mental disorders where an affective levelling is to be observed and where the other person as a human individual is denied, transformed into an object, or wrongly imagined to be a dangerous and terrifying enemy.

In this composition the heaviness of the journey and the burden of a life lived in slavery can be felt physically: the brief bursts of light are not enough to discover the individual's own identity. The sounds evoke mystery, depth and irrationality, and the changes in rhythm provoke a sense of dissolution and the fragmentary—elements which can be noticed in people who suffer from schizophrenia. The character of this work is marked by its intensity and its rhythm, which establish a strong sense of energy and involve its release, taking place at a physical rather than mental level. This is because the impulses are tangible, hard and not accompanied by a melodic line which could provide an affective experience of pleasure. When the melody appears in this piece it is expressed through a syncopated rhythm, a rebellion against the authority of flowing time, which passes inexorably over experience without providing any lasting change. This is because there is no personal or group theological movement which can improve the quality of life. Even joy is an artificial imposition, and for this reason there is no integration with the texture of the composition—the individual is left on his own, leaving him even more sad and worn out before a life which is empty of meaning.

Professor ADOLFO PETIZIOL
President of the Italian Society for Music Therapy

In the Image and Likeness of God
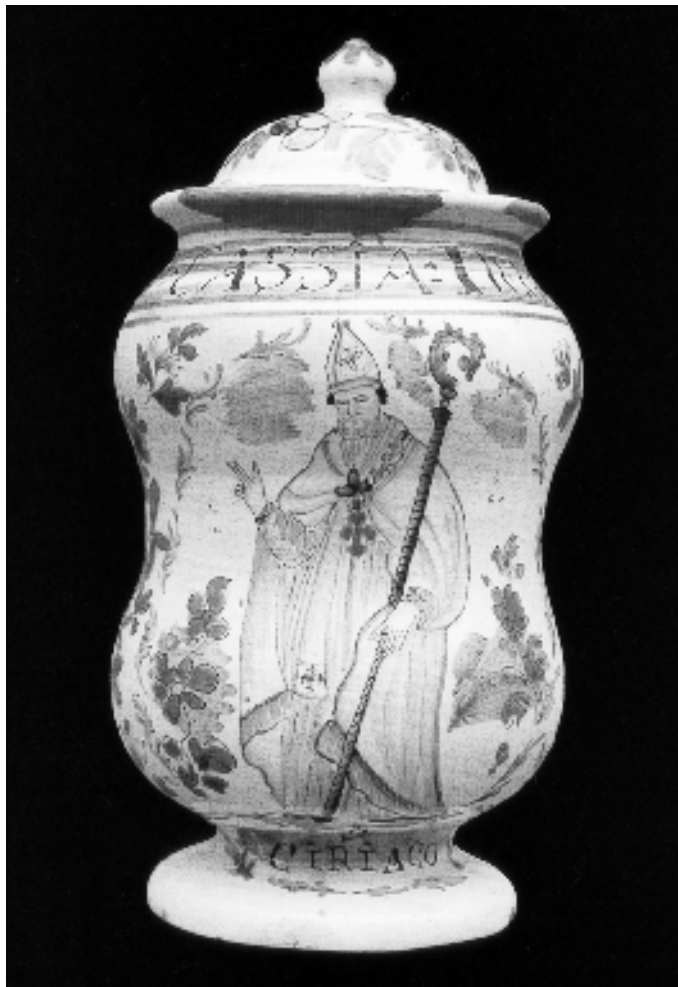
Disturbances
of the Human Mind

OPENING ADDRESS BY CARDINAL JOSEPH RATZINGER

The Likeness of God in the Human Being

The subject of this international conference brings disturbing memories to my mind. Please allow me, by way of introduction, to give you an account of my own personal experience. We return here to 1941, and thus to wartime and to the National Socialist regime. One of our aunts whom we visited very often was the mother of a strong and healthy child who was a few years younger than myself. However, he increasingly displayed the symptoms of the Down syndrome. The simplicity of his clouded mind aroused affection and his mother, who had already lost a child who had died early on in life, was bound to him by sincere ties. But in 1941 the authorities of the Third Reich ordered him to be taken to an institution to receive better care and assistance. At that time it was not yet suspected that an elimination of the mentally handicapped was being carried out, even though this program had already been set in motion. After a little while the news arrived that the child had died of pneumonia and that his body had been cremated. From that moment on news of this kind became ever more frequent.

In the village where we had previously lived, we most readily used to visit a widow who did not have any children and who was very happy if the children in the neighborhood went to see her. The little piece of land which her father had left her only just provided her with a livelihood. She was in good spirits even though she was rather afraid about the future. Later we learned that the loneliness which afflicted her more and more had increasingly darkened her mind. Her worries about the future had be-

come pathological because she was always anxious about what the future would bring—perhaps she would no longer have food to put in her mouth. She was then defined as being mentally disturbed, placed in an institution, and in this case as well the news arrived that she had died from pneumonia.

A little later exactly the same thing happened in our village. The small piece of property which was next to our house had previously been cultivated by three unmarried brothers to whom it belonged. It was alleged that they were mentally ill even though in actual fact they were able to look after their house and their property. They also disappeared into an institution, and soon afterwards it was made known that they had died. At this point there could no longer be any doubt about what was happening—a systematic elimination of all those who were not considered productive was being carried out. The state had arro-

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gated to itself the right to decide who deserved to live and who was to be deprived of the right to exist on the grounds of advantage to the community or to the state, employing as a criterion the idea that an individual could be eliminated because he was not useful to others or to himself.

This fact added a new and different kind of anxiety to the horrors of war, which were themselves becoming ever more deeply felt—we were touched by the chilling coldness of a logic based upon criteria of utility and power. We felt that the killing of these people humiliated and threatened us, the human essence that was within us: if patience and love dedicated to the suffering are eliminated from human existence because they are seen as a waste of time and money, not only do we do wrong to those who are killed, but those who survive are themselves mutilated in their spirits. We realized that when the mystery of God, his inviolable dignity, which is present in each and every man, is not respected, then not only are individuals threatened, but humanity itself is endangered. In the paralyzing silence, in the fear which held everyone in its grip, Cardinal Von Galen's condemnation was like a liberation—he broke the paralysis of that fear in order to defend man himself, the image of God, within the mentally disabled.

The luminous word of God with which Genesis begins the account of the creation of man combats all threats to man caused by calculations about power and usefulness: Let us create man in our image and likeness—*faciamus hominem ad imaginem et similitudinem no-*

stram, in the words of the Vulgate (*Gn* 1:26). But what does this word mean? What is the divine likeness present in man? The term, as used by the Old Testament, is, so to speak, a monolith—it does not appear again in the Jewish Old Testament, even though Psalm 8 demonstrates an inner connection with it: "What is man that thou art mindful of him?" The term is used again only in the sapiential writings. Sirach (17:2) roots the greatness of the human being in this fact without seeking to give an interpretation of what is actually meant by this likeness to God.

The Book of Wisdom (2:23) takes a further step forward and sees the state of being in the image of God based in essential terms upon the immortality of man—what makes God God and distinguishes him from created man is precisely his immortality and everlastingness. Created man is in the image of God precisely because he participates in immortality—not because of his own nature, but as a result of a gift bestowed upon him by the Creator. The orientation towards eternal life is what makes man the created counterpart of God. This line of argument could be developed, and one could also say that eternal life means something more than mere eternal subsistence. It is full of meaning, and only in this way is it life deserving and capable of eternity.

An orientation towards eternity, therefore, is an orientation towards the eternal communion of love with God, and the image of God thus bears the marks of its nature beyond earthly life. It cannot be determined in a static fashion and bound to some particular quality, but is a prosthesis of time beyond earthly life. It can be understood only with reference to its tension regarding the future, in its dynamic impulse towards eternity. Those who deny the existence of eternity and who see man as a merely terrestrial creature do not have any possibility—from the very outset—of penetrating the essence of the likeness of God. But this is only touched upon in the Book of Wisdom and fails to be developed further.

In this way the Old Testament leaves us with an unanswered question. We must recognize that Epiphanius was right when he declared—with reference to the various attempts to give a precise definition of the nature of this divine likeness—that we should not "seek to define the framework of the image but recognize its existence within man—if, that is, we do not want to abuse the grace of God" (*Panarion*, LXX, 2,7). But in truth we Christians always read the Old Testament within the context of the entire Bible, in its unity with the New Testament. From it we receive the key by which to achieve a sound and accurate reading of its texts. Just as the creation account of "in the beginning God created" receives its correct interpretation only in its re-reading in the "in the beginning was the Word" of John's Gospel, so the same process is at work here.

Naturally enough, in this brief introductory talk, I cannot dwell at length upon the rich and many-faceted treatment of the subject which is to be found in the New Testament. I will confine myself to exploring two aspects of the question. It should be observed first and foremost—and this is a most important fact—that in the New Testament Christ is described as being "the image of God" (2 *Co* 4:4; *Col* 1:15).

The Fathers of the Church here made a linguistic observation which perhaps cannot be really sustained, but which certainly corresponds to the inner direction of the New Testament and its re-interpretation of the Old Testament. They

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declare that only Christ should be taught as being "the image of God." Man, on the other hand, is not *the* image but *ad imaginem*, created in the image, according to the image. He becomes an image of God in proportion to the degree to which he enters into communion with Christ and conforms to him. To put it in other words: the original image of man, which in turn represents the image of God, is Christ, and man is created by starting from his image, with reference to his image. The human creature is at the same time as being such a creature also a preliminary project in anticipation of Christ—or, rather, Christ is the fundamental idea of the Creator, and he forms man with a view to Christ, starting from this fundamental idea.

The ontological and spiritual dynamism which is hidden in this conception of things becomes especially evident in Romans 8:29 and 1 Corinthians 15:49, but it is also to be found in 2 Corinthians 4:6. According to Romans 8:29, men are predestined "to be molded into the image of his Son, who is thus to become the firstborn among many brothers." This conformity to the image of Christ is fulfilled in the resurrection, by which he preceded us. Yet the resurrection—and this should be made clear at this point—presupposes the Cross. The First Letter to the Corinthians makes a distinction between the first Adam, who became a "living soul" (15:45; cf *Gn* 2:7), and the last Adam, who became a Spirit giving life—"and it remains for us, who once bore the stamp of earth, to bear the stamp of heaven" (15:49). Here we encounter a completely clear expression of the inner tension within the human being between clay and spirit, earth and heaven, terrestrial origins and divine future.

This tension within the human being in time and beyond time belongs to the essence of man. And this tension determines what he is exactly at the center of life in this time. He is always in a voyage towards himself or he distances himself from himself. He is on a voyage towards Christ or he distances himself from Him. He draws near to his original image, or he hides it and ruins it. The Innsbruck theolo-

gian F. Lakner has given fine expression to this dynamic conception of the divine likeness of man which is characteristic of the New Testament in the following way: "Man's being in the image of God is based upon predestination to divine filiation through mystical incorporation into Christ." The image being is thus an inherent finality of man from the point of creation "towards God through participation in divine life in Christ."

However, we thus come to the decisive question of the subject here under discussion: Can this divine likeness be destroyed? And if it can, by what means? Are there human beings who are not in the image of God? In its radicalization of the doctrine of original sin, the Reformation gave an affirmative answer to this question and declared: Yes, through sin man can destroy the image of God within him and in fact has destroyed it. Indeed, man the sinner—who does not want to recognize God and does not respect man, or, indeed, kills him—does not represent the image of God, but deforms it, contradicts Him who is Holiness, Truth, and Goodness. Bearing in mind what was said at the outset, this can and must bring us to the question In whom is the image of God more obscured, more disfigured, or more extinguished—in the cold-blooded killer who is well aware of what he is doing, strong and perhaps intelligent as well, who makes himself God and derides God, or in the suffering innocent person in whom the light of reason glimmers weakly or is perhaps no longer discernible?

But such a question at this point is premature. First of all, a key point must be made—the radical thesis of the Reformation has been shown to be untenable, precisely when the Bible is taken as a point of departure. Man is in the image of God because he is man. And as long as he is man, a human being, he is mysteriously directed towards Christ, to the Son of God made man—and, therefore, oriented towards the mystery of God. The divine image is bound up with the human essence as such, and it is not within man's power to destroy that image completely.

But what man can certainly do is

to disfigure the image, to achieve an inner contradiction with it. At this point, Lakner should be cited once again: "The divine force shines again precisely in the laceration caused by the contradictions.... In this way, man as image of God is thereby crucified man." Between the figure of terrestrial man, formed out of clay, whom Christ with us has assumed in the incarnation and the glory of the resurrection, there is to be found the cross—the path of the contradictions and the disfigurements of the image towards conformity with the Son in whom the glory of God is manifested passes through the pain of the cross. Among the Fathers of the Church, Maximus the Confessor most reflected upon this connection between divine likeness and the cross. Man is called to "synergy," to cooperation with God, but has placed himself in opposition to God. This opposition is "an attack on the nature of man." It "disfigures the true countenance of man, the image of God, because it detaches man from God and directs him towards himself, erecting thereby the tyranny of selfishness among men."

From within human nature itself Christ achieved the overcoming of this contrast, his transformation in communion—the obedience of Jesus, his dying unto himself, becomes the true exodus which frees man from his inner fall and leads him to unity with the love of God. The Crucified thus becomes the living "icon of love." Precisely in the Crucified, in his flayed and beaten face, man once again becomes the transparency of God, the image of God which shines forth anew. In this way the light of divine love lies specifically upon suffering people, in whom the splendor of the creation has been externally dimmed. Because these people are in a special way similar to the crucified Christ, to the icon of love, they have drawn near to a special shared nature with him who, alone, is *the* image of God.

We can say of them, as Tertullian said of Christ, "However wretched his body may be..., it will always be my Christ" (*Adv. Marc.* III, 17, 2). However great their suffering may be, however disfigured or dimmed their human existence may be, they

will always be the favorite children of our Lord and they will always be his image in a special way. Taking the tension between the hidden and future manifestation of the image of God as our point of departure, we can apply the words of the First Letter of John to the question we have posed: "We are children of God even now, and what we shall be hereafter has not been made known as yet" (3:2). In all human beings—but especially in those who suffer—we love what they shall be and what in reality they already are. They are already children of God—they are in the image of Christ even though what they will become is not yet manifest.

Christ on the cross likened himself in definitive fashion to the poorest, the most defenseless, the most abandoned, and the most despised. And among these there are those who are the topic of our discussion here today, those whose rational soul is unable to express itself perfectly because of an infirm or sick brain, as though, for one reason or another, matter were resisting being taken up by the spirit. Here Jesus reveals the essence of humanity, that which is its real fulfillment—not intelligence or beauty, and even less wealth or pleasure, but the ability to love and to consent lovingly to the will of the Father, however disconcerting this may be.

But the passion of Jesus leads on to his resurrection. The risen Christ is the culminating point of history, the glorious Adam towards whom the first Adam, the "terrestrial" Adam, was directed. The end of the divine project thus expresses itself: every man is on a voyage between the first and second Adam. None of us is fully himself. Each one of us must become himself, like the grain of wheat which must die in order to bear forth fruit, in the same way as the risen Christ is infinitely fruitful because he has given of himself infinitely.

One of the great joys of our paradise will undoubtedly be to discover the wonders which love has worked within us, and which love has worked in each of our brothers and sisters, and in the sickest of us, in the most unfairly treated, in the most afflicted, in the most suffering of our brethren, while we did not

understand how love on their part was even possible, while their love remained hidden in the mystery of Christ.

Yes: one of our great joys will be to discover our brothers and sisters in all the splendor of their humanity, in all their splendor as images of God.

The Church believes now in this future splendor. She wants to pay great attention to this and to emphasize even the smallest sign of this splendor which can already be seen. This is because in the beyond each of us will shine more brightly the more we have imitated Christ in the context and the opportunities we have been given.

But I would like here to bear witness to the love the Church bears towards those who suffer mentally. Yes, the Church loves you. She not only bears towards you that natural "preference" borne by mothers towards the most suffering of their children. She not only adopts a stance of admiration towards what you will be, but also towards what you are now: images of Christ.

Images of Christ who should be honored, respected, helped to the utmost, certainly, but, above all, images of Christ who are bearers of an essential message about the truth of man. A message which we tend to forget too often: our value in the eyes of God does not depend upon intelligence, stability of character, or the health which enables us to engage in many actions of generosity. These elements could disappear at any moment. Our value in the eyes of God depends solely upon the choice we have taken to love as much as possible, to love as much as possible in truth.

To say that God has created us in his image means that he wanted each one of us to express an aspect of his infinite splendor, that he has a design for each of us, that each of us is destined to enter—by means of an itinerary which is specific to him—into blessed eternity.

The dignity of man is not something which presents itself visually—it is neither measurable nor quantifiable; it escapes the parameters of scientific or technological reason. But our civilization and our humanism have achieved progress only to the extent to which this dignity has been more universally and more fully bestowed upon ever greater numbers of people. Every step backwards in this movement of expansion, every ideology or political action which expels certain human beings from the category of those who deserve respect, would involve a return to barbarity. And we know that, unfortunately, the threat of our barbarity always hangs over those of our brothers or sisters who suffer from an impediment or a mental illness. One of our tasks as Christians is to ensure that their humanity, their dignity, and their vocation as creatures in the image and likeness of God are fully recognized, respected, and promoted.

I would like to take this opportunity which has been given to me to thank all those—and there are many engaged in thought or research, study or the promotion of different kinds of treatment—who are committed to ensuring that this image becomes ever more recognizable.

JOSEPH Cardinal RATZINGER
Prefect of the Congregation
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Altea
Althea officinalis.

CORRADO MANNI

Introductory Remarks

After the introduction by His Eminence Cardinal Angelini and the magnificent address by Cardinal Ratzinger, we now open this first session of those deliberations and reflections which Cardinal Angelini, with esteem and benevolence, has asked me to chair.

I would like to thank him very deeply for this invitation, even though other people, because of their special training and their cultural interests, would perhaps have been more suited to this task than I.

Whoever has drawn near to the central nervous system for reasons of professional duty or cultural interest has without doubt been fascinated by its functional and anatomical complexity. Certainly the most extraordinary feature of the central nervous system is the transformation of bioelectric and biochemical events into higher cerebral functions which are in turn able to express the will and the identity of each individual.

In this miraculous integration of external signals and stimuli with mental processes there is to be found the very essence of the human soul, the person created in the image and likeness of God.

During this session of this international conference and through the contributions of the expert speakers who are here present we will address ourselves to the questions and problems relating to:

– the mechanisms by which the neuroanatomical structures support the very functions of the human mind;

– the problem of physical pain (*algos*) and its transformation into emotional and cognitive experience (*pathos*);

– the importance of modern psychiatry as a discipline which can perceive precise dysmetabolic processes at the root of mental illness and then propose common paths for treatment;

– the socioeconomic relevance of mental illness, one of the most frequent and crippling illnesses of this century; the causal mechanisms of mental illness, the etiological integration between genetic substrata and environmental influences;

– the question of the dignity of the mentally-ill person, who is created in the image and likeness of God, a person who expresses the suffering of Christ through his own illness and his own socioenvironmental disturbance;

– and, finally, the most important advances in research in the neurosciences.

The contribution of the neurosciences, over the last fifty years in particular, has allowed us to delve deeply into the mechanisms by which a nervous signal becomes transformed into a bioelectric event (potential for action), a biochemical event (synaptic transmission), and finally into an event of perception or a cognitive experience.

We will now listen to the contributions which the various participants in this session are going to offer. I would like to thank them at the outset for what they will say—which will certainly be of great interest.

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ERWIN NEHER

Basic Mechanisms of Signalling and Information Processing in the Brain

The central nervous system gathers the information which is conveyed by our senses. It constructs a representation of the outside world within us, and coordinates our movements and our bodily functions. It is also the material substrate of the so-called higher brain functions like thought, memory, and consciousness. Research in the Neurosciences during the last century, particularly during the last 50 years, has revealed many mechanisms by which information is received, by which signals are propagated, and by which information is processed and stored in the central nervous system. At the center of these findings are the two basic mechanisms: Propagation of the action potential—the electrical nerve impulse, and the mechanism of synaptic transmission—the passing of the signal from one neuron to the next one.

We have learned that each of the 100 billion of our nerve cells is connected via synapses to about 1000 to 10,000 other neurons and that the strength, and nature of these connections is determined both by genetic predisposition and by our experiences. Most neurobiologists believe that our memories and many of our individual abilities are laid down in the pattern of connections between neurons in our brain. Learning and acquisition of new skills, then, require changes in these connections, so-called 'plastic changes'. It has become clear over the last few years that the central nervous system utilizes and adapts the whole spectrum of signal mechanisms which have evolved in different parts of our body in order to induce such changes. These include mecha-

nisms for regulation of metabolism and those which govern the formation and repair of tissues.

While we know many of the principles underlying the action potential, the synaptic transmission, the way by which a synapse can be strengthened and weakened, and many of the general principles of the architecture within our network of neurons, we know little about the higher organization, about how the individual parts and subsystems cooperate in order to produce the so-called higher brain functions such as consciousness, thought, emotion, and recollection. Regarding these issues, it seems, modern neuroscience is in a state where the best progress can be achieved by formulating an appropriate question rather than trying to give an answer.

In this lecture, I will, therefore, try to explain some of the basic mechanisms which I have men-

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Aloi perfoliata.

tioned so far. In doing so, I will emphasize mechanisms mediated by ion channels, because this has been my own area of research over many years. I will then describe some of the very fundamental principles of neuronal architecture. I will do this by using the example of the first few stages of information processing in our visual system—largely following the work of Hubel and Wiesel.

Ion channels underlie the propagation of the action potential and the action of neurotransmitters

Neurons are specialized cells, which—like all other cells of our body—are surrounded by a membrane, separating the cell interior from the extracellular fluid. The nerve impulse is a wave of positive electric charge propagating along the nerve axon, a cylindrical extension of the cell body. In 1952 Hodgkin and Huxley were able to describe this electrical signal as a consequence of permeability changes of the nerve membrane to the major cations of the body fluid, which are Na^+ and K^+. For a long time it was not known what the molecular mechanism of this permeability change was. In the years 1976 to 1980 my colleague Bert Sakmann and myself were able to show that membrane current fluctuates in discrete steps. This was taken as proof that there are protein molecules embedded in the nerve membrane, so-called ion channels, which have an annular structure. They constitute membrane pores which open and close when they are appropriately

stimulated. We developed a method which allowed us to record membrane currents with sufficient sensitivity so that discrete step-like changes upon opening and closing of these pores could be studied in detail. Subsequently, it was found that various types of such pore-like molecules are operative both in action potential propagation and during synaptic transmission (see Fig. 1).
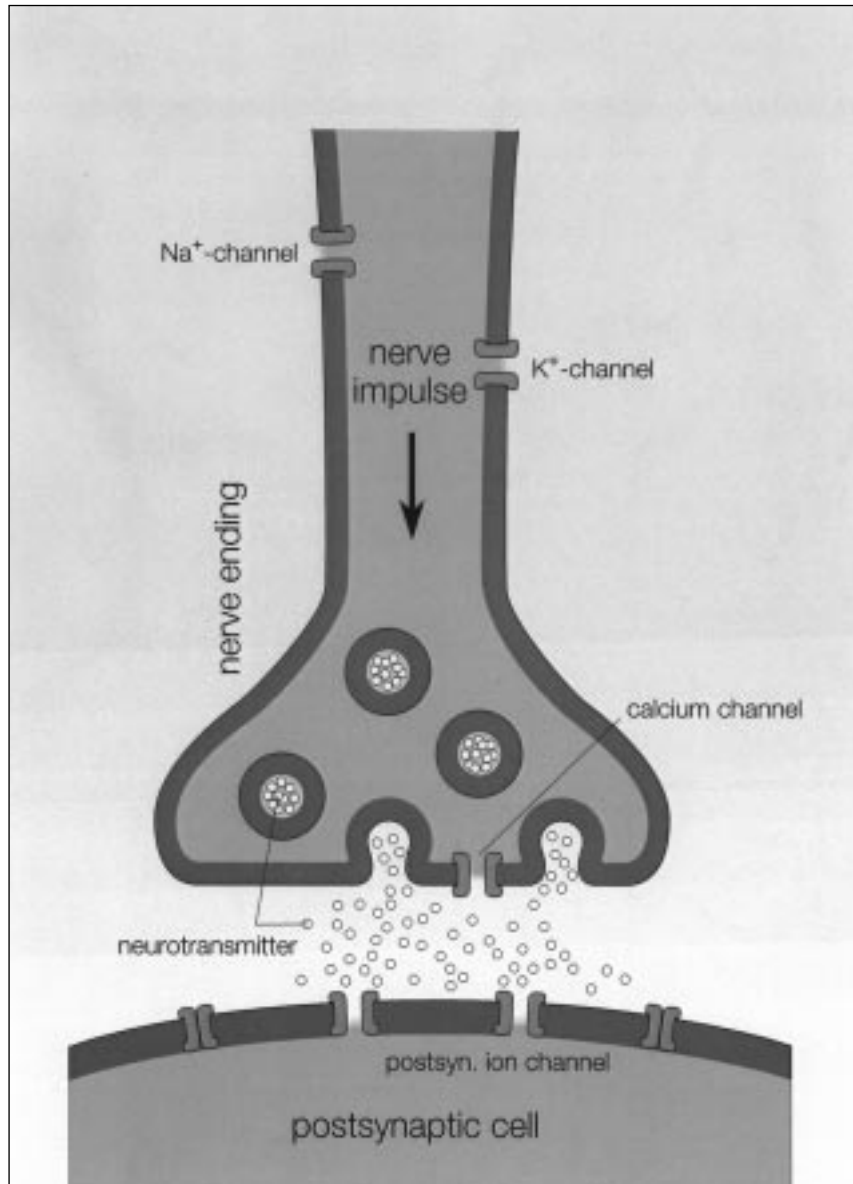
Fig. 1 - The mechanisms of action potential propagation and synaptic transmission. The action potential propagates along the nerve fiber due to the opening and closing of Na⁺- and K⁺-channels, which generate a sequence of inward and outward current across the membrane. At the nerve ending Ca-specific ion channels—which open and close in response to voltage changes in a way quite similar to Na⁺-channels—cause an influx of Ca⁺⁺. This, in turn, triggers the fusion of synaptic vesicles with the plasma membrane. The vesicles thereby release their content (neurotransmitter) into the cleft between presynaptic nerve ending and postsynaptic cell. Neurotransmitter diffuses to the postsynaptic membrane where t binds to specific receptors. The receptors, in many cases, are themselves ion channels which open upon binding of a neurotransmitter. This way an electrical signal is generated across the postsynaptic membrane. Signals from a large number of synapses are 'integrated' at the dendritic membrane of neurons, generating a stream of action potentials, which, in turn, propagate to subsequent cells.

Furthermore, it was found that a multitude of other types of channels operate in diverse cell types fulfilling a variety of cellular functions, such as in sensory transduction, regulation of fluid secretion, cell volume changes etc. Basically, all types of cells in our body are equipped with specific sets of ion channels. Of particular importance are channels which are permeable to the Ca^{++} ion. This is so because the concentration of free Ca^{++} inside the cells is orders of magnitude lower than its concentration in the blood and tissue interstices. Opening of these channels, resulting in Ca^{++} influx, leads to a sudden increase in cellular Ca^{++} with the resulting activation of a variety of Ca^{++}-dependent proteins, such as contractile proteins (in muscle cells) or Ca^{++}-dependent enzymes. Ca channels, which are regulated by membrane voltage, therefore, constitute the link between electrical signals of the nervous system and the metabolism and functions of effector cells. Ca^{++} channels and cells responding to Ca^{++} changes can be considered as the 'output' of the nervous system—if the latter is considered as an electrical signal processor. Ca^{++} signals, however, are also very important in forming and modifying the central nervous system itself, as will be detailed below.

Synaptic Connections Change in a Use-dependent Manner

Neurons utilize all known mechanisms of cellular regulation to 'modulate' electrical activity and to induce 'plastic changes.' It was mentioned above that neuroscientists consider the pattern of connections among neurons as the material correlate of memory. Such memory includes both the so-called 'declarative memory'— the memory contents that we are aware of and can be described in words and the 'procedural memory', the memory underlying the performance of tasks, and governing unconscious reactions. If this is so, then learning of a task or an acquisition of knowledge must go along with changes in this connectivity. Therefore, neuroscientists over the last 20 years have studied

mechanisms by which connections among neurons (synapses) are formed, severed or changed, depending on activity of the nerve cells involved and depending on the 'use' of a given synapse. One mechanism, which received particular attention, is the so-called long-term potentiation (LTP)— the observation that certain synapses are strengthened for hours and longer, after having been heavily used. Particularly interesting is the finding that certain forms of LTP were only observed if stimulation was effective, i.e. when the presynaptic stimuli actually were successful and elicited postsynaptic action potentials. Such 'coincidence' of pre- and postsynaptic activity is an important element of theoretical considerations on learning and memory. In many cases it could be shown that the influx of calcium, going along with the postsynaptic action potential, was necessary for longterm potentiation. Studying these phenomena, neuroscientists found that Ca^{++} as well as all other so-called second messengers— which have been known for a long time as regulators of cellular metabolism—are involved in mediating LTP and in modifying ion channels as carriers of nervous signals. The modifications occur on all levels: Covalent modification of existing ion channels by phosphorylation, expression of new channels by activating transcription, degradation of channels, enlarging synapses morphologically, formation of new synapses and elimination of entire cells by the process of programmed cell death or 'apoptosis.' This range of mechanisms, in all of which Ca^{++} forms links between electrical activity and material changes, provide options for alterations in the connectivity among neurons which can last over seconds to minutes or else for hours, days, or for the entire lifetime of the individual.

Sensory Information Is Processed by Progressive Abstraction in Consecutive Layers of Neurones

The lens of our eye projects an image of the outside world onto the retina. Here, a layer of neuron-like cells, the photoreceptors, transduce light intensity into electrical signals. This is the only known place in the visual system where there is a strict one-to-one correspondence (at fixed orientation of the eye) between a given cell and the light intensity of a location in the outside world. The signals of the photoreceptors represent a map of light intensity around us.

Within the retina the photoreceptors pass their electrical signals through a complicated network of neurons to another layer of neurons—the ganglion cells of the retina—which constitute the output elements of the eye. Each ganglion cell sends an axon through the optic nerve to the next stage of information processing within the brain, the lateral geniculate body. Although the ganglion cells represent again a map of the outside world, they no longer encode strictly light intensity, but rather local light contrasts. Thus, for instance, members of one class of ganglion cells respond particularly vigorously, if there is high light intensity at the center of their 'receptive fields' and low light intensity in the immediate surroundings. Uniform illumination, no matter whether of low or high intensity, evokes only minor responses.

In the geniculate body, again, layers of neurons are found in which each cell responds to local contrast at a certain position in the outside world. The response characteristics of a given cell are quite similar to those of ganglion cells. However, the fibers of the optic nerve are distributed between 6 parallel layers of neurons, each layer giving rise to a downstream pathway which handles a certain aspect of visual perception, such as color, form, or movement. Besides, the cells of the geniculate body receive many inputs from other areas of the brain, which are believed to control the flow of information between the retina and the brain. In this way the brain may have a means to prevent being overwhelmed by huge amounts of information in situations when this information is not considered relevant.

The nerve fibers of the neurons in the geniculate body project onto layers of cells in the primary visual cortex. Here cells are found which no longer respond optimally to spots of light, but rather to lines or bars moving across the visual field. In one class of cells, the simple cells, a given cell responds optimally to a line of a certain orientation being moved through a certain position of the visual field. For another more remote class of cells (complex cells) again lines are optimal; however, they no longer have to be localized precisely at a certain position in the field of view. Still, the orientation of the line is important, however.

We can see, as we go step by step through the first stages of information processing in the visual system, how the representation of the outside world is more and more abstracted. At each stage one property or specificity is lost, while another one is gained. So, when we go from photoreceptors to ganglion cells, absolute intensity is lost while sensitivity to local contrast is gained. Stepping from ganglion cells to the cells of the geniculate body, the property that all information from one receptive field is represented by one area in the network is lost, while parallel processing in separate layers is gained. Advancing to the simple cells of the primary cortex, specificity of point-location is lost while directional selectivity and edge detection is gained. Finally, when moving on to complex cells, the sensitivity for the exact position of edges is lost, while a given cell gains the capability of responding to a wide part of the visual field. We can see that at several early stages of visual information processing, our 'view' of things is primarily represented by edge contrasts. This may be the reason why we readily recognize objects of scenes, even if they are only sketched as simple line drawings.

Neuronal Networks Can Perform Surprisingly Complicated Tasks

The examples of visual information processing outlined above

show that layers of neurons are perfectly capable of performing complicated computations. Since we know many of the signalling properties of individual neurons, we can ask the question, How do the neurons of one layer have to be connected with the neurons of the subsequent layers in order to achieve the particular processing between layers? It turns out that it is not difficult to design connection diagrams—based both on observed morphology and on knowledge about functional properties—which are expected to generate the observed signalling pattern. In several cases, indeed, several alternative schemes have been proposed which seem to be appropriate, and it is currently not known which of them is used by the central nervous system.

The general architecture of layered neuronal networks, observed in many parts of our brain, has given rise to a discipline—computational neurobiology—which has the ambitious goal to reproduce these mechanisms in computers and in control circuits for technical applications. In these studies elements are defined (either as 'objects' in a computer or as logical elements on a circuit board) which represent neurons. They are arranged in layers and are connected to 'neurons' of subsequent layers in a way similar to real neurons. It turned out, both in theory and in practice, that such an architecture can perform surprisingly complex tasks—not only spatial abstraction, as described above for the visual system. It can also be designed to display features such as associative memory, completion of patterns stored in such memory after presentation of partial inputs, pattern recognition, detection of weak correlations between patterns, and control of robot arms. A very interesting property of such networks is that they can 'learn' or can be 'trained' in the sense that there are algorithms available which indicate how the connections between the 'neurons' of layers have to be changed (based on the response to trial presentations of stimuli) so that the network will respond optimally to a set of input patterns. Such networks very often display surpris-

ing complex 'behaviour,' despite the fact that the interactions among their elements are restricted to the most simple ones found for neurons. Interactions among neurons are orders of magnitude more complex, so that it is not at all proven that our brain works in any way similar to the artificial 'neuronal nets.'

Thus, it is fair to say that research in the field of neuroscience over the last 20 to 30 years has led to an understanding of many of the accomplishments of our central nervous system. On the other hand, it is also apparent that we are far from an understanding of the higher brain functions, such as cognition, consciousness and emotions. From the present point of view it is not even clear whether there is a path to improve understanding of these phenomena. The approach which I have presented is the 'bottom-up approach,' an attempt to explain some of the properties of the system by studying its elements. The alternative is to consider the system as a whole, by studying its accomplishments and its limitations. Unfortunately, there is no continuity between the two approaches. Current methodology in cellular research is quite limited—even when restricting study to only a single cell. At-

tempts to simultaneously record from or to visualize the activity of many neurons are even more restricted. On the other hand, all the evidence indicates that information processing is highly parallel and distributed, and that most tasks of the brain are accomplished simultaneously by large assemblies of neurons. The two approaches can definitely complement and advance each other; however, it also has to be recognized that there is a very large gap and currently no vision of how it might be filled.

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PIERLUIGI ZUCCHI, BONIFACIO HONINGS

Algos and Pathos: Fundamental Moments in Man's Spiritual Growth

As I was entrusted with a very complex and rich topic, I will immediately come to the heart of the matter, trying to proceed schematically in order to make the subject of my report more comprehensible. I am going to divide my report into three parts: an ethical-philosophical introduction, an anatomico-clinical part supplied with epidemiological data, and a therapeutic part in which the fundamental role of prayer is pointed out—together with the administration of drugs, it can bring the patient's life-quality great advantages, as is stated in a recent statistical study conducted with the highly valued collaboration of Professor Honings.

Ethical-philosophical introduction

As far as their etymology is concerned, I would like to give a definition of the two Greek terms, *algos* and *pathos,* whose meaning is physical pain and moral suffering, respectively.

The former—*algos*—represents a physiological reaction to nociceptive stimulations, e.g., a trauma; the latter—*pathos*—is considered a lacerating emotional reaction subsequent to a psychological background the subject regards as negative, such as the loss of someone close or under particular psychological conditions due to stress, anxiety, and depression.

In the grammar of suffering *algos* and *pathos* are apparently two negative algebraical entities which, according to a religious perspective, always lead to a pos-

itivity that involves, in interest if not in consent, all men, both believers and agnostics. In fact, only a transcendent view can give significance to pain and suffering, also in their relation with guilt, since, in this case, suffering is not only interpreted as penalty and punishment but rather as atonement and redemption. Thus pain is the real concealed energy in man's psychophysical heritage, able to overcome the real lethal effects of evil: it is the real point of contact in solidarity between God and men.

However, it is necessary to think deeply over how, in everyone's ethical-religious education, only the conditions of physical pain and moral suffering lead man to think and raise himself to God and, under these conditions, how God is able to instil Himself completely in man.

The individual and individual-

Ceranica
Ceranium Bonjeanc

izing experience of pain leads man to a better knowledge of his own self, whose identity and interpretation are often sought after breathlessly in such a difficult and complex articulation of soma-psyche.

If he could not succeed in giving a sense to what he is suffering, no man would be able to live and overcome his own suffering. Therefore, the Christian sets a neoethical image of man against a biologistic and immanentistic view: *homo patiens*, where pain tries to find a significance of its own, is set against *homo sapiens,* who is set against *homo faber*. The aim of consecrating pain as a sacrifice proves true in giving it significance. Every man's pain and suffering will make sense only if they lead him to accept the sacrifice these factors call for.

As Christianity taught first through the suffering of God in Christ, it is only possible to understand pain and suffering better in the concept of sacrificial suffering—the bases to understand the grammar of any act of love are only laid through the Cross. In fact, as Cardinal Angelini states, "a society of Love cannot exist without giving pain a value, for the human condition is necessarily accompanied by pain" (F. Angelini, *Quel Soffio sulla Creta*, A.M.C.I., Roma, 1990).

Christian doctrine on suffering does not only call for a mild acceptance of sufferings, but also for a suffering endowed with beatitude in which man can give himself up to God so as to accept any pain and suffering, which are to be loved and sometimes even searched for. As far as this out-

look on life is concerned, Christianity opposes eudemonism. While eudemonists seek pleasure and find suffering, Christians undergoing pain try to interiorize this moment they regard as privileged, for it includes the beatitude and joy of their faith.

Now let me show you the important function pain may perform in the clinical field.

Anatomicoclinical part

In the clinical-biological field, pain is certainly the greatest ally of man and all beings. In confirmation of this assertion, which may sound very peculiar, unfortunately there is a very rare syndrome, namely *congenital analgesia*—the patient comes to death, usually in his early years, because he does not have the nociceptive system indispensable to prevent either situations of injury, e.g., a burn, or even more serious dangers, e.g., an abscess or a visceral perforation. Apart from that very rare syndrome, in its continuous and very slow phylogeny, nature devised extremely refined and intelligent mechanisms which adjust themselves to the changing environmental conditions in order to defend itself against situations of injury.

There is also a clinical condition opposite to that of congenital analgesia, namely *hyperalgesia* or *allodynia*, in which any stimuli, even the most innocuous ones, are felt as pain.

Both pain as a precious "alarm bell," so properly defined by Descartes in 1600, and all the systems for pain control, i.e., analgesia, are important for man's survival. In order to obtain the homeostasis indispensable to the individual's kinesthesia the organism has at its disposal the sleeping-waking rhythm, thermoregulation, and hunger and thirst instincts.

These are fundamental and inalienable biological mechanisms in human beings' life.

Now we are going rapidly to examine one of the most important systems for the body's defence—the Pain-Analgesia System. Classically, the Pain-Anal-gesia System is a neurohormonal system consisting of a) afferent pathways carrying a nociceptive stimulus from periphery (cutis, subcutis, muscle, joints, viscera) to the upper centers; b) upper centers as points of arrival of sensibility and cognitive integration interpreting a painful message and carrying out a responsive strategy; c) systems modulating and reducing a nociceptive input.

This schematization of the Pain-Analgesia System, where, as we will see, pathways and centers are morphologically identifiable, has only a didactic purport because clinically pain does not always follow the above-mentioned typical course, but it may arise in one of the three stations: peripheral algogenic receptors or nociceptors, nociceptive afferent pathways, or even the brain.

One of the most important and current problems of neurophysiology is to understand and then to interpret its own physiopathological mechanism of passing information from one cell to the other more and more completely. Therefore, the physiopathologist's aim is to have the theoretical and practical knowledge of the pain neuroendocrine substrate he will have to deal with in the near future.

But where does the painful sensation start and where is it received?

Various kinds of algogenic noxae—mechanical, thermal, chemical—are received by organules located in different districts—cutis, muscle, joints, viscera—which are called receptors (Fig. 1).

An algogenic receptor or nociceptor is the most distal histological formation for stimulus transduction, connected with two different kinds of fibers: Aδ myelinic fibers, so named because they have a myelinic sheath, and C amyelinic fibers, not covered with a sheath.

Experiments with electrical stimulation on nerves showed that these two kinds of nociceptive fibers conduct two different kinds of pain. In fact, while after a selective stimulation of Aδ fibers there is an acute, stabbing, well-localized pain, also called first pain, the activation of C fibers evokes a diffuse, dull, burning pain, also called second pain, which is typical of chronic pathologies.

But which pathways transmit to upper centers various kinds of nociceptive noxae?

The characteristic anatomical pathways, which conduct and modulate pain to the upper centers, are: a) the Neospinothalamic

Fig. 1 - Schematic representation of sensivity receptors
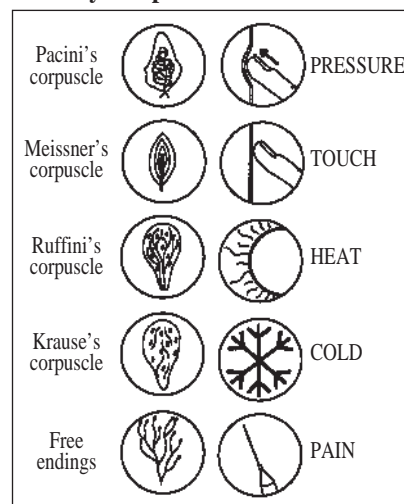
Fig. 2 - Schematic representation of neospinothalamic and paleospinothalamic tracts.
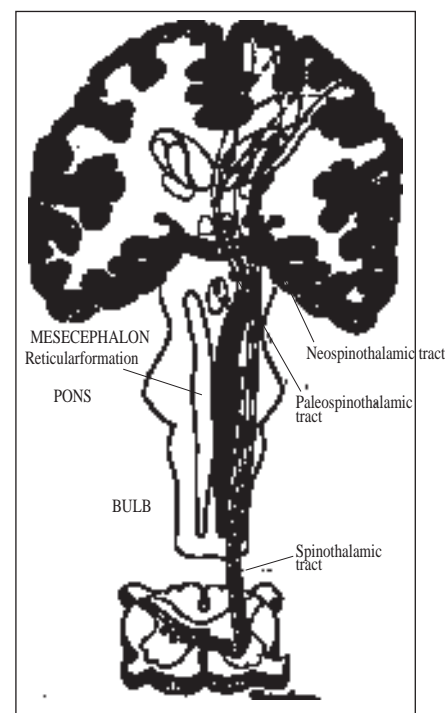
System, mainly consisting of Aδ myelinic fibers, and b) the Paleospinothalamic System, consisting of C amyelinic fibers (Fig. 2). The pathways I have just described are the anatomico-physiological substrate of every algogenic condition where all bioelectrical, ionic, and molecular events take place. After a nociceptive stimulus, they appear in the Nervous System from the receptor to the cortex and form *nociception.*

As we have seen, the first event of nociception occurs at the receptors level, so-called nociceptors; the second event of nociception consists of a transmission along the fibers—along the first afferent neuron fiber, that takes the message from the receptor to the spinal cord's posterior horn, where the second neuron fiber leads to the thalamus, from which the third neuron fiber leads to the cortex. There the integrative mechanisms of the algic condition take place (Fig. 3).

In addition to the nociceptive system there is the *antinociceptive system,* which consists of all the neuronal networks and those of neurotransmitters which pro-

vide for pain control and modulation (Fig.4).

But what is the basic situation the individual begins to perceive pain in?

This condition is represented by the *algic threshold,* which is determined by the slightest intensity felt as pain a nociceptive stimulus can provoke in man or which evokes behavioral responses to pain in animals—the reflex of flight or vocalization.

All the anatomicoclinical aspects we have described so far are the fundamental substrate to interpret the physiopathological mechanisms that are at the basis of physical pain or ALGOS. Unfortunately, even in the latest treatises on physiopathology and pain therapy, the perspective you get is limited as far as the neurophysiological formulation of pain is concerned. In fact, many researchers are almost exclusively interested in the study of nervous pathways and centers in the reptilian brain, i.e., that brain which includes the systems starting in the primary afferent neuron and reaching the posterior horn, ascendant pathways, nuclei, mesencephalic bulb pathways, and thalamus. There is

very little mention of the other two phylogenetically more recent brains—*limbic* and *neocortex*—in which pain takes on the psychoaffective features so proper to cognitive and emotional experience, that is, PATHOS. However, it is right in these areas of the nervous system that the most intelligent strategies of response and modulation for the *pain phenomenon*, learnt and memorized, take place, but only a few research groups are interested in them.

Cultural dynamics of pain

At this point, after identifying the anatomico-physiological areas where the mechanisms of pain perception occur, we wonder what fundamental role the individual's cultural elements play in his psychological elaboration of pain.

Everyone's education plays a very important part in perceiving a nociceptive noxa and responding to it.

Concerning this, in order to make you understand the problem's extent in a very simple way, I would like to report two exam-

Fig. 3 - Schematic representation of *nociception* stations (I neuron: receptor-spinal cord; II neuron: spinal cord-thalamus; III neuron: thalamus-cortex).
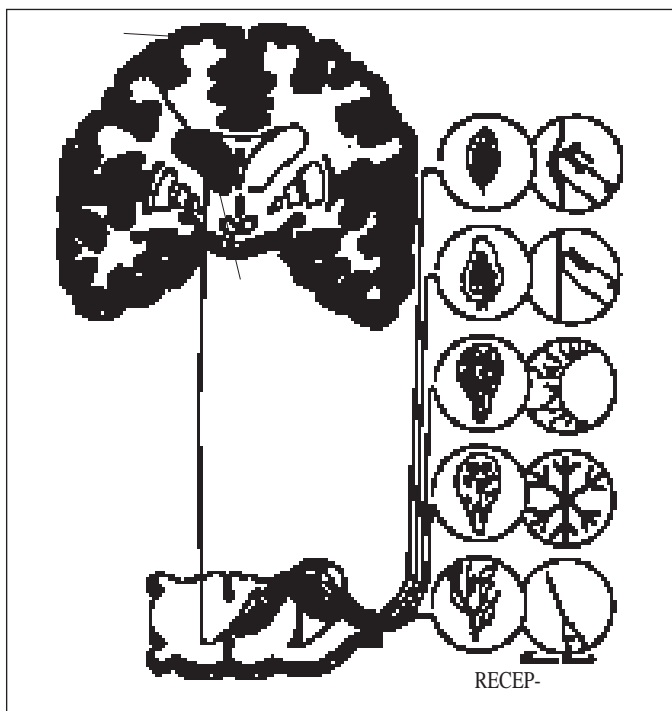
Fig. 4 - Schematic representation of *antinociception* main stations.

RECEP-

limbic system

intralaminar and medial thalamic nuclei

postero-lateral ventral nucleus

posterior thalamic nuclei

hypotalamus

reticular formation

periaqueductal gray m.

gigantocellular nucleus

spinal cord (I LAMINA)
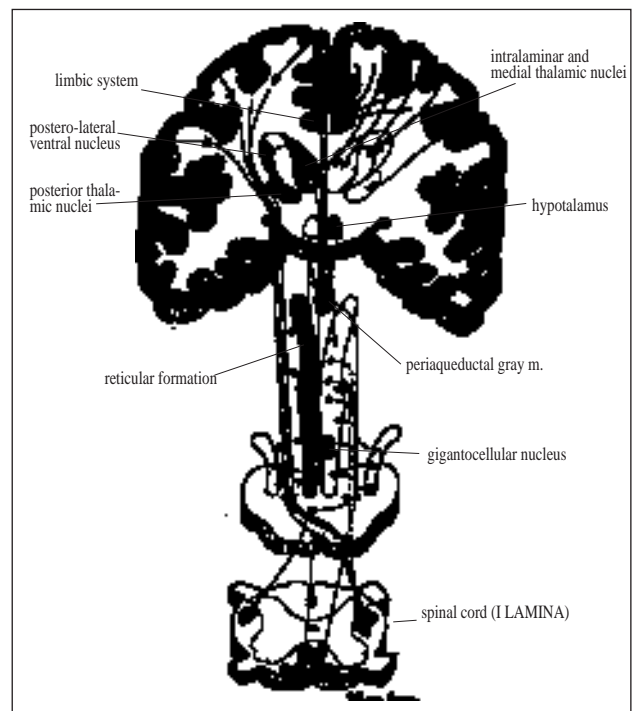
ples from literature—the *Couvade* and the *Initiation of the Chieftain.* We well know that labour is the most intense physiological nociceptive experience a human being can feel. In their anthropological studies of some populations in India, South America, and the Basque Countries, Kroeber and Kosambi pointed out that in the *Couvade* at a baby's birth while the man is regarded as parturient, the woman goes on working in the fields with no pain until the moment of her delivery. The chieftain's initiation rite is another example testifying how emotional, motivational, and affective factors have a fundamental role in perceiving pain. In this rite steel hooks pierce through the back muscles of the man chosen to represent God's power among the inhabitants of the tribe. By ropes inserted in these hooks, he is lifted up to the top of the wagon tower, where he is supposed to bless people in the nearby villages he is being taken to.

Therefore, we can deduce from the two examples that psychological conditions of great emotional involvement can raise the physiological threshold of pain perception so that pain is not felt even in clearly algogenic conditions.

On the other hand, emotional conditions psychologically opposite to those examined so far—anxiety and depression—lower the algic threshold so that commonly painless nociceptive stimuli are felt as painful. As a consequence, a condition of pathos which is often disproportionate to the algogenic noxa is created.

Psychological dynamics of pain

As we have just seen, cultural and psychological elements can influence the individual's psychoaffective elements, raising or lowering his pain threshold.

As we will see further on in the course of this report, both in the psychologically-ill man and in the physically-ill man the physician can establish different responses to a therapy according to the patient's ethical-religious and cultural bents.

The suffering brought to maturity in physical pain may not be only a heritage of the *patient's* solely spiritual growth, but it may involve his *relatives* and *physician* as well, establishing a mode of testing the *three entities* which interact intimately.

A particular syndrome, namely *Burn-Out Syndrome* (Mayou, 1987), hits some physicians who certainly have poor spiritual training yet have to face very stressing psychological situations, such as those occurring in pain therapy wards. *Burn-Out Syndrome* is characterized by a depressive symptomatology with a tendency to ataraxy and often to sadness and a sense of reduced personal realization. His daily relation to a patient affected with an algogenic pathology inevitably causes the physician to interiorize these sufferings, often leading him even to severe psychic consequences.

It is precisely in the patient's physical pain and moral suffering that the physician, if a believer, and the patient's family, ethically well educated, find a special moment of spiritual growth and enrichment. In fact, the family cannot be only a union among sound and self-sufficient people; on the contrary, it must set itself up as the natural site of affective symbiosis, especially when one of its members becomes inactive or needs care. Only in this way will it accomplish the main task of be-

Cicuta. Maggiore.
Famiglia delle Ombrellifere.

ing a real physiological meeting point of solidarity, availability, and love—ethical qualities that should be intrinsic and ingrained within every family group.

In fact, the experience of physical pain and moral suffering the patient is involved with cannot be reduced or reified within the context of experiences from outside the human condition. On the contrary, they must be an indelible way-of-living in which pain is not levelled or emptied of its significance.

Each patient's pain-background, which is always a pain we can term *global,* due to its constant involvement with man's psychophysical sphere, cannot be "banalized" or "psychologized" as a period in his life which does not represent, even for the agnostic, any contact with the supernatural or lead his mind to maturity and personal introspection. In fact, man, whatever his bent may be, tends to absolute truth, but it must not be regarded as an addition of partial truths, though multiplied to infinity; insufficiency and partiality will always be insufficiency and partiality.

But let me show you the kind of dialogue the physician sometimes may conduct, especially when an optimal relation has been established with his own suffering patient and when his patient's health is really precarious.

The physician, especially if a Christian, must feel called to take a "deacon-like" attitude towards his suffering patient, establishing a kind of communication identifying itself with a mystagogic pastoral approach, as Zulehner defined it. As a dialogical method, mystagogy (from Greek *mysterion agein* = to initiate into mystery) gets the physician to establish a suitable intersubjective communication able to develop the intrasubjective communication the growth of both interlocutors depends on.

Respect for those who suffer requires of the physician a tactful and sometimes silent approach as well. After serious mystagogic training, silence as a kind of dialogue with his patient shows the physician's great availability and
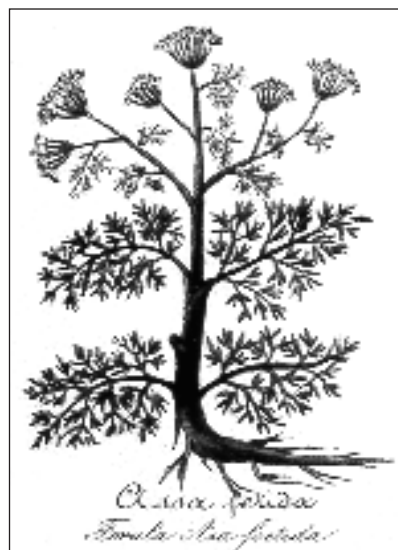
may be his most constructive response, for in these cases a *silent word* is expressed by his total presence. In fact, in the face of pain and suffering, *silence* represents a mutual enrichment and plays the fundamental role of spiritual development in the peculiar language which develops between the physician and his patient. Leston Havens points out properly that it is precisely in his silence that the individual "takes up an empathetic position" towards the sufferer, allowing himself affective resonances, for it is in this agonizing circumstance that the physician identifies himself with the other's suffering, though without losing his own identity. The silence of the physician, then, shows a full empathy between him and his patient: by this tactfully silent attitude the believing physician and some psychotherapy schools do not mean to stay behind or in front of, but *next to their patients,* sharing their condition. This *dialogic silence* between physician and patient, especially when a really empathetic relation is established between them, gets the sick person to introspect continuously so as to revalue the language of his own suffering in close diologue with his own life.

Depending on circumstances, then, to alternate *words* with *silence* is the most significant kind of language in the physician-patient dialogue.

Not surprisingly, sick people, particularly those who suffer very much, are disturbing elements often left to live alone with their own miseries in a technocratic and thanatophobic society which is only interested more than ever in its output and production—life-parameters tending to rise to "ethical values" of indivual reference more and more.

But what is the delicate role of the physician in his relation with his patient, especially in the light of the present laws?

The *physician* happens to play the very important role of a "path" between contrasting personal and social necessities, especially when there are financial pressures to cut costs which have no sufficient cost-profit ratio.

The possibility of reconciling often opposite positions between the physician and hospital administration could lie in following the principle of helping those who need more care.

Epidemiological aspects of pain

In order to understand better how much the "pain-question" may affect society, let me report the most important epidemiological data published.

Pain incidence with reference to pathology is 10% *neoplastic pain* and 90% *non-neoplastic pain* (Fig. 5); the problems associated with neoplastic pain consist of: 21.5% of cases cannot sleep, 7.4% can do nothing, 18.2% cannot sit longer than 15 min., 11.7% cannot watch television, 14.8% cannot read a book, 26.4% cannot see other people (Fig. 6); handicaps associated with neoplastic pain consist of: 27.1% of cases cannot run or dance, 5.5% cannot look after personal hygiene, 15.8% cannot walk in the country, 5.6% cannot cook, 8.3% cannot go shopping, 13.5% cannot clean the house, 10.9% cannot go upstairs and downstairs, 5.4% cannot get dressed, 7.8% cannot walk on the road (Fig. 7); in the United States the incidence of pain compared with the number of affected people is 11 million for neoplastic diseases and 86 million for non-neoplastic ones (Fig.8); in the United States the economic cost

PAIN INCIDENCE
(in relation to pathology)

NEOPLASTIC PAIN (10.0 %)

NON-NEOPLASTIC PAIN (90.0%)

Fig. 5

PROBLEMS ASSOCIATED WITH NEOPLASTIC PAIN
pain makes it difficult

SLEEPING (21.5%)
DOING ANYTHING (7.4%)
SITTING LONGER THAN 15 MIN. (18.2%)
SEEING OTHER PEOPLE (26.4%)
READING A BOOK (14.8%)
WATCHING TELEVISION (11.7%)

Fig. 6

HANDICAPS ASSOCIATED WITH NEOPLASTIC PAIN
pain prevents

RUNNING (27.1%)
GETTING DRESSED (5.4%)
CLEANING (13.5%)
WALKING ON THE ROAD (7.8%)
GOING UPSTAIRS AND DOWNSTAIRS (10.9%)
COOKING (5.6%)
WASHING (5.5%)
WALKING IN THE COUNTRY (15.9%)
GOING SHOPPING (8.3%)

Fig. 7

PAIN INCIDENCE IN THE U.S.
data reported in millions of people

NEOPLASTIC PAIN (11)
HEADACHE (29)
RACHIALGIA (21)
PAINFUL ARTHRITIS (24)
MUSCULO-SKELETAL PAINS (12)

Fig. 8

of pain calculated in millions of missed working days is 58 million for neoplastic pain and 375 million for non-neoplastic pain (Fig.9).

The cost of direct medical assistance,—i.e., the utilization of medical and paramedical staff, hospital facilities, diagnostic examinations, drugs—is 9 billion dollars every year for neoplastic pain, 4 billion for recurrent headaches, 11 billion for painful arthritis, 13 billion for rachialgia and 8 billion for musculoskeletal pathologies (Fig. 10); the yearly indirect cost—i.e., missed working days, claims for damages, legal controversies—is 6 billion dollars for neoplastic pain, 12 for recurrent headaches, 6 for painful arthritis, 7 for rachialgia, 3 for musculoskeletal pathologies (Fig. 11).

Medical-theological interpretation of pain and suffering

After examining these important epidemiological data, according to a medical-theological interpretation we will see what etiology might be assumed for this clinical symptom, so incisive and decisive in everyone's life (Fig. 12). We learn that man's original *guilt* and so the resulting *evil*, leads to *pain*—a physical perception suffered by man as pure *passivity*. Man goes from this *biological phase* to an *ethical phase* where the initial physical entity develops the moral affectivity that leads the individual to an interiorization of his own pain according to which *suffering* becomes a moment of free and conscious *re-activity* involving his *will*. This passage from a biological to an ethical phase of pain leads man to a greater introspective activity of his own self. This condition leads man to have a better knowledge of God and then to increase his faith—a fundamental moment that enables him to accept even clinical situations of very intense pain due to an increase in his physical endurance that such an attitude of ethical introspection can establish more in everyone who believes in a Supreme Being.

Pharmacological therapy and ethical therapy

Now let me show you how positively ethical therapy—that is, prayer—interacts on the sufferer's pharmacological therapy.

Fig. 9 - PAIN ECONOMIC COST IN THE U.S. millions of missed working days

Fig. 10 - PAIN DIRECT COST IN THE U.S. in billions of dollars

Fig. 11 - PAIN INDIRECT COSTS IN THE U.S. in billions of dollars
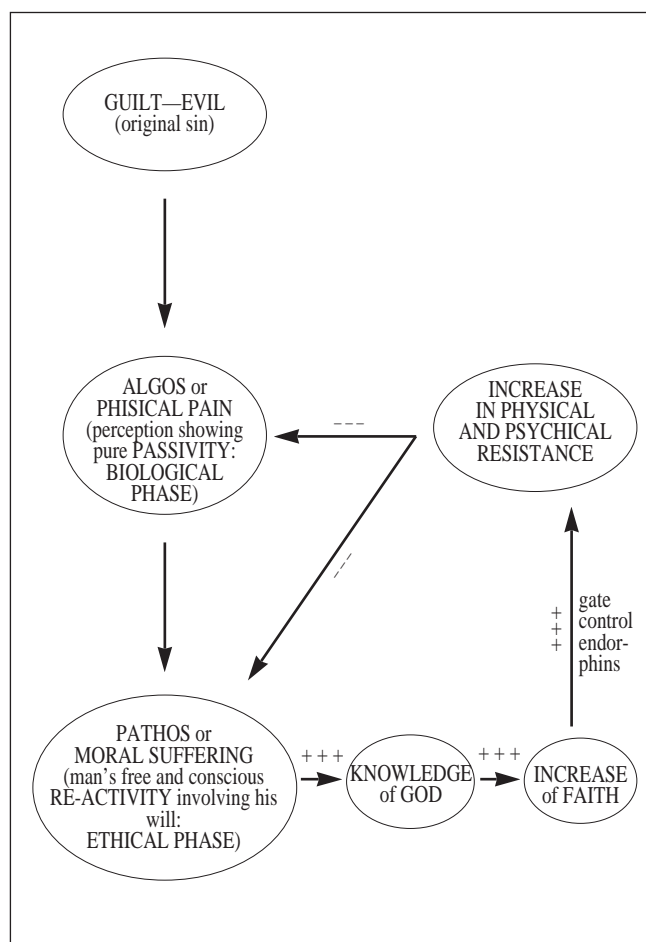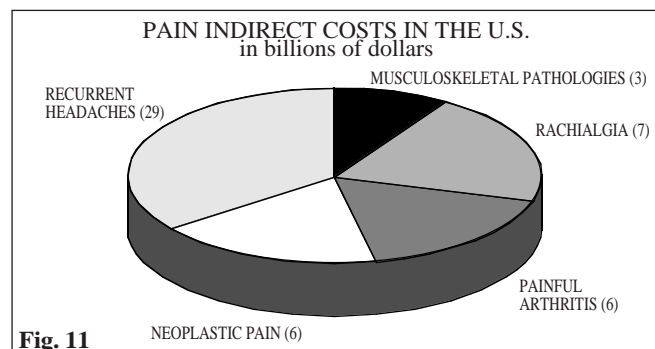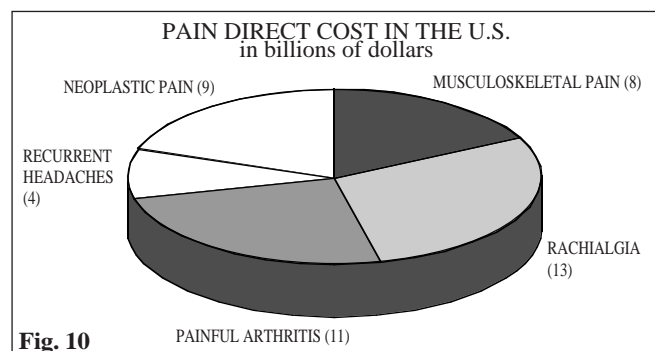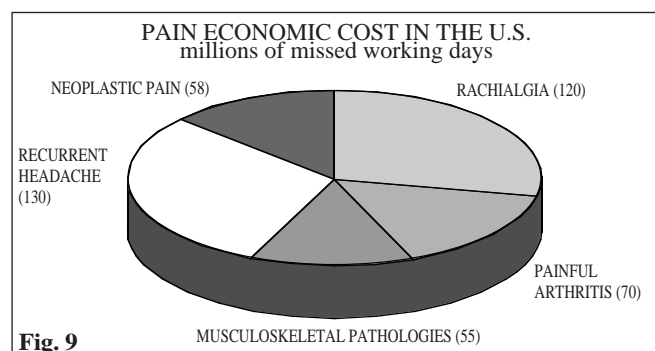
Fig. 12 - Medical-theological interpretation of pain and suffering.
Gate control of nociceptive afferences.
Endorphins: opiate endogenic substances with an analgesic action.

Algos and pathos, fundamental moments of spiritual growth in man, are surely influenced by *pharmacological* therapy but also by *ethical* therapy, i.e. prayer.

In a recent study by Zucchi and Honings a blind sample of patients (i.e., their religious beliefs were unknown) was invited to read a Gospel passage and meditate on it. A scientific and statistical analysis of these data proved that this experience could stimulate every subject's intimate heritage with very positive results on his pain. In fact, it appeared that a) the basic pain threshold is higher in believers, i.e., they feel less pain; b) believers get better results from therapy than non-believers; c) agnostics who read the Gospel passage compared with their control group, i.e., those who do not read it, have a better response to the therapy.

On the grounds of this study the authors think that the physiopathological mechanism by which faith in believers and the stimulation of their intimate heritage in agnostics are able to modulate the perception of a painful stimulus consists:

a) *neurophysiologically,* of an activation of descendant inhibitory tracts causing the gate closing to nociceptive inputs and thus less pain perception, as in the "Gate Control Theory" (Melzack and Wall, 1965);

b) *neuropharmacologically,* of a liberation of endorphins, endogenic substances of an opiate (morphinic) nature with analgesic action, localized at hypothalamus, nucleus of the great raphe, and periaqueductal gray matter level (Hughes *et al.* 1985).

This study, whose results amply rewarded the efforts of the authors, points out that *Faith*, during fundamental periods of believing patients' lives—such as pain and suffering—has a chief role as an etiological agent essential to raising the pain threshold. Even concerning agnostic patients, the authors observed that transcendent references, such as *reading and meditating on a passage reminding them of a Supreme Presence* to refer to, facilitate raising of the pain threshold because every individual represents an entity in God's own image, even if unconsciously.

Conclusions

To conclude I would like to say that pain and suffering, which are such pressing and frequent elements in our lives, are, however, excluded from contemporary culture, where everyone's ego tends to steer physical and psychic energy towards implementing exclusively hedonistic aims.

It is from the wild and no-limits hedonism that *pain as entertainment* appears, as can be often seen on TV, where pain is shown using violent, gruesome, and horrifying scenes. It is in this *esthetic* statement of pain that present neo-paganism tries to present an *ethical* perspective on life exclusively based on an immanent concept of science, on seemingly revolutionary and falsely innovative ideologies, on economics based only on profits.

Therefore, man has to remember that historically he comes from a culture able to transcend earthly things, even when he has no religious background, for this need of the supernatural is his first experience as a human being.

No other condition like that the individual affected with pain is in can urge him so intensely towards ethical-spiritual elements fostering either the capability of transcending or the possibility of

Psillio.
Psyllium plantago.

being opened to a fundamental experience of introspection which may be qualitatively similar even to a mystical experience.

Thus, the sufferer cast out of a materialistic society finds the capability of thinking over and meditating all the same on a unique experience which prompts him towards union with the Absolute.

It is in pain that man finds a development of his own inner sphere with his spiritual feelings when resources depending on his bodily vigour and strength tend to weaken, losing their intensities, interests, and motivation. In fact, physical pain and moral suffering are fundamental moments of man's spiritual growth because they tend to improve his relation with his own inner-life in this agonizing phase of life. Subsequently, the indvidual is able to transcend human events and tends to a more synchronic telegenesis with his soul. In these conditions pain, regarded as a fundamental moment in one's lifetime, encounters its intrinsic significance.

It is only in contact with pain, excluded from view in a society mythicizing productivity and social value, that man can find a relation with the transcendent again and get closer to spiritual behavior due to an imperative yet often repressed need to search for the Absolute. However, all this seems to be really difficult in a society where pain more and more easily becomes an etiological agent of affective mourning due to the debasement of the fundamental values whose loss prevents reaching the transcendent and causes an annihilation of one's own self.
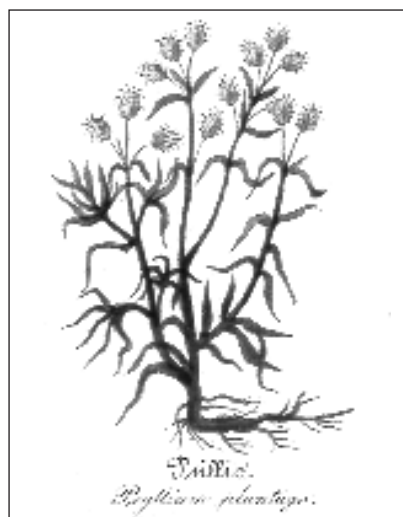
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GIUSEPPE ROCCATAGLIATA

From the Diseases of the Soul to the Psychoneuroses

The soul is, in Pythagoras' theorization, the organizing principle of the organism, which, without its harmonizing energy, would be a mere assemblage of organic matter. There exists a "pivot" which marshals and imposes order, balancing opposite forces, and which Heraclitus locates in "fire," Hippocrates in humours, Aristotle in heat: it is the vital force which connects the organs, "moves" the organism according to a predetermined scheme, and is in close correlation with the cosmic soul. According to Bichat and Stahl, the soul is active in controlling those forces which might drive the organism to become inorganic matter. It contains within itself the "via essentialis," adaptive and finalized, qualitatively different from the so-called "natural" energy which is characteristic of each organ and which is activated secondarily through the soul's impulses, according to automatic rhythms; this is the way in which body and soul exist.

Socrate's opinion on the biological model of mental disorders is ironically negative. Referring to Hippocrates, he calls the humoral theory a "fairy tale." The rigorous therapy of the soul's ailments, rigidly opposed to somatic diseases, is "maieutics," a technique which brings one to know oneself through the revelation of the inner "truth," thus "purifying" the sick soul. The study of "nature" is, in Socrates' opinion, entirely useless; the essential thing is to know the life of man, through the study of virtue, of good and evil, of truth and falsity. Ethics alone is fundamental to obtain excellent men: virtue and mental health, in Socrates' opinion, coincide completely.

Plato also adopts a singular position regarding the diseases of the soul. It issues from an original formulation of the soul-body relationship: the soul presumably entered the body, starting from an originary condition of "purity" and autonomy. Once in the soma, it supposedly differentiates itself by localizing in the body's various organs, cohabiting with them as a vital energy and in turn receiving from them both physiological and pathogenic stimuli, hence losing its natural integrity, like an "amphora which, lying on the sea-bed, becomes covered with mud and debris." The noblest part of the soul is that which is localized in the brain, where it carries out superior functions, consonant with its primary "divine" condition.

Plato maintained that it is the body which pollutes the soul, thus deteriorating it and causing mental disorders. Also, education, character, and a disharmonious family life may exert a negative influence upon the soul.

The coexistence of body and soul, according to Plato, lays the foundations for the origin of psychopathology: hysteria reflects the "wrath of the womb's soul" due to the lack of orgasm and pregnancy: the suffering thus caused "induces the womb to wander about the body" and hence the symptomatology. Reactive depression is sustained by "anger" which—because it is suppressed and not given vent to, through psychosomatic outlets—"contracts the canaliculi of the black bile," so that the latter accumulates in the blood and reaches the brain in excess, thus deteriorating it and generating melancholic illness. In Plato's theory, the two main ailments of the soul—hysteria and reactive depression—find their origins respectively in the dissatisfaction of the soul of the genital apparatus and in the feedback of this rage onto the body. Other psychopathologies are caused by nonfulfillment of eros, a pulsion which is by nature unhappy because it is poor and voracious and therefore in search of an object which might enrich it; a dissatisfied eros underlies an existential state of suffering due to the lack of the love object which might satisfy the eternally pursued, primeval, lost unity: an unsatisfied desire is a cause of suffering for the eros, which therefore "withdraws, gloomy and sad, into itself." If Plato holds that mania and melancholy are sustained by humoral disturbances due to the pituita and the black bile, he is nonetheless of the opinion that some types of mania, which he calls "enthusiastic," are creative, because they express a "divine obsession." Aristotle, likewise, was later to grant a positive role to "atra bilis" in "generous" melancholy.

It is probably, on the historical level, the soul-body dichotomy, as formulated by Socrates and Plato, which lays the foundations for a psychogenetic-passional interpretation of some psychiatric conditions: i.e, those in which, seemingly, the soul's passions—more than biological data — play a decisive role in their etiopathogenesis. By reflecting themselves onto specific organs, they trigger the surfacing of symptoms, as this philosopher typically believed for the above-mentioned disorders: hysteria, re-

active depression, and love melancholy.

According to Aristotle, the soul is nothing but an "energy" activated by an intrinsic force which aims at creating forms; the soul is therefore an "entelechia" which controls behaviour: verbal, motor, mental, imaginative, intellective. The soul's energy comprehends all forms within itself; it receives nothing from other organs, but dominates the body and coordinates its complex functions, cerebral ones included. The brain is the "instrument" of the soul, which uses it according to a plan elaborated by the intellect. The soul's task is the creation of forms which are adequate to life: objects, operative systems, scientific and philosophic models. In this perspective a harmonious soul will give life to suitable forms, a disharmonious one, to psychopathological forms. The soul is therefore the seat of all possible psychiatric symptoms; this is the sense in which one must interpret Kraepelin's assertion: "The psychiatrist is concerned with the diseases of the soul."

A physiological bond exists, sustained by the soul, between all parts of the organism: it modulates "the more and the less," with a view to a harmonious balance which might impose unity upon differences and prevent all possible "discordance": the soul therefore contains within itself a plan which it imposes upon the body, and which, according to Philolaus, is sustained by a transcendentally established cosmic scheme—a term etymologically deriving from "cosmos," i.e. order. Oneness takes shape through harmony between all the energies of the organism, which, without the soul, would lack equilibrium, thus giving rise to a sickness of the soul itself: a disorder of the soul brings about a complex symptomatology of varying levels, degrees and extension with proportionate somatic, visceral, emotive-affective and mental disorders.

The present-day biochemical model of psychiatric disorders is based upon a perspective similar to the classic one. The soul in fact is to be identified with the biochemical energy of the neurochemical, neuroendocrine, and neurovegeta-

tive systems of the cerebral cortex, the hypothalamus, the brain stem, the epiphysis, the hypophysis, and the vegetative system. These structures are coordinated according to a plan aiming at self-balancing, for the prevention of possible deranging mechanisms. The chemical energy contained in neurotransmitters gives rise to systems which, by stimulating the body, produce specific motor, mental, affective, emotive forms. The dopaminergic system, for instance, has different functions, according to its varied anatomic connections: the hypothalamus-hypophysis axis governs the discharge of prolactin, the nigro-striatal that of motor activity, the mesolimbic the emotions and affections, the mesocorticofrontal imaginative activity. All neurotransmitters, such as NA, 5-HT, DA, are balanced among themselves in a mutual control of inhibitory, excitatory, and modulating activities, in which the neuroendocrine, the neuropeptide and specific aminoacid systems take part. The complex system thus described is formed of billions of interactive cells, interconnected by specific neurotransmitters. Psychiatric disorders express a lack of balance in this "network" multisystem diffused throughout the body; if one single circuit is unbalanced—becoming hypo- or hyperactive—this passes on, in a more or less diffuse manner, also to other meshes of the network. What the ancients called "soul" coincides with the present-day model of psychiatric disorders: a balanced soul expresses "eutimia," an unbalanced one expresses the so-called "storms," i.e. "pathos," "aegritude," caused by "one of its movements against nature, from which irrationality arises." Order deriving from equilibrium in the "corporeal substance of the soul," Galen held, sustains reason, while a disorder in the "humoral constellation... (sustains) irrationality."

The brain-intellect problem is always the crucial point in the effort to interpret the soul's ailments; one is faced with a soul, a body and a structure called "hegemonic"; the latter marshals the brain by means of neurochemical systems. Humors, like the modern transmitters, are the link between the intel-

lect and the brain. The somatic structures, such as the heart, muscles, glands, and lung would in themselves be inert, if they didn't receive stimuli from acetylcholine, adrenaline noradrenaline and dopamine. In this model, an equilibrium within the homeostatic system is at the basis of harmony between logos and soma; a lack of balance caused by the neurotransmitters reflects upon the somatic, visceral, and mental functions, generating the symptomatology which presents to the ego as a parasitic and disturbing phenomenology. It has now been proved that the neurochemical network (the soul for the ancients) is formed of molecules with specific functions: excitatory, inhibitory, and modulatory, connected both with each other, and with neuroendocrine and somato-vegetative systems, i.e. with the visceral, sympathetic-parasympathetic centres. NA stimulates, GABA inhibits and 5-HT modulates—inhibiting hyperactive systems and stimulating hypoactive systems—in order for the balance of the organism to be maintained. If initially visceral molecules, such as acetylcholine, cortisol, cholecystochinine, reach the C.N.S. in excess, and if, for instance in the brain and particularly in the hypothalamus, there is a deficiency of NA and 5-HT, they destabilize homeostasis in such a way that specific symptoms will appear: anxiety, panic attacks, depression, coenestopathies and visceral dysfunctions; perspiration, nausea, diarrhoea. This explains why a stressful event, in an individual with a deficit in NA and 5-HT, gives rise to a hypothalamus-hypophysis-suprarene hyperactivity, plus an increase in cortisol, in acetylcholine and in cholecystochinine. Nowadays it is documented that this can also have an idiopathic origin; in any case the unbalancing is caused by the complex neurochemical system; the deficiency of DA causes inhibited depressions, of NA, vital depressions, of 5-HT, seasonal depressions and a high incidence of suicides. In any case, whether the disturbance be psychoneurotic—based on the confluence of stress factors upon a given temperament—or endogenous, the result is

"tempests of the soul, as the Stoics called them."

From a clinical-nosological point of view, in past times the ailments of the soul, the so-called *perturbationes animi*—present-day psychoneuroses—were nearly always considered, both by doctors and by philosophers, only those of a reactive origin, the consequence of a reaction to stress, on the basis of a predisposed temperament; as to symptomatology, we do not find here the psychotic features present in manic-depressive and schizophrenic disorders; the latter—present-day endogenous psychoses—were called *alienationes mentis*. This conceptualization has been handed down, more or less unaltered, until the second half of the present century, when a series of research efforts, initiated on the basis of pharmacological data, yielded surprising results. The first insight to be gained is how the diversity of the symptomatology is connected with the degree and extension of the destabilizing process, and how, nearly always, a stressful event proves to be the triggering cause of all psychiatric disturbances, which later, due to a "sensitization" phenomenon, may occur once more, even in the absence of stress; whether the etiology be endogenous or exogenous, it is invariably the homeostatic system that is destabilized—in many cases, indeed, the system is found to be genetically meiopractic. In fact a deficiency of 5-HT and a hypersensitivity of acetylcholinergic receptors remains even when the individual is clinically cured, thus becoming the basis for future relapses. *Proclivitas* plays a powerful role, one which is the Gordian knot of all psychopathologies, both on a primitive basis and, as the ancients were wont to say, on a "sympathetic" one. Nowadays it is documented that the neurotransmitters control functions which, if impaired, might present as symptoms: 5-HT controls sleep, alimentary and sexual behaviour; its hypofunctioning will generate bulimia, insomnia, daytime sleepiness, and sexual dysfunctions. NA governs the life drive, energy and visceral stability; its dysfunction will involve asthenia, vital sadness, vegetative disorders. DA controls

the discharge of prolactin, the motor function, the affective tone and mental representations; its hypo-functioning will be expressed through inhibitions, abulic depression, and an increase in prolactin, with ideas of guilt, ruin, death. An excess of DA, conversely, will bring about an opposite condition, a manic state, with euphoria, motor and verbal acceleration and megalomania. Besides, the vitalistic doctors, also, insisted on the fact that a cold "pneuma" determines melancholy and a "hot" one mania, and the followers of the atomistic model believed that an acceleration of the movement of the atoms in narrow caniculi was at the basis of mania, while a slowing down of the movement of the "corpuscola" in broad caniculi was at the basis of melancholy. The biological model of psychiatric disorders, though varying in the choice of the basic matter (humours, pneuma, atoms) implies that sickness of the soul is due to either an excess or a lack of energy, or to so-called "mixed" conditions, where molecules with differing activities work simultaneously; black bile with yellow bile, fast atoms with slow atoms, and so on, determine psychopathologies which are atypical, because they associate inhibited symptoms with excitatory symptoms. A decisive factor is temperament, which in some cases conditions the arising of psychiatric disorders. Temperament, if disharmonic, sustains a constitutional predisposition called *proclivitas* by the ancients and "humoral constellation" by Galen.

The abnormal temperament promotes the emergence of pathos following a stressful event; though often, as Aretaeus of Cappadocia maintained, a morbid state of health is already present, as in love melancholy, which only comes to light when the tie with the love object is broken.

Temperament is determined by the physical factor which is dominant at the root of the dissymmetry: if we have a slight constitutional excess of black bile, there will be a depressive temperament, if of yellow bile a choleric one, if of blood a hypomanic type, if of pituita an abulic-apathetic temperament. Modern research also has evidenced how abnormal bio-

chemical data remain present even after recovery and can be the cause of a relapse; namely, they consist in a central constitutional hypersensitivity of the acetilcholinergic neurons in the context of a 5-HT deficit in the hypothalamus and a low content of NA in the "locus coeruleus," so that a stressful event will favour a hyper-activity of the hypothalamus-hypophysis-suprarenal axis with a consequent appearance of somatic and affective symptoms caused by the emission into circulation of massive quantities of cortisol and cholecystochinine. Hysteric, neurasthenic, hypochondriac, depressive, anxious and obsessive symptoms simply express the contents and the form of the morbid mental image, as it is determined by the type and character of the underlying biochemical dysmetabolism.

In their nosological classification, up until the 17th century, psychiatric disorders comprised what is now called psychosis; only hysteria and love melancholy were disturbances believed to be of reactive origin. In the 17th century Pisoni and Willis held that all neuropsychiatric manifestations, from epilepsy to mania, from apoplexy to hysteria, should be classified as "neuroses," since they are always preceded by a "chemical" disturbance of the C.N.S. Perdulcis, on the other hand, believed that neurological manifestations were to be considered a part of general medicine, while psychiatric ones were to be classified as "diseases of the soul." At the beginning of the 19th century Pinel—though including in the concept of "neurosis" both neurological and psychiatric disorders—observes how psychoreactive mechanisms are involved in the latter. However, in the sphere of cerebral neuroses, he identifies two sub-classes: one, where tangible organic impairment of the brain is present, and the other, *vesaniae*, where the disorders are caused by the intellect and the affective functions. All the psychopathological disorders, such as melancholy, mania, catalepsy, acquired idiotism (modern schizophrenia), hypochondria and panic attacks, belong to the latter. He then isolated the so-called "genital" section of the neu-

roses, which includes satyriasis and priapism in the male, and nymphomania and hysteria in the female. For the genesis of *vesaniae* he identifies the decisive role of two factors: a primitive disposition of the temperament associated with sorrow, fear, loss of love, alcohol abuse and so on and stressful events. In the case of hysteria, Pinel acknowledges two factors: a predisposition ("excessive physical and sentimental sensitivity") and occasional events such as "lively emotions and the privation of amorous pleasures." Towards the end of the 19th century we have, with Dubois, a rigorous classification of all psychopathological disorders into two categories: psychoses and psychoneuroses, the latter being so called both because of the absence of tangible organic damage, and because their insurgence is due to a psychogenetic mechanism on a reactive basis.

At the beginning of the 20th century psychoneurosis is thus considered as opposed to the psychoses; as Kraepelin asserts, it is a psychogenic disorder, while the latter are of somatogenic origin. Previously Dubois, while exalting the scientific medicine of the time—based on Virchow's cellular model, applicable, in his esteem, to the psychoses—had maintained that "psychoneuroses" were a disturbance of psychogenic origin connected with "thought and the imaginative processes," wherefore their pharmacological treatment is out of the question: a "psycho-moral treatment" is the most indicated; the psychiatrist must apply himself to "man's moral renovation." Psychoneuroses, particularly reactive-neurotic depression, coincide with the "pathos" of the Stoics and are nosologically opposed to the psychoses, since they are not triggered by humours but by erroneous thoughts, false judgments and mental representations invalidated by passions. The "phantasm", uncontrolled by the logos, agitates the body, thus provoking a perturbation with somatic-vegetative repercussions: as Zenon had previously maintained, it might be likened to the "convulsive" flight of an alarmed bird, or to a storm of passions by which the

vegetative pneuma is deranged. Only a domination "as firm as a rock" is able to control pathos, i.e. the so-called "waves" of passion: a domination that "turns" towards the ideal sane reality can—as Socrates, Plato, and Crisippo believed—manoeuvre pathos.

While medical theories believe that the derangement of the soul is brought about by visceral humours which modify the brain's chemico-physical state *(corruptio cerebri),* thus giving rise to the symptomatology, the philosophic trend of thought, along with vitalistic doctors such as Stahl, sees the process from an opposite point of view: the morbid image favours congruous thoughts and affections, which influence the logos, giving rise to the visceral symptoms. Aristotle had previously correctly defined this problem in his "Physiognomica": "the mind can operate on the body and the body on the mind." The body-soul dichotomy has been handed down to the present day and is currently elaborated according to two perspectives: "The tenth revision of the international classification of syndromes and behaviour disorders" confirms the psychogenic origin of neurosis, while APA's "DSM IV" excludes it, believing it to be an ambiguous clinical concept, and places it under the generic heading of "disorder": anxious, obsessive, of conversion, and often *ad dystimia* and minor depressions.

Asparago
Asparagus officinalis.

Indeed, Hippocrates had already identified two types of melancholy: one *sine causa* and the other *cum causa,* i.e. connected to "motivated sorrows... in an individual with a depressive temperament." Humours are always at the core of psychopathology, but in the first case, it is actually they that, originating from the viscera, create a *demissio animi* in the *thumos* and indirectly derange the C.N.S., thus generating the symptoms; while in the second case a predisposed temperament, along with a triggering event, underlie their dysmetabolism. The latter is a typical case of classic *aegritudo,* the sad and painful suffering of the soul, in reaction to a triggering event. However, although nosology might attempt to substantially discriminate, separate and identify the basic symptomatology of each psychopathology—endogenous or reactive—as Galen declared, "fear and sadness", cannot be eluded by confirming interpretative and metaphoric symptoms. In his *Secretum,* Petrarch calls *aegritudo* a sickness of the soul, but is actually describing a major depression with melancholia: "In this distressful desolation everything is hard, wretched, frightful; all leads to desperation and drives to ruin;... this is no longer a time of light and life, but is infernal night and cruel death."

The morbid image created by the *atra bilis* evokes fear and sadness, bows down the ego and drives an individual to death; according to Crisippus, this psychopathology finds its origin in an evil part of the self which creates and agitates horrid spectres and incites to false judgments, and thence to delirium. It is exactly in this context that Socrates and Plato believe an inner transformation to be therapeutic—taking a new direction, turning one's gaze towards goodness and truth. This education, based upon self-awareness, gives the ego such a power that it becomes capable of challenging every disease of the soul—as Socrates demonstrated in the face of death. Lack of self-awareness fosters sickness of the soul; the foolish individual is opposed to the wise, who remains imperturbable when assailed by the waves of passion. The biological

trend believes that the morbid image is created by humours, while the philosophical model sees it as a terrible spectre ensuing from passions or from the evil part of the self. Therefore, although the semeiologic design is identical, that which discriminates between the two models in the role played by the etiological factor: humoral or psychogenic.

In its interpretation of the sicknesses of the soul as minor psychopathological structures, the medical model borders onto the philosophic one: in hysteria, hypochondria, love, melancholy, the symptoms are determined not so much by humors as by "vapors", i.e. by gaseous emanations which the passions promote by "heating" the humours: fear, rage, sadness—of reactive origin—cause the formation of aeriform substances which act upon the viscera, the "thumos", and the mind, giving origin to the symptomatology. An analogous answer is nowadays given to psychopathologies with anxiety, panic attack, asthenia, reactive depressions, somatoform and psychosomatic disorders, such as the irritable colon. In these cases it is proved that a constitutional deficit of NA and DA in the locus coeruleus and in the *nucleus accumbens* facilitates a destabilizing of homeosthasis due to an irruption into the central nervous system of cortisol, acetylcholine, and, above all, of an intestinal neuropeptide, cholecystsochinine.

Moreover, triggering events are to be found both in psychotic mood disorders and in dystimic (psychoneurotic) disturbances, while in recurrent bipolar and diphasic form one witnesses a singular phenomenon already described by Galen and Aretaeus of Cappadocia: for a certain period the patient is sad and frightened, he desires death and is overcome by feelings of guilt caused by black bile, which "surrounds and smothers reason"; but suddenly, due to a biochemical veering, he becomes euphoric, active, he believes himself a strong man, he thinks he is a great poet, a very wealthy person, "he advances as if wearing a crown." In these cases the sickness of the soul, according to Aristotle, is the result either of a deficit or of a hyperactivity of the idiopathic energy of the soul; it is evident that here the symptoms express nothing but an underlying biochemical mutation acting upon the energy of the soul.

The biochemical transformation of the C.N.S. can therefore be determined by an event whenever there exists an individual disposition due to a central deficit of NA, DA and 5-HT along with a hyperactivity of the visceral molecules; whereas, in endogenous disorders, this unbalance is favoured by an innate familial/genetic disposition which can cause it in absence of triggering factors, via a phenomenon of sensitization called "Kindling."

The bridge between endogenous diseases of the sound and psychoreactive ones has been adequately documented by both pharmaco-therapeutic results and by experiments performed upon newly born rhesus monkeys precociously estranged from their mothers; a percentage of the latter present depressive behaviour with apathy, abulia, refusal of food, and isolation; moreover, there occurs also a reduction in liquoral NA, DA, and 5-HT. The symptomatology recedes with antidepressive treatment; pretreatment with psychotropic drugs prevents the depressive reaction of abandonment.

In this perspective the concept of a "frustrated eros," i.e. the stressful event which, according to

Hippocrates, causes an *uteri transmotio* and its consequences, hence called "hysteric" symptoms—a theory which Freud had resumed with an interpretation transferring the emphasis onto the pathogenic role of a mental image full of libido which overflows into the body—currently appears outdated; conversion hysteria has disappeared and a clear accentuation of depressive disorders in women can be observed; that which, due to the customs of the time, took on a psychosomatic expression, today appears for what it is in reality: the phenomenic manifestation of a depressive suffering of the soul.

Love melancholy, also, along with Theophrastus' *lassitudo tensiva,* or the panic attacks described by Aretaeus of Cappadocia, Celius Aurelianus' aerophobia and Temison's pantophobia are nowadays believed to be symptoms associated with a minor depression called *dystimia.* Eutimia is not comparable to Parmenides' perfect Oneness, but it is rooted in an optimal balance between opposed molecules. It is well know how the intercellular relationship is founded upon two receptors, one pre- and the other post-synaptic; eutimia is based on their well-balanced relationship. The presynaptic receptor with inhibitory functions controls the discharge of the neurotransmitter in such a way that it be neither excessive nor insufficient, and so that the number of the post-synaptic receptors will be adequate to the stimulus. An excess or a defect in pre-synaptic activity, caused by a deficit of 5-HT with modulatory function, triggers an imbalance. If the presynaptic receptor is more efficient in inhibiting, fewer neurotransmitters are discharged and, in turn, the post-synaptic receptors increase.

Conversely, if it is less active, a greater quantity of neurotransmitters are produced, and the post-receptors decrease. This gives rise to the imbalance and hence to the appearance of the symptomatology: the sense of malaise, the *aegritudo,* epiphenomenon of a pre/post receptorial deregulation, with inhibited or excited symptoms—just as the doctor friend of Lucretius, Asclepiades of Prusa, had hypothesized, with an interpretative mod-

el deriving from the reductionism of Democritus.

The answer of psychiatry to the inclusive interpretation of all sicknesses of the soul as expressions of psychopathology, is based upon extremely reliable experiential data; semeiological variations are correlated with co-morbidity phenomena: e.g. depression in the young presents with varied symptoms, often behavioural, not infrequently with dependence on substances, in an attempt to control a biochemical imbalance. Even schizophrenia is seen nowadays as an imbalance between 5-HT and DA in a subject presenting a congenital structural cerebral impairment caused by temporo-limbic atrophy. A 5-TH deficit might cause suicidal behaviour, obsessive compulsive disorders and bulimia, besides seasonal depressions connected with the decrease in duration and intensity of sunlight. Janet's psychasthenia, deriving from mental weakness, Charcot's hysteria, called "traumatic neurosis," Bead's neurasthenia—attributable to the stress of the convulsive life of big cities—prove to be psychoneuroses from a phenomenological point of view but, biochemically, mere dystimias. It is well known how heroin, alcohol, cocaine are made use of in an—albeit vain—attempt to balance an underlying *aegritudo* of a depressive type. It is also the case of psychopathic personalities such as inveterate gamblers, aggressive characters, and obdurate philanderers, who achieve, by means of their behaviour, an increase in their cerebral NA and hence a chemical euphoria.

The course of life is complex, and not infrequently hampered by mental and physical disturbances which make it difficult and dangerous; Plato has referred to the philosophic "life-raft" one needs to go through life, and St. Augustine has observed how only Christ can be of valid assistance in the existential journey of man. The philosophic answer to the soul's ailments as given by Crisippus and Seneca, by Socrates and Kierkegaard, by Kant, Hegel and Nietzsche have not always attributed the proper value to the biological factors, which Morel called "degenera-

tive," and which often make it impossible to adequately adapt the requirements of life; the journey from the subjective spirit to the objective spirit to the objective and finally to the absolute spirit, as the classics had pointed out, is only for the wise. Indeed, psychiatry does not assume the responsability of educating humanity; good and evil express two moments of life, not infrequently social epiphenomena of an imbalance which is not only individual but, indeed, arises from biochemical derangements.

To summarize, the soul—according to classic thought, from the philosophers of nature to Aristotle and Galen—is endowed with a physical nature, an intrinsic energetic power, "it is the effector of itself" and activates the body; in physiological conditions the logos governs the soul. Logos, body and soul are in harmony with one another, in the sense that the guide, the active system and the body are finalistically coordinated with one another. The soul lives in a cosmic system, by which it is influenced, because it is made up of the same elements as nature. When interpreted, in this way, the soul coincides completely with the neurochemical and neuroendocrine systems and its relationship with cognitive and somatic functions takes place as outlined by Aristotle. The cosmic influences upon the soul are widely proved also on the level of psychopathology: let it suffice to mention the variations of aminic metabolism in relationship with the duration and intensity of sunlight, and how certain types of depression and mania are correlated with variations in 5-HT which occur in autumn and in summer.

The ailments of the soul, when released from astral hypotheses—one might recall Saturn and melancholy, pseudoreligious configurations, such as the myth, which considers them as indicators of a divine curse, or the sociologic model which sees the symptoms as signs of antisocial behaviour—are seen by Hippocrates, who acquires the way of thinking of Heraclitus and of Anaxagoras, as the "epiphenomenon" of a humoral imbalance. Melancholy is no longer an indicator of Saturn's influence, nor is the desperate weeping of Bellerofon

seen as a divine curse; hysteric crises are not considered a sign of antisocial behaviour; the "humours" (i.e. the soul) influence both the brain and the intellect; they are an intermediary which conforms mental representations and supplies energy to the analytic and synthetic activities of the logos; if the soul is disturbed, the body is disturbed, the logos is overwhelmed and loses its autonomy. The malaise of man, all that—as Bleuler asserted—makes humanity unstable, can be traced back to the dissymmetry of the soul, to that disorder which, if slight—as Aristotle and Ficinus thought—underlies "generous melancholy," by which the death drive is sublimated in artistic, philosophic, and scientific forms "so that not all of me might have an end." All that man has created finds its origin in a slight biochemical dissymmetry of the soul which, if rigidly symmetric, would become monotonously and physiologically contented and blissful, wholly absorbed in placating desire with the object of desire, and then waiting for a new urge to appear, just for the pleasure of satisfying it.

As regards therapy of the disorders of the soul, strictly speaking, i.e. present-day psychoneuroses, the ancient physician would generally accomplish it by prescribing drugs such as hellebore, mandrake, opium—the latter especially in cases of hysteria because, as Galen believed, it is the eutimic tranquillity medicine. In the case of love melancholy, the first stage is characterized by advising the patient to travel, thus removing him from his habitual context, or suggesting that he take up pastimes, or other distractions, which might lessen tension of the mind and the memory of the loved one, such as reading, physical exercise, convivial meetings; medical therapy is centered on a moderate use of wine, opium, and hellebore, which is considered an antidepressive substance. In straightforward reactive cases, ailments of the soul are dealt with by means of a supportive psychotherapy called *consolatio.*

If we look at Dubois and Freud, this psychotherapeutic approach is centred upon an educational strengthening of the self, in the

first scholar's opinion and, with Freud, in the effort to reach-by means of free associations and the interpretation of dreams the core of the conflict, the "hidden" image which nurtures the symptomatology. In both cases the *consolatio* of the Stoics and the Socratic maieutic method may be recognized: the more one understands of oneself, the more one is freed from the symptoms. Today—from a psychiatric point of view, given the results of biological research—neurotic, obsessive, phobic, hypochondriac, bulimic, anorexic, anxious and neurasthenic disorders are all treated with the same therapy prescribed for the treatment of humour disorders, i.e. smaller doses of drugs which have an effect on the specific systems believed to be involved in the symptomatology, though supported by an associated cognitive or relational psychotherapy. Considering that the neurochemical derangement proves to be the final common outcome proceeding from a series of pathogenic factors—somatic, familial/genetic, exogenous/stressing—and that it is the symptom which expresses it, a re-equilibrium of "the power of the soul," in Alcmeon's words, may be reached through the biological route, by acting on the pathogenic mechanism; this might seem to be a reductionistic approach, but one might also recall how Epicurus emphasized that a "narrow model" always gives excellent results.

We believe, with this modest contribution, to have cleared up a crucial misunderstanding—in contrast to the psychiatric tradition—supported by a grossly mistaken view of the basic structure of the soul. The latter is seen, according to some interpretative models (such as the one based on the ethic rationalism of Socrates or modern idealism) as something immaterial and impalpable, while for classic medico-philosophic thought and for all the vitalistic scholars, the soul's substance is completely material and intrinsically autonomous as the derivability of its own energy, just as we find it in the activity of the so-called biogenic amines.

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Salsapariglia
Smilax salsapariglia.

JOSÉ MANUEL BERTOLOTE

Mental Disorders Around the World: An Epidemiological Overview

Introduction

The origins of psychiatry

Before we start to say how many people there are with mental disorders and where they are, we must say who people with mental disorders are today; or, in other words, what the currently prevailing concept of mental disorders is.

What we consider today as major mental disorders have always and everywhere been perceived as something beyond normalcy, something which caused suffering, awe, fear. Admittedly, explanations on the cause and meaning of these phenomena have varied across time and place. Nevertheless, there is solid documentary evidence that the ancient. Egyptians already identified and devoted their attention to hysteria, proposing the displacement of the uterus as its cause. This was also seen in ancient Greece, where Hippocrates, the Father of Medicine, also described melancholia and where some forms of psychotherapy (e.g. catharsis) were already employed. In old India the roots of psychopharmacotherapy can be found in the use of preparations of *Rauwolfia*, *Papaver* (opium) and *Cannabis* (marihuana) for the control of different forms of human suffering.

In the Talmud we can find early references to current principles of mental hygiene, and in the Islamic world we have the first examples of institutional care of people with mental disorders, in maristans, madrasas and tekkes. From the Arabs we also inherited examples of community care for people with mental disorders. The great Avicenna left us an excellent example of clinical work with remarkable descriptions of meningitis, melancholia and dementia.

During the Middle Ages, mental disorders were seen mostly as consequences of sins, of demoniac possession and of witchcraft, being treated accordingly. Nevertheless, this period also witnessed the establishment of the first hospitals exclusively dedicated to people with mental disorders. The names of Father Juan Jofré and Joao Cidade (later known as Saint John of God) must be remembered in this context.

The birth of scientific psychiatry

Despite all the rich tradition so far mentioned, it was not until the 18th century that scientific psychiatry developed. It came on a par with the development of the clinical and basic sciences which took

Santonico
Artemisia judaica.

place during that period. Under the influence of the prevailing scientific climate set by giants such as Darwin, Claude Bernard, Pasteur, Comte, and following the paths opened by masters such as Kock and Virchow, the knowledge and practices which constituted Psychiatry as a special branch of Medicine were structured by what could be called the Fathers of Modern Psychiatry: Pinel and Kraepelin.

This new, scientific and modern psychiatry was basically an institutional psychiatry, based in mental hospitals, paralleling what was happening in medicine as a whole. However, psychiatrists of this period were acutely concerned with the well-being of patients and the question of Human Rights recently raised by the French Revolution. In addition to the humanization of psychiatric care represented by the removal of chains and shackles of patients and a policy of "open door" hospitals developed by Ellis and Conolly in the UK, a concern with broader social issues is represented by the promulgation of the landmarking French Mental Health Law of 1838, whose influence extended until the present in some places. Here, the name of Esquirol must be mentioned as an example of a psychiatrist who excelled as both a clinician and nosologist and as a social reformer. During this period, Charcot was one of the most remarkable neuropsychiatrist, as psychiatrists were then considered.

Drawing from the experience of the past, and like the dwarf on the shoulders of the giant, psychiatrists of the present century have greatly expanded and extended the

benefits made available by successive generations of clinicians, researchers and administrators. In fact, Pelicier considers that in the 20th century, psychiatry has reached the age of maturity.

In 1892 a first International Nomenclature of Diseases was adopted which contained some 13 categories related to what we consider today as mental disorders.

TABLE No. 1

BERTILLON'S NOMENCLATURES OF DISEASES, 1892	
56	Acute or chronic alcoholism
64	Apoplectic dementia
65	Brain necrobiosis (softening)
67	General paresis
68	Other forms of mental alienation
69	Epileptic dementia
73	Choreic dementia
74	Hysteria
120	Uremic dementia (Bright's desease)
140	Puerperal madness
154	Senile debility
173	Fatigue (surménage)
179	Delusion

That Nomenclature was the forerunner of the WHO International Classification of Diseases (ICD-10), currently in its 10th Revision, with more than 300 types of mental disorders, which makes the ICD-10 chapter on Mental and Behavioural Disorders the longest one in the whole ICD—10. All these disorders are grouped under ten major categories, as indicated in Table 2.

TABLE No. 2

WHO's ICD-10, Chapter V, 1992	
F0	Organic, including symptomatic, mental disorders
F1	Mental and behavioural disorders due to psychoactive substance use
F2	Schizophrenia, schizotypal and delusional disorders
F3	Mood (affective) disorders
F4	Neurotic, stress-related and somatoform disorders
F5	Behavioural syndromes associated with physiological disturbances and physical factors
F6	Disorders of adult personality and behaviour
F7	Mental retardation
F8	Disorders of psychological development
F9	Behavioural and emotional disorders with onset usually ocurring in childhood and adolescence

The frequency of mental disorders

Now let us move to some data on the magnitude of mental, behavioural and neurological disorders in the general population. I should start by saying that the frequency of these problems are counted in millions, which already gives an idea of its size, and that roughly one in every four or five inhabitants of this planet is affected by some form of mental disorder.

TABLE No. 3

PEOPLE WITH MENTAL DISORDERS AROUND THE WORLD

26 %
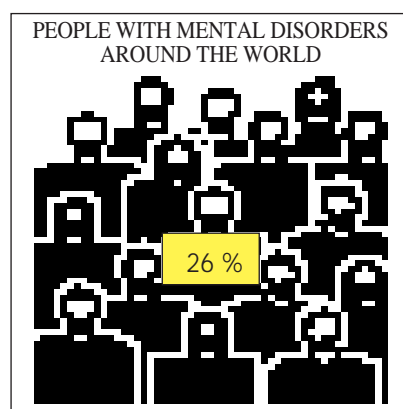
Globally speaking, we estimate that there are more than one and a half billion people with some form of mental disorder, if tobacco dependence is included in our calculations.

TABLE No. 4

As for mental disorders *sensu strictu*, we have, approximately, more than 480 million cases of anxiety disorders, 350 million cases of mood disorders, 250 million cases of personality disorders, 60 millions cases of mental retardation, 22 million cases of schizophrenia and 29 million cases of dementia.

TABLE No. 5

In relation to anxiety disorders, specific disorders represent 154 million cases of generalized anxiety disorders, 80 million of panic disorders, 66 million of post-traumatic stress disorder (PTSD), 58 million of obsessive-compulsive disorders (OCD) and 57 million cases of somatization disorders.

TABLE No. 6

Looking specifically at mood disorders, epidemiological studies anticipate that there are 335 million people with major depression (which emerges as the most frequent of all forms of mental disorders) and 23 million cases of bipolar disorder.

TABLE No. 7

In terms of dependence on a psychoactive substance, we have 1,100 million cases of nicotine dependence, 250 million cases of alcohol dependence and 15 million cases of dependence on other drugs. Epilepsy cases are counted as over 40 million.

Mental and psychological problems in PHC settings

TABLE No. 8

In a study conducted by WHO in 14 countries during which 25,916 people seeking care in primary care facilities were examined, well-defined mental disorders were found to be frequent in all the general health care settings: 24%. This means that one in four persons seeing a doctor had a current diagnosable mental disorder.

In addition, a significant proportion of the patients (9%) suffered from a "subthreshold condition" that did not meet the diagnostic criteria for research but nevertheless had two or more clinically significant psychological symptoms (e.g. sleep, fatigue) and dysfunctioning in their daily lives.

TABLE No. 9

DIAGNOSES FOUND IN PRIMARY HEALTH CARE SETTINGS	
Current Depression	10.4
Generalized Anxiety Disorders	7.9
Neurasthenia	5.4
Harmful Use of Alcohol	3.3
Alcohol Dependance	2.7
Dysthymia	2.1
Panic Disorders	1.1
Somatization Disorders	2.7
Agoraphobia with Panic	1.0
Hypochondriasis	0.8
Agoraphobia without Panic	0.5
Two or More Mental Disorders	9.5
Total	24.0

TABLE 4 - PEOPLE WITH SOME MENTAL DISORDERS AROUND THE WORLD

	million
Anxiety disorders	480
Mood disorders	360
Personality disorders	250
Mental retardation	60
Dementia	29
Schizophrenia	22
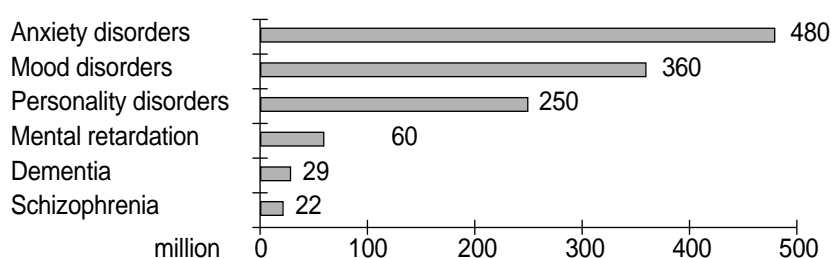
TABLE 5 - PEOPLE WITH ANXIETY DISORDERS AROUND THE WORLD

	million
Generalized	154
Panic	80
PTSD	66
OCD	58
Somatization	57
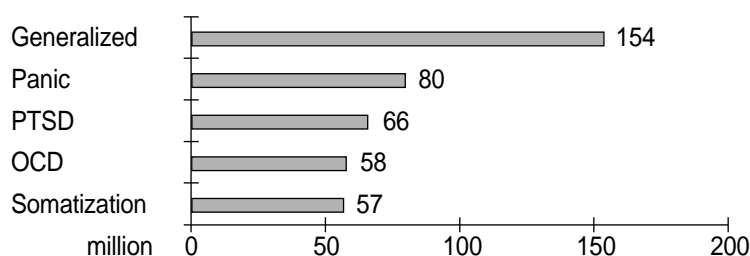
TABLE 6 - PEOPLE WITH MOOD DISORDERS AROUND THE WORLD

	million
Major depression	335
Bipolar disorder	23
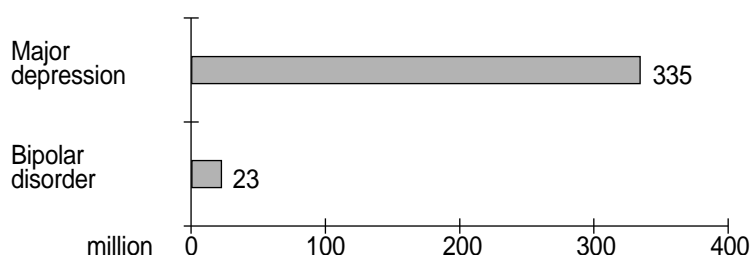
TABLE 7 - PEOPLE WITH SUBSTANCE USE DISORDERS AROUND THE WORLD

	million
Tobacco dependence	1100
Alcohol dependence	250
Drug dependence	35
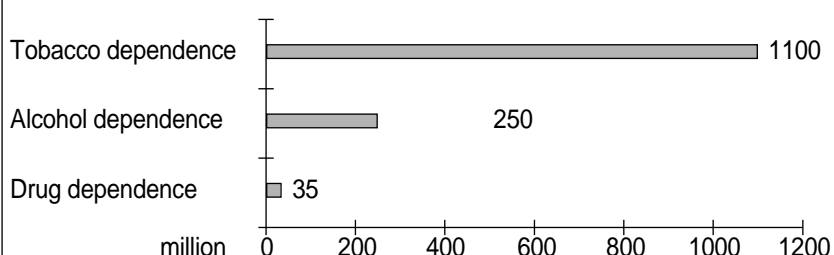
TABLE 8 - PSYCHOLOGICAL PROBLEMS IN PRIMARY HEALTH CARE SETTINGS

Current mental disorder	24%
Subthreshold	40%
No psychological symptom	36%

It is legitimate, then, to conclude that among primary care attenders at least one third requires careful attention for psychological problems. Given the huge numbers of people attending PHC everyday, we are confronted with a real major public health problem. We cannot overemphasize the importance of primary health care settings for the control of mental disorders.

Although many practitioners at PHC settings were aware of the nature of psychological disorders, many patients with psychological problems were not recognized by doctors. Doctors identified one quarter of PHC attenders as having a psychological problem, whereas the research instrument (CIDI-PHC), identified one third; however, the agreement between the two modalities of identification was not sufficiently high. There was also evidence that many cases who were adequately identified were not properly treated.

From other WHO studies we also know that no more than one percent of all people with mental disorders become psychiatric inpatients. Therefore, in the community remains an "invisible majority"; as is the case with an iceberg, as psychiatrists we usually only see the tip.

The social burden of mental disorders

We can look at these facts from another perspective, and measure the impact of mental disorders through the burden of the disability created by them. The World Bank did this, in collaboration with WHO, and came to the conclusion that mental disorders cause 8.1% of the burden due to all diseases.

TABLE No. 10

The disability caused by mental disorders is markedly higher than disability associated with chronic physical disorders such as diabetes, back pain, hypertension and arthritis; all types of cancer, for instance cause 5.8% of all disability. If we extend our definition of cas-

TABLE 10 - ECONOMIC BURDEN DUE TO DISEASE AROUND THE WORLD

All other diseases

8% Mental disorders

55%

37%

Behavioural disorders

TABLE 11 - MENTAL DISORDERS AROUND THE WORLD

Individuals with mental disorders

26%

74%

TABLE 12 - MENTAL DISORDERS AROUND THE WORLD

22%

78%

People affected by mental disorders (individuals & family members)
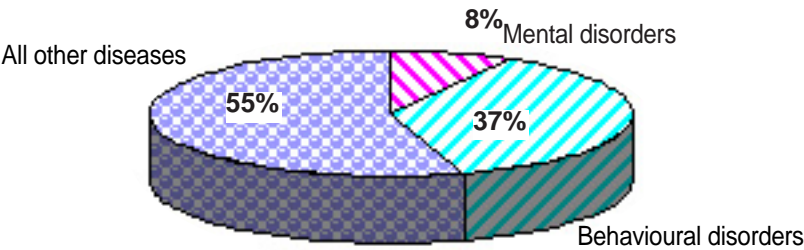
es to include behavioural disorders (such as those associated with substance abuse, violence and suicide) we reach a proportion of approximately 45% of the burden.

TABLE No. 11

If we look at the social burden from a more humanitarian rather than economic perspective, the number of affected people jumps from 25% of individuals suffering from mental disorders to an astonishing 78%, which also include their relatives.

TABLE No. 12

From this perspective three-quarters of mankind is directly or indirectly touched by mental disorders, which is more than a good reason to give them a high priority from both a public health and a social development perspective.

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*Scamonea
Convolvolus scammonia.*

YVES PÉLICIER

Genetics and the Environment

It seems to me that the observations which have been made now require a brief consideration of the question of the relationship between genetics and the environment.

The environment is not only that which surrounds the individual in a physical sense. It is also that which exists for him at a moral and physical level. Husserl here is referring to *Umwelt*. Von Uexkull employs the term *Umgeburg* to refer to an overall material environment. He defines *Umwelt* as this field of presence—the environment within which man expresses himself.

The way in which the world is conceived establishes the concepts which refer to a set of empirical realities. The living being maintains his contact with the environment, Jaspers maintains, but subjects this life to a knowledge which is both physiological and psychological. The real world—which is objectively empirical—is the world of technology, society, the economy, and politics.

The environment is the outcome of complex and intricate actions which at the same time force and impel the individual to defend himself. Jaspers goes on to say that the individual must defend his history, the opportunity to experience his liberty—that liberty from which his personal continuity springs, a world which is also the temporal dwelling-place of an existence. This existence is at a fundamental level the site and location of transcendence.

We can define the environment as a set of natural and cultural conditions which are likely to act upon living organisms and upon human activity. Nature is what exists independently of such human activity, whether this activity is deliberate or a question of chance. These changes are such that it is difficult to distinguish between "natural" nature and a "natural" product which has been used, modified, altered, or improved by man. The human environment develops side by side with or against nature, or physis. The plant or animal species, the directions which rivers take, and the quality of water should direct human work within a framework of respect for all the objects of this work and for the ethical needs which are revealed in this site and location.

What the problem and the threat of pollution serve to do, for example, is to place things and words in a place of primary importance in the questionings and anxieties of modern man. How can we withdraw from the imposing responsibility of having avoided the adoption of ethics which have no weaknesses and no false appearances? The world of nature, like that of human activity, does not escape the range of this constant question which will either protect us against human evils or lead to us being overwhelmed.

In an etymological sense "progress" is what describes and explains forward movement. Ever since the nineteenth century "progress" has been a key word. It is true that the reality of progress cannot be disputed but questions can be raised about its value. It cannot be affirmed that safe progress exists merely because the history of the world seems to demonstrate such progress. What can be said is that such progress exists when it is useful, productive and beneficial for men and for nature. This is often forgotten not least because of the damaging and negative impact of power—and we often have to pay a heavy price for this error.

The history of biological inheritance began with Haeckel who demonstrated that the development of an embryo contained within it the development of its species—its phylogenesis. Later Mendel described the classic features of reproduction in plants and the laws which can be deduced from the mechanics of that reproduction. In 1903 Sutton advanced the chromosomic theory of inheritance (*chromos*—color). Morgan studied the development of the drosophila of vinegar. De Vries (1880) and Darwin analyzed pangenesis—that is, the existence of elements which are separate from inheritance. The pangenes (Johannsen) have four properties: replication (that is, the ability to form copies of themselves); functions (the capacity to determine a given characteristic); recombination (the ability to form typical bonds); and mutation (the ability to change the environment on their own). Bateson invented the term "Mendelism" and explained the results that Mendel had achieved with reference to the fact that every characteristic depends on a gene which involve two alternatives or states—the alleles. The somatic cells have two similar examples. One of the chromosomes comes from one parent and the other from the other. There are two types of chromosomes—those of gender and the autosomes. Thus one can observe that the male has one chromosome—chromosome XY—whereas the female has two XX chromosomes.

The number of chromosomes

varies according to the species. The human genome (or genic structure) has twenty-two pairs of autosomes and two sex chromosomes. Some ferns have five-hundred chromosomes. An intestinal worm has two chromosomes. One species of monkey has forty-six chromosomes and a gorilla has forty-eight chromosomes.

What is called gene chemistry has been a subject of study for some fifty years. Deoxyribonucleic acid (or DNA) is a molecule composed of four nucleotides with an azoic base and a phosphoric group. The letters A, B, G and T are used to define the DNA sequence. DNA exists in the form of a double line which forms a double helix.

The DNA of a living creature contains the genetic information of that species. Each locus is the site of a gene on the chromosome. We know how to transcribe genes, translate them, clone them (that is, insert a fragment of DNA into a vector), use hybrids, and so forth. In 1990 the genome program was set in motion by the United States of America and other countries which have the research facilities and resources which allow them to support such an initiative. The aim of this program or project is to construct a genetic and physical map of the human genome. In this way it is hoped that many illnesses caused by genetic factors would be discovered and understood in their workings.

This program and the mapping of the human genome rely to a great extent upon computer methods and techniques. Various approaches are employed. For example, there are the genome studies of the hybrid irradiation phenomena which take place when fractures occur. At the present time new genes and the way they work are studied. But this is neither sufficient nor decisive for our purposes.

A researcher at the Massachusetts Institute of Technology (MIT) has called for a new program which studies chromosome 17 and its role in the inheritance of diabetes.

"The human genome program tends to produce a periodic biological classification involving not a hundred elements but one hundred thousand genes. Not with a rectangle which reflects the values of the electrons, but with a tree which describes the functional and ancestral affinities which exist between human genes." He goes on to explain that "in the same way as chemists can recognize atoms from their mass and their charge, so biologists will be able to create systems by which it will be possible to recognize every gene from an examination of a characteristic fragment."

Cancer of the ovaries involves a hereditary predisposition in 5-10% of victims. The genetic link is found through the BRCA1 locus on chromosome 17qA1. The average age is lower in instances of this tumor (forty-one as opposed to sixty-one). One is dealing here primarily with a serious kind of cancer whose potential evolution is more favorable. The prognosis is better. The same kinds of results have been found in relation to colon-rectum cancer.

10% of prostrate cancer cases also display a hereditary predisposition and often involve genetic risk.

Ethnic differences have an important role to play in the presence of cancer. However, this does not apply to breast cancer and womb cancer. Black Americans are seven times more likely to fall victim to prostrate cancer than Koreans. Rare kinds of tumor are to be found among the Eskimos (cancer of the bladder); the American Red Indians (thyroid cancer); and the Chinese (nose and pharynx cancer).

It appears that in the case of CADASIF (cerebral autosomal dominant artheriopathy with neuroencephalopathy) which is marked by early and returning cerebral hemorrhage, the gene is connected to chromosome 19. However, here the mapping process is not yet complete.

We already knew how to tell the truth, or what was believed to be the truth. We also know how to lie and to falsify.

Should we be surprised that the human genome project has involved fraud at the very highest level? Collius Francis, the director of the project, has revealed that one of his assistants modified the data and invented a mass of work over a period of two years. The seventh stage of work involved an error of reasoning which suggested the presence of a deception. The investigation carried out by the OSI (Bureau pour l'Integrité de la Science) has not yet been finished. The whole episode brings out the risks that are involved in high science. Given the consequences for research and for patients, it is clear that prudence is of the essence.

But we also have to guarantee medical secrecy. In 1995 New Hampshire was the first state to prohibit employers and insurance companies from carrying out genetic tests to achieve a diagnosis and make an assessment. During a conference held in Berlin the Association Internationale du Barreau called for limitations to be placed on access to an individual's genetic dossier in the same way as reference cannot be made in certain situations to a person's religion, political beliefs, ethnic group, or sexual preferences.

However, legal experts have certain doubts as regards insurance and the premiums to be paid! Each illness involves genetic risks, but their evaluation is not always easy or precise. This explains the difficulties in such measures, whose importance in the life of a man cannot be disputed.

In this way the use of genetic data is not relevant when information is provided about the possibility of a tumor many decades before it occurs!

Should we speak out or keep quiet? We should assess the direct risks which are involved, but we should also examine the consequences for a person's way of life. Quite apart from genetic risks, there are also certain risks in the consumption of alcohol or other toxic substances, in the excessive intake of food, in exaggerated exposure to the sun (melanomas), in the absence of treatment for benign conditions which can degenerate into more serious forms, and so forth.

Man has responsibilities which we should meet with medicine, education and charity. This is the meaning of the Christian message from which we cannot depart. It is our duty to know this message and to uphold it—we have before us an opportunity to be men among men.

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BONIFACIO HONINGS

The Man of the New Creation: From the Image of God to the Likeness of Christ

In his first letter the apostle St. Peter writes: "If, after all, you should have to suffer in the cause of right, yours is a blessed lot. Do not be afraid or disturbed at their threats; enthrone Christ as Lord in your hearts. If anyone asks you to give an account of the hope you cherish, be ready at all times to answer for it, but courteously and with due reverence."[1] These revolutionary words of the first Vicar of Christ challenged, and still challenge, men of all times and of all places, and they are words which, above all, challenge the men of the third millennium.

The title of this international conference is "In the Image and Likeness of God: Always? Disorders of the Human Mind." This conference seeks to give an interdisciplinary answer to this "historic challenge" of the Christian faith. My contribution, which goes under the title "The Man of the New Creation," is thus one of the answers which this international conference seeks to give to those who pose questions about this faith. I hope that it is an answer which will give a solid base to the trust of all those who suffer but also, and above all, to those whose spiritual soul experiences the "organic" limits of its own faculties or finds itself impeded in the exercise of those faculties.

In order to explain the organization of this paper in clear and concise fashion, I would like to observe at the outset that this answer is based upon the divine project of the creation. Indeed, the person who refers to the man of the "new or second creation" cannot but have in mind the man of the "old or first creation." Furthermore, he

must also think of the man created by God in paradise and, above all, he must also acknowledge fallen man or man the sinner, the man who abused the freedom of his paradise at the beginning of history. In other words, the man of the new creation is the same man whom God—after creating him in his image, both male and female—established in a state of grace.

An argument based upon biblical theology, such as that which I present in this paper, must for this reason take as its point of departure the divine project of the creation. At a more specific level it must begin with the first of the three key moments of that creation and then go on to examine them in detail. This paper is thus organized into four separate subsections, which indeed correspond to this endeavor: 1) the three moments of the divine project of the creation of man; 2) the moment of the creative act of "in the image"; 3) the mo-

Scialappa
Convolvulus Jalapa.

ment of the constitutive act "in paradise" and its loss; and 4) the moment of the new creation "in the likeness of Christ."

The man of the new creation finds his origin in Christ, the Anointed of the Father, who became man like us so that every man could become once again "like" God—that is, a new creature in the likeness of the Risen Christ.

1. The Three Moments of the Divine Project of the Creation of Man

If we read closely what God in Genesis reveals about man, we can perceive at the outset the act of creation. In the symbolic presentation of the work of God as a series of six days of divine "work," there is nothing which does not owe its own existence to God. The world began when it was created from nothing by the Word of God. All existing creatures, the whole of nature, and the whole of human history find their roots in this primordial event. Every creature has its own goodness and its own perfection. The various creatures whose specific being was willed by God received their own character, truth, goodness, their own laws, and their own order at this precise moment. For this reason, every creature reflects a ray of the infinite wisdom and goodness of God in its own particular way. However, the concept of the "six days" not only seeks to express the interdependence of the created beings, but also, and above all, communicates their hierarchy, their structured order from the least perfect to the

most perfect.[2] "The sun and the moon, the cedar and the little flower, the eagle and the sparrow: the spectacle of their countless diversities and inequalities tells us that no creature is self-sufficient. Creatures exist only in dependence on each other, to complete each other, in the service of each other."[3] The order and the harmony of the creation spring from this diversity of beings and the relationships which exist between them. We can grasp that the beauty of the creation reflects the infinite beauty of the Creator.

However—and this is what most interests us in this paper—the inspired account of the creation clearly reveals that man is at the summit of the creation. Indeed, the Creator clearly distinguishes between the creation of man and the creation of other beings and organisms. The formation of man is described in a way which is peculiar to him even though it is clear that man, like other beings, has his origins in a divine act of creation. The oldest account that we have tells us that man was taken from the dust like other animals and is thus mortal in the same way as they are. However, his breath of life comes from the breath of God, something which does not apply to the creation to any other animal.[4] The most recent account of the creation thus presents man as the work of a solemn divine decision: "Let us make man in our image."[5] Because of this special form of divine creation, and, therefore, because of his resultant special nature, man occupies the central and summit position of the visible world. Such, indeed, is the first moment of the divine project of the creation of man.

Against this background of the creative act of God, the Old Testament revelation enables us to understand not only that God created the first man as good, but that He also wanted to create him in an original state of holiness, and thus in a state of original justice. The sign of friendship between man and his Creator lies in the fact that God places him in a garden where he lives "to till it and keep it."[6] Work is not a heavy burden,[7] "but rather the collaboration of man and woman with God in perfecting the

visible creation."[8] Thus the Church, in giving an authentic interpretation to the symbolism of biblical language in the light of the New Testament and Tradition, teaches that our progenitors, Adam and Eve, were created in an "original state of holiness and justice."[9] Such is the second moment of the divine project of the creation of man.

But "this entire harmony of original justice, foreseen for man in God's plan, will be lost by the sin of our first parents."[10] However, and here we encounter the third moment of the creative project of God, after this fall man is not abandoned by God. On the contrary. God calls him[11] and informs him in mysterious fashion that evil will be defeated and that man will rise above the fall.[12] "This passage in Genesis is called the *Protoevangelium* ("first gospel"): the first announcement of the Messiah and Redeemer, of a battle between the serpent and the Woman, and of the final victory of a descendant of hers."[13] Such is the announcement to man of the new creation. The Magisterium of the Church specifies that this creation exceeds the original holiness and justice of man in paradise. "The first man was not only created good, but was also established in friendship with his Creator and in harmony with himself and with the creation around him, in a state that would be surpassed only by the glory of the new creation in Christ."[14] We will now consider the individual

Scilla
Scilla maritima

moments of the creative project of God and in this endeavor especial attention will be paid to the moment of the new creation.

2. The Moment of the Divine Act Creating of Man "in the Image of God"

All, whether believers or not, agree that everything that exists on the earth should be seen in the context of man, and that man is its center and its summit. But the answers to the question What is man? vary and are also contradictory. Indeed, man often exalts himself to such an extent as to become an absolute rule or, on the other hand, debases himself to the point of desperation only to end up, as a consequence, immersed in doubt and anxiety. The Church feels this difficulty very keenly and believes that she can give an answer which comes from the teaching of divine revelation. This teaching describes the real condition of man, gives a reason for his sufferings, and helps him to achieve a just recognition of his dignity and vocation.[15]

With the authority of the Council Fathers, the Church answers man's question about his identity with the statement that he is created "in the image of God." This means that man is able to know and to love his own Creator and to rule over all creatures, over which, indeed, he has dominion, for the glory of God.[16] This is the reason why "man expresses within himself, because of his very corporeal condition, the elements of the material world, with the result that through him they reach their summit and take on a voice to freely praise the Creator."[17] In the same way, man is a being "in the image of God" because he has the dignity of a person. He is not something, but somebody, or, rather, he is an individual human who is capable of knowing himself, of possessing himself, of giving himself freely, and thus of entering into a communion of life and of love with other people.[18]

Among the visible creatures, man is the only creature made "in the image of God" and he is thus able to enter into dialogue with Him, to know Him, and to love

Him. Man is a "subject aware of himself, free, and open to the infinite. He knows himself, he asks himself questions, he possesses himself, and he gives of himself. A corporeal and sexualized subject, he receives and transmits life in a fabric of relationships."[19] This is why man is not in error when he perceives himself as being superior to mere corporeal entities and why he sees himself as something more than a mere particle of nature or an anonymous element of the human city. "Indeed, within his inner self he transcends the universe. It is to this profound interiority that he returns when he turns to the heart where God is waiting for him, God who sees into hearts, there where he decides upon his own destiny under the watchful gaze of God. For this reason, in recognizing that he is an immortal and spiritual soul, he does not allow himself to be deceived by fallacious fictions which derive solely from social and physical conditions, but comes, rather, to touch the truth of things at their deepest level."[20]

At this point, it is very important to dwell upon the symbolic language of the biblical account of the divine creation of man. In order to reveal that the human person created in the "image of God" is a being made up of both body and spirit, the sacred author employs the following terms: "Then the Lord God formed man of dust from the ground, and breathed into his nostrils the breath of life; and man became a living being."[21] This clearly reveals why the body of man takes part in the dignity of being in the "image of God." It is, indeed, "a human body precisely because it is animated by a spiritual soul."[22] For this reason "spirit and matter in man are not two natures united, but, rather, their union forms a single nature."[23] This unity of the soul and the body is thus so deep as to render the soul the "form" of the body. It should be observed here, and the point is most important, that "the Church teaches that every spiritual soul is created immediately by God—it is not 'produced' by the parents—and also that it is immortal."[24] Therefore, and here we encounter the great dignity of each and every person, man is cre-

ated "in the image of God" precisely as a "unity of soul and body."

Moreover, he is also the "image of God" when male and when female. This does not mean that God is in the image of man. God is neither man nor woman. "God is pure spirit, in whom there is no place for the difference between the sexes. But the respective 'perfection' of man and woman reflect something of the infinite perfection of God: those of a mother[25] and those of a father and husband."[26] Man "in the image of God" is a corporeal and sexualized subject who receives life from God and he himself, as male and female, transmits it in the form of responsible collaborators of the Creator.[27] But what has been hitherto observed about man created in the image of God is not all that there is to be said on the subject. On the contrary. There is an action on the part of God the Creator which is even more sublime and more elevated in character.

3. The Moment of the Establishment of Man "in Paradise" and Its Loss

Man came into the light as a project to be carried to its conclusion because God called him to cooperation. This is what is well revealed by the words of God: "I have set before you life and death, a blessing and a curse; therefore, choose life, that you and your descendants

Segala cornuta.

may live."[28] This is what St.Paul means when he declares: "So may the God of peace sanctify you wholly, keep spirit and soul and body unimpaired, to greet the coming of our Lord Jesus Christ without reproach."[29] It should be observed at this point that the Apostle does not introduce a duality into the soul with this distinction. "Spirit" means that from the moment of his creation man is destined for a supernatural end[30] and that his soul is able to be freely elevated to the communion of life with God.[31] Man, therefore, in the divine project of the creation, was from the outset ordained to a supernatural end. As a result, his soul was capable of being elevated through grace to sharing in the life of love of his Creator.

Here we encounter the theological reason why God created our progenitors in a state of original holiness. "The eternal Father," explain the Council fathers, "created the universe with a most free and arcane plan of wisdom and goodness. He decreed the elevation of men to sharing in his divine life."[32] Because it well characterizes the second moment of the divine project of the creation, attention should be paid here to this grace of original holiness or, rather, this sharing in the divine life which potentiated through its radiance every dimension of the life of man. The force of this radiance of the divine innerness of man by God meant not only that man did not suffer but even that he did not die. The Church teaches that "by the radiance of this grace all dimensions of man's life were confirmed. As long as he remained in the divine intimacy, man would not have to suffer[33] or die.[34] The inner harmony of the human person, the harmony between man and woman,[35] and, finally, the harmony between the first couple and all creation, comprised the state called 'original justice.' "[36]

However, the sharing of man in divine life "was realized, above all, within man himself: *self-mastery*. The first man was unimpaired and ordered in his whole being because he was free from the triple concupiscence[37] that subjugates him to the pleasures of the senses, covetousness for earthly goods,

and self-assertion, contrary to the dictates of reason."[38] The second moment of the divine project of the creation, therefore, consists in the fact that the man and the woman found themselves in a state of friendship with God from which sprang the happiness of their existence in paradise. The life of man in paradise was marked by a threefold harmony—the religious, the intra and inter personal, and the cosmic. This man, it should be observed with care, "was destined to be fully 'divinized' by God in glory."[39]

This would have happened were it not for the fact that, when tempted by the devil, man "let his trust in his Creator die in his heart[40] and, abusing his freedom, *disobeyed* God's command."[41] "In that sin man *preferred* himself to God and by that very act scorned him. He chose himself over and against God, against the requirements of his creaturely status and therefore against his own good... Seduced by the devil, he wanted to 'be like God,' but 'without God,' and not in accordance with God."[42] The dramatic and immediate consequence of this first sin of disobedience was the loss of original holiness and, as a result, of original justice as well.[43] The Fathers of Vatican II clearly lay down that all men are involved in the sin of Adam. "Indeed, if man looks into his heart, he finds himself inclined also towards evil and immersed in many sufferings which certainly cannot derive from the Creator, who is good... In refusing to accept God as his principle, man fractured due order in his relationship to his end and at the same time the whole of the order towards himself, both towards other men and towards the other created forms."[44]

But in line with a promise made by God towards our progenitors, his project of the creation also has a third moment. The universality of the salvation of Christ follows on from the universality of sin and death.

4. The Moment of the New Creation of Man in "the Likeness of Christ"

Indeed, "one man commits a sin, and it brings condemnation upon all; one man makes amends, and it brings to all justification, that is, life."[45] The Apostle of the gentiles is convinced that this is the third and last moment of the creative project of God. He says so in explicit terms when he reveals the divine plan of salvation to the Ephesians: "Blessed be that God, that Father of our Lord Jesus Christ, who has blessed us, in Christ, with every spiritual blessing, higher than heaven itself. He has chosen us out, in Christ, before the foundation of the world, to be saints, to be blameless in his sight, for love of him; marking us out beforehand (so his will decreed) to be his adopted children through Jesus Christ. Thus he would manifest the splendor of that grace by which he has taken us into his favor in the person of his beloved Son."[46] The victor over evil and the raiser of man from the fall predicted by the Father of the Book of Genesis, therefore, is Christ. Indeed, Christian tradition perceives in the *Protoevangelium*[47] the announcement of the "new Adam",[48] who, through his obedience "until death on the cross",[49] "makes amends superabundantly for the disobedience of Adam."[50] The Apostle is right when he refers to superabundant amends because the original holiness and justice of paradise are greatly surpassed by the glory of the new creation in Christ.[51]

I would like to point out that with this salvific mission of Christ

Sena.
Cassia senna.

we enter to the full into the answer to the question posed by this international conference, which is at the same time an answer to the "lighter-flint" challenge of our bearing witness to hope. To the question whether a man with a disorder of the mind is always in the image and likeness of God I reply: he is certainly always "in the image" but he is also in a certain way always, and to a greater extent, "in the likeness of Christ." For the sake of clarity and to avoid misunderstanding, I would like to observe that I am not entering here into the question of the state of grace of individuals or of what religion they belong to. I am referring here to every human person who suffers from a mental disorder.

In part the answer is based upon the doctrine of the Church that *man* "Disfigured by sin and death..., remains 'in the image of God'...but is deprived 'of the glory of God,'[52] of his 'likeness'."[53] But in part also, and above all, upon the fact that the divine promise "made to Abraham inaugurates the economy of salvation at the culmination of which the Son himself will assume that 'image' and restore it in the Father's 'likeness' by giving it again its Glory, the Spirit who is 'the giver of life'."[54] The answer of our hope is that of hope against all hope of the descendance that God promised to Abraham, namely Christ. In Him the outpouring of the Holy Spirit was to reunite "the children of God who were dispersed".[55] Indeed, God undertook by an oath[56] that he would make the gift of his Chosen Son[57] and the gift "of the Holy Spirit; a pledge of the inheritance which is ours, to redeem it for us and bring us into possession of it, and so manifest God's glory."[58]

The Chosen Son, therefore, took on our flesh: "And the word was made flesh, and came to dwell among us; and we had sight of his glory, glory such as belongs to the Father's only-begotten Son, full of grace and truth."[59] However, and this is a very important point, the man for whom Christ made himself man was lacking in original holiness or rather the Glory of God, of the "paradisal" likeness to God. This is why in his letter to the
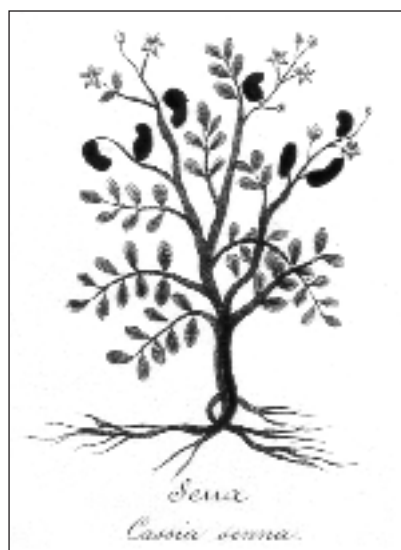
Galatians St. Paul writes: "God sent out his Son on a mission to us. He took birth from a woman, took birth as a subject of the law, so as to ransom those who were subject to the law, and make us sons by adoption."[60] In other and more incisive words the Word became flesh so that *we would become* participants "in the divine nature."[61] "Indeed," observes St. Irenaeus of Lyons, "this is why the Word was made man, and the Son of God, Son of Man: so that man, entering into communion with the Word and thereby receiving divine filiation, could become a son of God."[62] St. Athanasius of Alexandria writes in a similar vein: "The Son of God was made man to make us God."[63] And St. Thomas Aquinas declares in the same way: "The Only-Begotten Son of God wanted us to be participants in his divinity and took on our nature so that, when made man, he could make men gods."[64]

Christ, therefore, restored "that likeness to God" which is "specific to Him" to fallen man—that is, man deprived of his likeness to God. Indeed, "Christ's human nature belongs, as his own, to the divine person of the Son of God, who assumed it. Everything that Christ is and does in this nature derives from 'one of the Trinity'. The Son of God therefore communicates to his humanity his own personal mode of existence in the Trinity."[65] And given that each one of us has been taken on by the Word[66] we can observe and understand that all of the riches of Christ "are for every individual and are everybody's property."[66]

This is true for every human person, but it is also and "always" true—and here we touch upon the title of this international conference—for the individual who suffers from a mental disorder. *The Catechism of the Catholic Church* makes it clear that: "We are called only to become one with him, for he enables us as the members of his Body to share in what he lived for in his flesh as our model."[68] Furthermore, to every man, wherever he may be, the Church has the following good news to announce: "God loves your life, whether healthy or sick, happy on unhappy, virtuous or disfigured by sin, be-

cause Christ lives it together with you, shares your ill-destiny and your well-being, as if they were his."[69] From the " likeness to Christ" it follows that Christ, precisely because he is the "perfect man," is the model of life for each and every man.

St. Paul declares proudly and quite rightly that he does not preach his own cause but that of Jesus Christ the Lord. For this reason his words and above all his life bear witness to a force which is present, in specific fashion, in the fragility and the suffering of man. As St. Paul writes to the Corinthians: "Always we, alive as we are, are being given up to death for Jesus' sake, so that the living power of Jesus may be manifested in this mortal nature of ours. So death makes itself felt in us, and life in you."[70]

We should observe with very great care that St. Paul intrinsically connects the death of Christ which he (the Apostle) carries in his mortal flesh with a transcendent force of life which is inherent in suffering and death. In the light of faith St. Paul does not hesitate to write about this nexus of "power" between suffering/death and life and to observe accordingly: "He who raised Jesus from the dead will raise us too, and summon us, like you, before him... No, we do not play the coward; though the outward part of our nature is being worn down, our inner life is refreshed from day to day."[71]

The suffering and death of human existence on earth precisely because they are able each day to renew this existence are able to become effective factors—and even endless sources—of looking forward to eternal life. This hope which will never be disappointed not only is never discouraged but directs its gaze beyond the visible and the ephemeral world. For this reason the man of the new creation becomes evident when he professes and confesses with the absolute certainty of the faith of St. Paul and all those who believe in Christ that: "Once this earthly tent-dwelling of ours has come to an end, God, we are sure, has a solid building waiting for us, a dwelling not made with hands, that will last eternally in heaven. And indeed, it

is for this that we sigh, longing for the shelter of that home which heaven will give us... For this, nothing else, God was preparing us, when he gave us the foretaste of his Spirit."[72]

In the light of this faith I feel myself authorized to declare that every suffering person, and above all every person who suffers from a mental disorder, not only *resembles* the Crucified One, but becomes in a special way a person "in the likeness of Christ" because he shares in the suffering and the death on the cross of Christ. This reply, obviously enough, leads to a reflection upon the salvific value of the mystery of the cross. Whatever the circumstances involved, a person marked by the cross of a mental disorder challenges us to judge the cross that he bears: either it is madness or it is strength. It is really true that this person more than any other can pose to the men of today the provocative questions of St. Paul: "What has become of the wise men, the scribes, the philosophers of this age we live in? Must we not say that God has turned our worldly wisdom to folly?"

And the person suffering from a mental disorder, more than any other person, has the right to answer: "When God showed us his wisdom, the world, with all its wisdom, could not find its way to God; and now God would use a foolish thing, our preaching, to save those who will believe in it. Here are the Jews asking for signs and wonders, here are the Greeks intent on their philosophy; but what we preach is Christ crucified; to the Jews, a discouragement, to the Gentiles, mere folly; but to us who have been called, Jew and Gentile alike, Christ the power of God, Christ the wisdom of God."[73]

And thus we come to the concluding observations of this paper. The people who suffer from a mental disorder are like every other person, *always beings* "in the image of God." And from a certain point of view they are such to a greater extent because the Son of Man took upon himself man suffering because of sin, pain, and death. In the same way, the people who suffer from a mental disorder are, more than any other person,

always beings "in the likeness of Christ" precisely because they challenge all to express themselves in relation to the salvific value of the mystery of the suffering and death of Christ on the cross.

Every person who suffers from a mental disorder, therefore, is "in the image of God" because one has before one an "anthropological-religious" title which does not depend upon having or knowing, or upon the more or less "effective capacity" of a sound mind, but upon their "being-a-person"—that is, their unity of body and soul. Their being as an image of God depends exclusively upon the fact that their corporeal-being has a spiritual soul. Their body, their mind, and their will are "in the image of God" precisely because they are animated by their spiritual soul which is *created directly* by God and *not produced* by their parents. It is not the use of their mental capacities which makes them be "in the image of God." It is certainly true that this use would demonstrate their being but it is not the cause and it is emphatically not the *conditio sine qua non*.

People who suffer from a mental disorder are from a certain point of view even more "in the likeness of God" because they all in varying degrees bear the "prophetic" characteristics of the suffering servant of Yahweh: "He had no form or comeliness that we should look at him, and no beauty that we should desire him... His appearance was so marred, beyond human semblance, and his form beyond that of the sons of men."[74] However, beyond this what we might term "external configuration with Christ" there is a likeness which is of a more interior nature. The fathers of Vatican Council II declared that: "By the incarnation the Son of God united himself after a certain fashion with every man. He worked with the hands of a man, he thought with the mind of a man, he acted with the will of a man."[75] Now if it is true that the mystery of each man in reality finds true light only in the mystery of the Word, this is true, above all, of each and every man who suffers from a mental disorder.

This is because Christ, as the suffering servant, united himself to every person suffering from a mental disorder. For this reason we can understand that Christ took on their suffering. There follows from this—and here we come to a witnessing to hope and the reply to the question posed by the title of this International Conference—a question about the term "always," for on the day of the resurrection every person suffering from a mental disorder will share in a very special way in the glory of the Risen Christ precisely because he will have shared in and expressed through his body—and in a very special way—the "re-animating" power of the suffering and death of Christ.[76] In finishing this paper, I would like to stress the witness to hope that is offered to us by all persons suffering from a mental disorder: they are a *disfigured* image of God offering the divine guarantee that all men have already been restored to the likeness of the *trans-figured* Christ.

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Notes

[1] 1 Pet 3:14-15.
[2] Cf Gen 1:1-25.
[3] *Catechism of the Catholic Church* (hereafter CCC), n. 340.
[4] Cf Gen 2:7.
[5] Gen 1:26.
[6] Gen 2:15. 7. Cf Gen 3:17-19.
[8] CCC, n. 378. 9. CCC, n. 375.
[10] CCC, n. 379.
[11] Cf Gen 3:9
[12] Cf Gen 3:15.
[13] CCC, n.410.
[14] CCC, n. 374.
[15] *Gaudium et Spes* (hereafter GS), n. 12.
[16] Cf *Ibidem.*
[17] GS, n. 14.
[18] Cf CCC. n. 357.
[19] CF CEI, *La Verità vi Farà Liberi. Catechismo degli Adulti* (Rome, 1995), p. 188.
[20] *Ibidem.*
[21] Gen 2:7.
[22] CCC, n. 364.
[23] CCC, n. 365.
[24] CCC, n. 366.
[25] Cf Is 49:14-15; 66:13; Ps 131:2-3.
[26] Cf Hos 11:1-4; Gen 3:4-19. Cf CCC, n. 370.
[27] Cf Gen 1:22.
[28] Dt 30:19.
[29] I T 5:23.
[30] Vatican Council II: DS 3005.
[31] Cf Pius XII, Encyclical *Humani Generis*: DS 3891. See also CCC, n.367.
[32] *Lumen Gentium*, n. 2.
[33] Cf Gen 2:17; 3:19.
[34] Cf Gen 3:16.
[35] Cf Gen 2:25.
[36] CCC, n. 376.
[37] Cf 1 Jn 2:16.
[38] CCC, n. 377.
[39] CCC, n. 398.
[40] Cf Gen 3:1-11.
[41] CCC, n. 397.
[42] CCC, n. 398.
[43] Cf Rom 3:23.
[44] GS, n. 13.
[45] Rom 5:18.
[46] Eph 1:3-6.
[47] Cf Gen 3:15.
[48] Cf 1 Co 15:21-2, 45.
[49] Phil. 2:8.
[50] Cf Rom 5:19-20; CCC, n. 411.
[51] Cf CCC, n. 374.
[52] Rom 3:23.
[53] CCC, n. 705.
[54] CCC, n. 705.
[55] Jn 11:52.
[56] Cf Lk 1:73.
[57] Cf Gen 22:17-19; Rom 8:32; Jn 3:16.
[58] Eph 1:13-14.
[59] Jn 1:14.
[60] Gal 4:4-5.
[61] 2 Pet 1:4.
[62] St. Irenaeus of Lyons, *Adversus Haereses*, 3, 19, 1.
[63] St. Athanasius of Alexandria, *De Incarnatione*, 54, 3: PG 25, 192B.
[64] St. Thomas Aquinas, *Opusculum 57 in Festo Corporis Christi*, 1. Cf CCC, n. 460.
[65] CCC, n. 470.
[66] Cf GS, 22.
[67] John Paul II, Encyclical *Redemptor Hominis*, 11.
[68] CCC, n. 521.
[69] CEI, *La Verità vi Farà Liberi*, n. 1015.
[70] St. Paul, 2 Co 4:10-12.
[71] *Ibidem*, 4:14,16.
[72] *Ibidem*, 5:1-2, 5.
[73] 1 Co 1:20-24.
[74] Is 53:2; 52:14.
[75] GS, n. 22.
[76] Cf Col 3:3-4; Eph 2:26. As an unmistakable and unequivocal confirmation, I quote a reflection in a discourse by St. Athanasius: "'For this reason Christ died and came back to life—so as to be the Lord of the dead and of the living' (*Rm* 14:9). Indeed, for no other reason did he come down to the earth, enchained by an ancient bondage, except to break the bronze gates and split the iron bars of death and draw our lives out of corruption to himself, giving us freedom to replace slavery. If the work of this divine plan does not yet appear to be finished (as men indeed go on dying and their bodies decay in death), this fact must not become a motive for lack of trust. In advance we have already acquired a pledge... As St. Paul says, `He has raised us up along with him and caused us to sit in the heavens, in Christ Jesus' (*Eph* 2:6)... In addition, the Apostle says that this fact, well known to him, will become a reality for the whole human race by means of Christ, `who will transfigure our wretched bodies to conform them to his glorious body' (*Ph* 3:21). If, then, the transfiguration is a changing into the spiritual body and this body is in conformity with the glorious body of Christ, Christ certainly rose with a spiritual body, which is nothing but the lowly body which is sown [cf. *1 Co* 15:43] and then changed into a glorious one" (St. Athanasius, *Fifth Discourse on the Resurrection of Christ*, 6-7,9; PG 89, 1358-1359; 1361-1362).

JUAN J. LOPEZ-IBOR, JR.

Research in the Field of Neuroscience and Mental Illness

Over the last few years countries such as the United States of America, Japan and the members of the European Union have developed and promoted research programs to study the human nervous system. These initiatives have taken place under the general title of "the decade of the brain" or "the decade of research into the brain" (European Commission, 1992). Their aim is to improve our knowledge of the most complex, intricate, and characteristic organ of the human being, and at the same time to discover practical solutions by which to tackle and treat various kinds of illnesses and their connected psychosocial problems, including all the malfunctions and pathologies which are associated with them. Later in this paper I will discuss and consider the most important achievements and discoveries of these initiatives.

At the same time we should also discuss and debate the limits and limitations of scientific research in this field, and reflect upon the importance which should be attributed to ethical principles in this whole area. These two aspects are of essential significance if we want to reach the basic goal of the inquiries and investigations carried out by men of science—the achievement of improved knowledge of human nature and the human condition in order to help those who suffer because they are afflicted by illness.

The Challenges of Mental Illnesses and the Brain

The need to coordinate the work of various disciplines under the single banner of neuroscience arises naturally from the important fact of personal suffering; the influence that such suffering has in the social field; and the economic impact of illnesses which are in truth widespread in their incidence. We should also add that the increase in life expectancy involves a greater incidence of dementia (such as Alzheimer's disease), of disturbance of the cerebral-vascular system, and of motility, and of the short- and long-term effects of such chronic illnesses as epilepsy and mental retardation.

The notable increase in dependency forms of behavior finds its most fertile terrain in modern-day consumer society. This means that pathologies of the nervous system produce individual problems, family tensions and—in terms of the community at large—an impact of major social dimensions, the loss of productivity, and other negative consequences of a markedly high profile.

When we talk about a prevalence of such disorders, in many cases we are talking about millions of people who are afflicted by mental illness in such medium-sized countries as France, Italy, or Spain. The data published by the National Foundation for Scientific Research (1989) indicate that the total cost of these forms of illness in the United States of America exceeds $400 billion every year—that is, 7.3% of the gross domestic product of America. Of this sum, $ 136 billion are lost because of psychiatric disorders, 104 because of neurological disturbances, 90 because of alcoholism, and 71 because of drug abuse. In order to understand these statistics to the full we should be aware of the fact that the indirect costs are higher than those of direct health care, and that we should place in the balance such factors as the personal suffering of these sick people, the distress of their relatives, and the suffering caused to those members of society who are directly affected by the presence of mental disturbance in others.

By extrapolation it may be calculated that in Europe the annual cost of such illnesses is probably around 109 million ECU; of this sum 43 million ECU are allocated to direct health care. The rest is taken up in secondary expenses (European Commission, 1992). It was calculated that in Germany in 1988 14% of the population—that is, 11.5 million people—suffered from one form or another of psychiatric disturbance. In the same year 18.9 million work-days were lost as a result of the same kind of disorder (Bundes Minster fur Arbeit, 1991). Overall, it is calculated that in the countries of the European Union the costs of caring for illnesses of the nervous system amount to 20% of the total health care budget.

Mental illnesses involve those who are afflicted by them—and those who fight against them—coming up against one of the greatest and most intimate mysteries of human nature. His Holiness John Paul II drew attention to this reality in his address to a delegation of the members of the American Psychiatric Association and the World Psychiatric Association in January 1992:

"By its very nature, your work often brings you to the threshold of the human mystery. It involves a sensitivity to the often tangled workings of the human mind and

heart, and an openness to the ultimate concerns which give meaning to people's lives. These are areas of great importance to the Church, and they call to mind the urgent need for a constructive dialogue between science and religion for the sake of shedding greater light on the mystery of man in its fullness.

"Only by transcending themselves and living a life of self-giving and openness to truth and love can individuals reach fulfillment and contribute to building an authentic human community".

The World Bank has published certain data which enable us to evaluate—albeit in a rather approximate way—the level of disability produced by certain illnesses. The index employed in this study is that of years lost because of this disability (Disability-adjusted life years, or DALYs). 34% of these years lost are caused by behavioral problems; 8.1% by mental illnesses in the strict sense of the term; and 3.2% by vascular-cerebral illnesses. It should also be stressed that 45% of the DALYs are connected in one way or another with the workings of the brain, or the brain itself— that primary organ which is at the core of all human activity.

Developments in the Field of the Neurosciences

Neuroscience has four principal objectives:

1. To study the brain and the nervous system in general.

2. To inquire into the various relationships between the brain, the mind, and human behavior.

3. To create bridges between biology, the human sciences, sociology, and computer science.

4. To explore the origins, and produce a diagnosis and treatment, of the illnesses connected with the brain and the nervous system.

The discipline of neuroscience has created a broad variety of instruments by which to conduct research and these have become ever more sophisticated over time. In analyzing these instruments special reference should be made to molecular biology—a discipline which studies how genes express themselves; to genetics; to biophysics—

a branch of study which enables us to perceive individual signs within the neurons; to new forms of electronic microscopy; to the construction of images through the employment of radioisotopes and magnetics—elements which enable us to have an ever clearer idea of the structure and the function of the brain in live individuals operating in normal conditions or performing certain tasks; to the culture of live cells and tissues; and to computer technology and automatic electronic instruments—discoveries which pave the way for techniques and strategies by which to produce drugs and medicines which are ever more effective in their impact.

The most important subjects of research conducted in the field of modern neuroscience can be placed within the following five major categories:

1. The neuron—that is, the nerve cell. Here we are dealing with such areas as:

a) the chemical elements which transmit the signal of one neuron to another (neurotransmitters, neuromodulators, neuropeptics, and hormones); its receivers, channels, transporters and messengers all of which play a role in communicating between neurons and the nervous system and such other systems as the endocrinal system and the immunological system;

b) the protein structure and the biophysical and biochemical aspects of these signals;

c) the genesis and migration of neuron particles, the cell skeleton, the interactions between neurons and other cells, the structure and function of synapsis, and the structure which links one neuron to another.

2. The brain considered and analyzed in overall terms through:

– examination of how this organ constructs its perception of the world beginning with elementary sensorial signs; inquiry into how the brain engages in visualization (cerebral imagination) and into the workings of its metabolism in living beings; and the study of how drugs and medicines which act on the central nervous system actually function—something which is of vital importance in the discovery and identification of new pharmaceuticals.

3. The development and the plasticity of the nervous system, including: the way in which the nervous system, its cells and intracellular organs develop, how the nervous system regenerates itself, growth factors and cell transplant. Here we should also include studies into cell damage and cell death (including spontaneous death), normal and pathological ageing, and neurotoxicity (the influence of exogenic and endogenic toxic elements on neurons).

4. The behavior of the individual. We should lay especial emphasis upon cognition, learning and memory, motivation, the emotions, intelligence, and upon the disciplines of psycholinguistics, psychology, neuropsychology, aetiology, and artificial intelligence.

5. Pathologies. This heading includes psychiatric, neurological and cerebral-vascular illnesses, the mechanisms of pain, drug abuse and addiction, and pathologies connected with the phenomena of growth and ageing.

Examples of Research with an Overall Approach

Two examples illustrate very well what are, and what could be, the forms of progress and advance in this whole field. The first concerns research into the origins of schizophrenia—a very serious form of mental illness which afflicts 1% of the population (Tsuang *et al.,* 1991) and which only a few decades ago was very likely to condemn those who suffered from it to live within the walls of a lunatic asylum. Today, however, treatment results in a success rate of at least 50%.

Over a long period of time psychiatrists have studied the influence of biological factors (whether genetic or acquired), psychological factors, and family and social factors, in the outbreak and emergence of schizophrenia. In recent years a model has emerged which is termed "the vulnerability model" and this allows us to explain—albeit in approximate fashion—what actually takes place during the course and development of the illness. The model is based partly upon the presence of a certain genetic

inheritance—the rate of presence of the illness in identical twins is 50% whereas in non-identical twins it is about 10%, the same rate as occurs in siblings (Tsuang *et al.,* 1991)—and partly upon environmental factors. Within this last category a broad range of psychosocial and biological factors are present, some of which affect the individual and his brain at very early stages of his or her development. Others, however, act during the period of adolescence when the illness first emerges.

Brain-image techniques such as computerized axial tomography (Nasrallah *et al.,* 1982; Messimy *et al.* 1984) and magnetic resonance (Andreasen *et al.,* 1986) reveal anomalies in the development of the brain, especially in relation to asymmetries. What is very interesting is that cerebral asymmetry is accompanied by a parallel asymmetry in the cranial bone (Messimy *et al.,* 1985; Falkai *et al.,* 1992) and this means what has happened within the brain took place within the first months of life—that is, before the cranium had completed its process of ossification. These anomalies are not progressive and are not connected to the development of the illness. This is a factor which plays a part in the early origins and not the evolution of such anomalies (Andreasen *et al.,* 1986).

The other data available which sustain this thesis of early origins are the studies upon cohorts—that is, the monitoring of a specific set of people over many years or decades. A good example of this is the Danish study on schizophrenia (Parmas *et al.* 1982; Mednick *et al.,* 1987). Such studies demonstrate the presence of such different factors as cerebral damage at an early age and negative conditions during the growth and development of the individual (broken families, orphanages, negative conditions, and an impoverished upbringing) during his or her childhood. The virus theory of schizophrenia (Adams *et al.,* 1993) is supported—but not always demonstrated by—a relationship between the illness and individuals who are born during the winter (and thus more exposed to viruses) or in certain years when there are greater viral outbreaks—factors which could leave subtle traces and effect the development of the brain.

The vulnerability model explains the interaction between cerebral factors and other factors of a biographical character. In general, the illness emerges during adolescence but manifests itself earlier in males than in females (Beiser *et al.,* 1990). It is often connected with very evident stress factors which are provoked by situations of rapid social isolation (as for example occurs in the phenomenon of emigration). These factors can provoke the emergence of schizophrenia in individuals who have a natural vulnerability to the illness. The disturbance of development and growth which has already been mentioned, manifests itself in specific expressions of the personality which involve a tendency towards emotional isolation and impoverished forms of interpersonal communication. At the outset these phenomena permit the individual who is afflicted by them to live at a certain—albeit limited—level but subsequently they create an inability to manage and tackle new situations and requirements.

The Danish study referred to above took a set of children all of whom were seven years old and all of whom ran the risk of falling victim to schizophrenia because their mothers suffered from the illness. Because of this family background,it was expected that 10% of these children would develop schizophrenia. The probability rate was therefore ten times higher than in the rest of the population. This study, which was carried out over a period lasting some decades, identified certain individuals who developed schizophrenia, others who were normal, and a third group of people who demonstrated a schizophrenia disturbance which is termed "schizoid disorder." The members of this third group displayed certain symptoms associated with schizophrenia such as isolation in communication with others, difficulties in the formation and maintenance of social relationships, problems in relation to their personal identity, and emotional instability. But they did not display symptoms of delirium or forms of hallucination and thus the course and evolution of the illness involved far fewer difficulties and problems for those who had to treat it.

In this study, an examination of biographical data and cerebral damage showed that such factors were more influential in schizophrenic patients than in those who did not develop any illness at all or in those who were schizoid. These data suggest that the schizoid individual inherits a genetic predisposition to the illness but that he leads an exceptionally favorable life which protects him against its outbreak and emergence. Exactly the opposite may be said of the schizophrenic individual. In his case such protection is not present or operative.

This kind of hypothesis opens the door to the prevention and the treatment of this malady. This is because schizophrenia is not a progressive illness but an illness which has a specific period of risk—that is, the period which runs from the ages of fifteen to twenty-five in males and a few years later than this in females.

The second example is to be found in patients who have a limited kind of disturbance (borderline disturbance) of the personality and who display an impulse towards suicidal behavior. In such people we have discovered (López *et al.,* 1990), through the use of a technique involving neuroendocrinal stimuli (the phenylfluramine test), the presence of very high basic concentrations of cortisol (something which suggests a very high level of stress) and a very flat response to stimuli (something which suggests a reduced ability to react to external stimuli). The same phenomena are present in individuals who are addicted to heroine and who as a result are undergoing naltrexone treatment.

The key by which to understand these results is to be found in the work of Sapolsky (1990). In the African savanna of the Serengeti this scholar studied the stress adaptation systems of a certain species of monkey (papiones). The colonies of these monkeys live in very favorable conditions and circumstances, distant from the threat of predators and largely protected against irregularities in the quantity

and quality of their food supply. The privileged society of the monkeys of the Serengeti is highly hierarchical. The dominant males reach their position of dominance through a system of alliances, betrayals and struggles which when reached is then maintained through the employment of a series of conventional gestures. The males of the lower levels constantly have high concentrations of hydrocortisone—the stress hormone—in their bodies whereas the high-ranking males have low levels of this substance. However, the concentrations rise rapidly within the high-ranking males during moments of stress only to diminish immediately afterwards. For this reason one can easily perceive that the low-level males, who indeed live in a permanent state of stress, are not able to bring other resources of adaptation into play (such as an increase in the secretion of hydrocortisone) when new stress-inducing situations arise and present themselves.

That one is dealing here with the consequence of rank rather than its cause (the alternative explanation is that the monkeys that are better equipped in a physiological sense reach the highest positions as a reaction to stress-inducing situations) was demonstrated by what happened after the revolution of 1981. During the revolutionary period the members of the colony came to occupy different roles and even though there was always a high-up monkey which managed to affirm and uphold his privileges, the monkey-society itself lost its stability. By this route the characteristic physiology of the dominant males which was marked by adaptation to stress was also lost. Furthermore, these males, like the rest of the monkeys, had very high concentrations of hydrocortisone in their bodies throughout the revolutionary period. When peace was restored, the normal results to be expected from the hierarchical position of each monkey were obtained, regardless of what the secretion levels of cortisol and testerone of each of them had been before the revolution. This means that the hormonal changes were a consequence and not a cause of the social position of each male monkey.

The Problem of Truth in Psychiatry

The classic definition of delirium—that proposed by Esquirol at the beginning of the nineteenth century—of a false idea which is imposed pathologically and inexorably over logical thought is one which has been criticized by many experts in the field, most notably by Jaspers (1955) and by Schneider (1930, 1949). The proposition that delirious ideas are pathological because they are imposed pathologically is a line of reasoning which is locked into its own vicious circle. The truth or falsehood of a delirious idea can be tested every day through an observation of ideas which are accepted in certain cultural contexts and not others. From this point of view, the boundary between delirium and belief becomes a more than evident matter of debate.

In an attempt to expand and deepen our knowledge of delirious ideas, Kunz (1954-55) sought an idea model of the psychology of a healthy individual which had a structure similar to the delirious ideas of people afflicted by schizophrenia. However, he found only one such idea—the idea of death. In this idea the same mechanisms of defence are manifest as those which are to be found in delirious ideas.

One of the central and dominant characteristics of the delirious person is his inability to tolerate ambiguity, and this is something which leads him to fall into an unalterable certainty. The human being lives in two worlds—that which is shared *(koinos cosmos)* and that which is his own *(idios cosmos),* this latter being made up of fantasies and illusions. This ambiguity also applies to his body (as was observed by Meleau Ponty, 1942, 1945) of which at one and the same time one can say that he is it and that he has it (Marcel, 1955). Ambiguity is a radical feature of human existence and thus of human knowledge as well. This intolerance which is experienced by the delirious person leads him to alienate an important part of his psychic life which thereby ceases to belong to him. To put it another way: he lives his body as though it were not his own, as

though it belonged to those who rebuke him, to those who search him in a physical sense or send out bolts to injure his body or invade his thought and his inner self.

The tandem of falsehood and the irrefutability of logical argument proposed by Esquirol reminds us of the concept of madness adhered to in classical Greece—the arrogant negation of reality. This arrogance, that which cannot be refuted by logic, is the delirious certainty which also imposes itself on the sick person himself.

For a long time psychiatry found itself in a position of unease in relation to the question of truth, even though, as is more than evident, this difficulty was built into the very definition of the delirious idea. It was for this reason that the removal of the classic definition was followed by a definition of the delirious idea which began with its structure and its content. This line of approach adopted by the Heidelberg school (Jaspers, 1955; Schneider, 1930, 1949). According to this approach, the fidelity of the wife is in a certain sense irrelevant in understanding the delirious idea of jealousy. Nothing prevents the delirious person from being certain of what he believes. Treatment of the delirium of the jealous person does not have anything to do with whether the other party is really betraying him. In the same way, it is not of importance whether the hypochondriac really suffers from a serious illness. This line of approach reached its culminating point in Schneider (1949), who argued that delirium expresses itself in two forms—the delirious perception and the delirious idea.

In my opinion this line of approach is no longer valid or sustainable. Schneider himself (1951) announced the end of psychopathology and dedicated his last years to the study of theology. Indeed, we can see that the analysis of the question of what truth is became the means by which the crisis of psychopathology could be overcome.

To express the point very simply, it is possible to affirm that truth is not a one-sided concept. A logical truth exists which is in opposition to falsehood and a metaphysical truth exists which is opposed to the

illusory, to the unreal (Ferrater Mora, 1979). From Aristotle onwards, truth was seen as the adaptation of the intellect to the thing. Despite this fact and tradition, Heidegger (1953, 1964) explored the concept of truth along the lines adopted by the pre-Socratic philosophers. He saw truth as a process of discovery, a means by which to unveil the hidden as it opens itself to us (that is, the truth as *aletheia*). In Heidegger's thought this concept of truth is similar to the process of the search for, and the revelation of, the hidden meaning of neurotic symptoms, which is promoted in psychotherapy.

But there is yet more to be said on this point. In Heidegger's system truth converges with freedom. The essence of truth is freedom— the freedom to leave things (and men) to express themselves through that which they are, to enable them to become what they really are. Truth, therefore, has an interpersonal character. It is a process between kindred elements. The question of truth in medicine thus becomes reduced—or expanded— to the authentic relationship between the doctor and his patient, to the process which unveils the meaning of the symptoms, the meaning of inquiry into negative and self-destroying practices, the meaning of the revelation of the meaning of the existence of the basis of mutual trust, and (finally) the meaning of the wish and the effort to achieve an improvement—a treatment which in the most favorable of cases involves striving to achieve a level of authenticity which is higher than that previously reached and which in essential terms involves greater freedom, namely a freedom to be a patient or to cease to be a physician. From this point of view the falsehood of the delirious idea becomes clearer. It becomes evident that it is a false truth which—taking the form of a lamb—is imposed by isolation into being a certainty and an agreed reality. It is an autistic truth which cannot be reached by shared forms of research without reference to a recognition of contingency, of the ambiguity which is present. The problem is not whether the idea of jealousy is certain or uncertain—it is the lack of mutual trust within

the jealous person which prevents him from going beyond his own state of jealousy.

We should not neglect the fact that these ideas have very important practical implications. The McNaughton norms (West and Walk, 1977), for example, have lain behind the evaluation of penal responsibility in mentally ill people for many decades in Anglo-Saxon countries. They are based upon the rigid application of an erroneous concept of truth. In other words, if the man who lives as a slave to his jealousy kills his wife or her lover—whether actual or presumed—he must have the punishment that he deserves. Indeed, even in cases where infidelity is certain the crime cannot be justified. This it is that McNaughton, a young schizophrenic who spent almost the whole of his life in the Bethlehem hospital in London, would have been hanged if the norms which bear his name had been applied to him.

The approach adopted by Heidegger has very important implications for the discipline of psychiatry. It is obvious that the process of unveiling, of the revelation of truth, is achieved through the psychoanalytic process and that in this process it is the interpersonal relationship which is the effective basis of knowledge. At the same time it should be observed that this approach has strong links with the religious tradition which in his day Heidegger perceived as being of a New Testament orientation (1988). However, there are even deeper religious roots and these should receive special—albeit brief—treatment in this paper.

The religious roots of Freudian thought have not passed unnoticed. López Ibor (1975) has drawn attention to the connections of the Freudian system with the agnostic thought which is latent in many religions and in various forms of religiosity. The Manicheanism implicit in agnostic dualism offers an apparently solid ethical basis in as much as it permits the existence of two natures—one of which justifies evil and can be—indeed must be—finally overcome or redeemed by the other, even though certain battles during the war will be certainly lost. The question of evil, the

structure of evil, has been seen as the fundamental question of science, or at least of social science (Becker, 1980). This means that science of necessity has an agnostic root.

This statement clashes with the point of view advanced by T.H. Huxley, the thinker who coined the term "agnostic." Huxley believed that agnosticism was an essential characteristic of science: "It merely means that a human being does not say that he believes or does not believe in something which cannot be proved scientifically." But this definition bears within it an obvious dualism—that which can be known scientifically on the one hand and that in which every human being believes (Huxley uses the term incorrectly) or does not believe on the other. The first is accessible to the realm of technology, the second belongs to the realm of mystery, enigma and imagination. This is very near to the two concepts of truth advanced by Ferrater Mora (1979). Modern science, therefore, is at one and the same time both gnostic and agnostic.

Freudian thought is not only gnostic because it is scientific. It is also gnostic because it is connected and linked to a Jewish mystical tradition (Bakan, 1964). It is interesting to observe that the process of the reading of the sacred texts of the Jewish religion is based upon an interpretation which becomes an act of re-creation. Why is this? Hebrew, like other Semitic languages, does not have written vowels. The reading of a Hebrew text thus obliges the reader to introduce the vowel sounds which render its understanding possible. In this process, at the same time, an attempt must be made to be loyal to the original text and to the meaning of the text taken as a whole. The reading of the text, therefore, is an exercise in unveiling, it is a revelation of the word.

Zarader (1990) has published a very profound book on Heidegger's thought which draws our attention to certain roots of that thought which have hitherto been ignored, or to put it in more precise terms, denied. This philosopher demonstrates that the principal aspect of Heidegger's system is that the whole of an individual's

thought is due to what is latent within him and which has never been formulated. The idea that the man who traced back modern thought to its roots in classical Greece, to the time and the place of the *logo,* of spoken thought, might "not think" or "not say" the essential elements of his approach—that is, the least surprising. Zarader's thesis is that the thought of Heidegger has a very deep Jewish basis. The texts go beyond analogy. For this reason, the poet Heidegger is none other than a prophet along the lines of those of the Bible and his poetry is an interpretation because it is a reworking of a previously cited text.

Towards a New Ethical System

The most important task we have before us is to understand from reflection on these considerations that in scientific inquiry involving the process of knowledge there is always a personal element which must develop within a specific context—that of the knowledge and the thought of other people. This process of acquiring knowledge, therefore, is a shared process. These ethical roots of knowledge have received a major impulse from what is now termed bioethics. This discipline is able to offer guidelines and provide rules of conduct for those engaged in professional activity but it should also be emphasized that each action of knowledge is in itself the subject of ethics. Perhaps Karl Popper (1992) is the thinker who has given best expression to this truth in recent years in his description and analysis of the ethical principles which should govern the search for truth. Popper formulates those principles in the following way:

The principles which are at the base of every rational dialogue—that is, of every discussion concerning the search for truth—are necessarily ethical principles. These ethical principles may be outlined as follows:

1. *The principle of fallibility.* Perhaps I am wrong and perhaps you are right but on the other hand perhaps both of us are wrong.

2. *The principle of rational dialogue.* Obviously enough, and without wanting to make a personal criticism, should we not apply reason in favor or against our different (and criticizable) theories? This critical approach to which we adhere precisely because we are obliged to do so, forms a part of the intellectual responsibility that we must assume.

3. *The principle of approaching the truth through the support of debate.* We can always approach truth with the help of critical, impersonal (objective) discussion. In so doing we can nearly always improve our understanding, even in cases where we do not actually reach agreement.

It is extraordinary that these three principles are of an epistemological character and at the same time are also ethical principles. Amongst other things, they imply and encourage an attitude and approach based on tolerance. Later in this piece Popper adds certain new principles for new professional ethics based upon the following twelve principles:

1. Our conjectural objective knowledge continues to increase and this distinguishes it from what one individual can understand. For this reason authority is not present.

2. It is impossible to avoid all errors, even those which in themselves are inevitable.

3. It is our duty at all times to go on striving to avoid errors. But to avoid errors we must above all else be aware of the difficulties that this involves and be conscious of the fact that nobody manages to avoid errors—not even the most creative of scientists guided by intuition.

4. Errors can remain hidden from the knowledge of everyone, and can be present even within the most accredited theories. As a result, the specific task of the scientist is to look for these errors.

5. We must therefore change our attitude and approach towards our errors.

6. The new basic principle lays down that to avoid making mistakes we must learn from our errors. An attempt to conceal the existence of errors would be the greatest sin that we could possibly commit.

7. We must be continually on the alert to identify and perceive errors, especially if they are our own. We should also hope to be the first to discover such errors. Once such errors have been identified, we must bear them in mind and examine them from all points of view in order to discover why they were committed.

8. The adoption of a self-critical stance towards ourselves which is both honest and frank forms an important part of our task and purpose.

9. Given that we should learn from our mistakes, we must also learn to accept them when others point them out and even in so doing adopt a stance of gratitude. This does not mean that our errors are generally excusable—we should always be vigilant in the search for mistakes.

10. We need other people in order to discover and correct our mistakes (in the same way as other people need us) and we need people who have been educated with different ideas in worlds which are culturally different from our own.

11. Self-criticism is the best form of criticism but criticism of others is also necessary.

12. Rational and nonpersonal (or objective) criticism must always be specific. We should be governed by the idea of drawing near to the objective truth. It is in this sense that criticism must be impersonal but at the same time it must also be benevolent and constructive.

The Madrid Declaration of the World Psychiatric Association

The World Psychiatric Association has just published certain ethical guidelines under the title of "The Madrid Declaration" (World Psychiatric Association, 1996). These replace the previous ethical guidelines which went under the name of "The Hawaii Declaration" (World Psychiatric Association, 1977, 1983). This latter declaration was made in the context of the abuse of mental illness and psychiatry in totalitarian regimes, and in particular in the Soviet Union. In the USSR political dissidents or people with other ideologies or having forms of religiosity which were different from Communism were diagnosed as being mentally

ill and were even placed in psychiatric institutions.

This kind of abuse has almost disappeared, but the stigmatization of mental illness and discrimination practiced towards those who are afflicted by such illness are present in all countries, even in those which are the most developed. We find evidence of this in laws and customs, in general attitudes, and in commonly-held opinions. There is no institution in which they do not in some way make their presence felt.

The Madrid Declaration begins with the principle of equality in human relationships, beginning with that of the relationship between the medical doctor and his patient. The most significant paragraph relating to this subject reads as follows:

"The patient must be accepted in the therapeutic process as an equal in his own right. The relation between the patient and the physician must be based upon mutual trust and respect, and it is this which allows the patient to take free and responsible decisions. The duty of the psychiatrist lies in providing the patient with relevant and meaningful information so that he can make rational decisions which are in line with his norms, his values and his preferences."

Only if one begins from this principle is it possible to combat stigmatization and discrimination. One must begin from the starting point of a deep and true human relationship, as indeed has already been pointed out in this paper. In this way it will be possible to adopt a positive approach to a very broad range of situations arising from obligatory admissions, research and treatment.

If psychiatry and neuroscience in general are able to overcome the barriers erected against mental illness, to establish communication and relationships with the most alienated of the alienated, and to search for truth with those people who are dominated by autistic truth, then it will be possible to engage in authentic research. But if all this is not achieved, then the discipline and practice of psychiatry, will disappear and neuroscience itself will find itself in great difficulties. This last discipline will have lost sight of the purpose of its mis-

sion: to explore the innermost depths of the human being and to examine his most characteristic features, with a view to reintegrating him into that world of human beings which has distanced him because of his illness and its related consequences.

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ANNA ROSA ANDRETTA

Family and Society: Places of Pain

I must first of all express my special gratitude to His Eminence Cardinal Angelini, who with his sensitivity as a man and as a careful student of social and healthcare questions has not remained indifferent to a great and imposing reality—that experienced by those who are involved in the tragic condition of mental disturbance. He has also demonstrated marked solidarity towards the mentally ill and their relatives, people who are all too often the very least among men.

The title of this international conference invites us all to engage in a reflection. Who is a mentally ill person? What explanation can we give for his behavior?

For my contribution to this conference I have chosen the title—"Family and Society: Places of Suffering." This is a subject which would involve great difficulties if it were not applied to personal experience.

For the mentally ill person and his family a frontier disappears, a frontier which led on to a serene and peaceful life. At one time it was easy to cross that frontier for anybody who knew how to do so. Then terrible times arrive, full of fear, and the road of life becomes a labyrinth without an exit. There follows the gradual dissolution of the prospect of a tranquil daily life. Great struggles occur before the towel is thrown into the ring and a surrender is made.

There are different reactions—the mentally ill person seems to enjoy his condition, but the family no longer has the energy or the strength to strive for an even partial recovery. There are no doubts about a reality which forces people to deal with the painful situations which arise, trusting only to their instincts as each problem presents itself.

There is an attempt to avoid such situations and at the same time a desire to meet them. The reactions are feared. There are moments when it is not clear whether the intention is to meet the reality head on as soon as possible or to avoid it.

There is a great need to reduce one's time and one's space and accept the inevitable destiny. One feels harassed, gripped by a desire to flee which amounts to a wish not to be present, to cut one's ties, to disappear. One becomes drawn into contradictory feelings of hatred and love.

Then everything falls back into place again. One's own desperation is hidden through a covering up of the feelings of intolerance which are an element of existential falsehood. The way in which mentally ill people are forced to live upsets us. Thinking about their fate worries us because our fears are very similar to their forms of delirium. There is an attempt to believe that the sick person is dangerous, but the unsettling feeling which society feels when faced with the mentally ill person shows only too well that at the innermost level the danger does not come from the mentally ill person but from the idea that we might be or might become like him.

The great characteristic of our time is a metamorphosis in the physiognomy of mental illness. This gradual drawing near of the normal man to the alienated man by small steps has not, however, been able to eliminate an atavistic approach of superstitious fear, of morbid curiosity, and of flight when faced with the reality of madness.

Notwithstanding the present attempts to treat the mentally ill person within the community rather through a process of exclusion, these feelings of repulsion continue to hold sway even when a kindly hand is extended to him. Even though the gesture is full of charity, the face of the helping person is turned in another direction.

Tranquillity and good conscience are greatly shaken when the walls of separation which are both material and virtual come tumbling down. Archaic fears come out again and the terrible power of madness springs out of a past full of rites and magical practices.

The unconfessed and unconfessable conviction that the mentally ill are different, useless, expensive and disruptive gradually gains ground. Seen as a strange species which should be looked at rather than approached, these people even become a reason for shame on the part of their own families.

People do not hesitate to talk about a son who is a drug-addict, but who manages to speak without embarrassment and in clear terms about a relative who suffers from mental illness? The extreme and irrational attitude of a family when faced with the hospitalization and treatment of their sick relative, the refusal that they express, and the insistence with which they ask for such an approach as a form of punishment which can eliminate blame—all these elements well demonstrate how the world of affections is powerfully assailed by the phenomenon of mental illness.

The feeling of opprobrium which we encounter here arises from ignorance and from the widespread conviction that mental disturbance can be transmitted from one generation to another. Society becomes a place of suffering because the mentally ill become an oppressed and defenseless minority, and the phenomenon of madness becomes pushed to the margins in the field of medical care as well.

The "madman" who is blameless and unable to resist the tide of rebukes which assail him and to defend himself against the suspicion with which he is treated becomes that which people want him to be—the hideous expression of madness.

The way in which a society considers and sees a person is the result of a complex of relations in which the individual lives and relates to the structure of society in relation to his ability to be active within that society. The most frequent and immediate objection to this kind of line of reasoning revolves around a questioning of the myths of productivity and functionality.

And thus the question arises: can the mentally ill person manage to live without suffering in a social context which refuses to accept him with all his limitations?

The answer when in the affirmative is of a utopian character. His reduced or nonexistent productive capacity lies upon him like an irremovable stain which deprives him of his respectability. He is condemned to a social death.

I would like to finish my contribution to this international conference with a reading of some short verses written by a mentally ill person: "When you think that things are finished, that is life; when you feel oppressed, sick, and marginalized, that is life; when you feel alone, that is life, because life belongs to you and to me and to God my brother."

My conclusion after these lines thus becomes easy. I would like to invoke the subject of this conference—"In the Image and Likeness of God: Always?" I reply: "Yes! Always!"

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MARY COLEMAN

Autism

I wish to give thanks to the Pontificium Consilium and Fiorenzo Cardinal Angelini for inviting me to the beautiful ancient city of the Vatican. I am here to speak about one of the most mysterious of human diseases. It is one that affects the thinking and behavior of young developing children—the syndrome of autism. It occurs in approximately one out of 2,000 live births.

The concept of infantile autism represents a comprehensive diagnosis, somewhat along the the same lines as cerebral palsy or epilepsy. Autism is not a single disease entity. There is now overwhelming evidence that the behavioral syndrome of autism represents the final (common?) expression of various etiological factors.

In 1943, a child psychiatrist, Leo Kanner of Johns Hopkins University in the U.S.A., reported eleven cases in a scientific journal introducing to the world medical literature this group of children he labeled "autistic." (Kanner 1943) The central feature of this disturbance seem to be a lack of reciprocity in social interaction with other humans and an apparent failure to recognize the uniqueness and "specialness" of other human beings. The typically autistic child avoids eye contact from before the end of the first year of life, gazes out of the corner of the eye and gazes only very briefly, does not show anticipatory movements when about to be picked up, resists being held or touched, and does not "adjust" himself to "fit" in a hug or something similar. Autistic infants often seem to lack initiative; and interested curiosity and exploratory behavior seen in normal babies is often completely lacking. The autistic child does not usually come to his parents, brothers or sisters—or anybody else for that matter—for help or comfort.

As the child grows older, the abnormalities of social relatedness become less immediately obvious, particularly if the child is seen in his familiar surroundings. The resistance to being touched and held usually decreases with age, even though rough and tumble play is often preferred to gentle stroking. Unfortunately, the inability to play reciprocally with age peers remains sadly unchanged throughout the years in most cases. In children with autism, the inability to reciprocate and the tendency to treat other humans as anything but objects remains evident. These hallmarks differentiate them from superficially similar behavior seen in emotionally deprived children.

There are other symptoms

which help diagnose a child with autism. Usually from a very early age, the autistic child shows major problems in the comprehension of human mime, gesture and speech. Approximately one out of every two autistic children fails to develop useful spoken speech. Of those that do develop speech, all show major abnormalities of speech development. Another problem is that a majority of autistic children demand that certain routines be adhered to in a pathologically rigid fashion. Also, they often form bizarre attachments to certain objects, such as stones, curls of hair, pins, pieces of plastic toys or metals. Food fads are the rule rather than the exception. The self—destructiveness (head banging, wrist biting, chin knocking, cheek smashing, clawing, hair tearing, etc.) seen in many autistic children has been proposed as concomitant to the mental retardation, but in fact could not be, since such behavior is often seen even in normally intelligent autistic children.

Why do these children have all these strange behaviors? We do not know enough about brain function to be sure exactly where in the brain the problems lie but we do know that these children have abnormal sensory responses. By and large, clinical experience suggests that perceptions relating to auditory and tactile stimuli are more impaired in autistic children than are the perceptions of visual and especially olfactory stimuli. Autistic children often want to smell people and objects, probably for purposes of identification. Finally, it is well established that some autistic children, though not all, show "islets of special abili-

ties," particularly in the fields of root memory (e.g. numerical skills), music, art and visuospatial skills (or skills with jig-saw puzzle). We call such children "autistic-savants."

Studies in the neuropathology of the brain show no abnormalities of gyral configuration or myelination, and no evidence of significant gliosis. (Bauman and Kemper 1994). However, compared to controls, the brain in autism often shows increased cell packing density and reduced cell size in the hippocampal complex, the entorhinal cortex, the selected nuclei of the amygdala, the mammillary body and septal nuclei which project to the hippocampus. In addition, loss of Purkinje cells are seen in the neocerebellum. The emboliform, globose and fastigial nuclei show small neurons reduced in number. There are lesions in the forebrain in areas related to memory. Imaging studies have tended to confirm the neurophatological studies. In summary, in the anatomy of the brain, there are subtle but probably significant changes.

What can be done to help these little children who live in a world of loud noises and confusing information all around them? There are two major areas where we can help them and make a significant difference in their future lives. One is special education techniques which need to be available to all children with autism; the second is a medical evaluation which sometimes can be followed by a medical therapy which reverses or improves the symptoms. Because of this, developing techniques for the earliest possible identification of children with autism is now a high priority for researchers in this field.

Special education techniques differ from country to country but all good programs have in common that the child needs to receive individualized teaching based on that child's particular constellation of symptoms. Many children with autism, who are started in good educational programs under three years of age and who develop language, improve sufficiently that they are able to be mainstreamed into classrooms with normal children by six years of age. It is impossible to overemphasize the importance of early, individualized education as a treatment for children with autism. Today for most of these children, education is their best hope.

The second way to help children with autism is to find out exactly what is causing the infant brain of each child to express such bizarre symptoms. This involves a detailed medical work—up because there are many different underlying diseases—all of which injure the brain and are expressed through the final common pathway we call autism. In fact, autism is a syndrome of many etiologies. [Gillberg & Coleman 1992 (English)]; [Coleman & Gillberg 1986 (French)'] [Gillberg & Coleman in press (Italian)]; [Coleman & Gillberg 1985 (Japanese)]; [Coleman & Gillberg 1989 (Spanish)].

There are so many different causes we group them into categories as follows:

1. Infectious etiologies
2. Metabolic disease entities
3. Chromosomal aberrations
4. Structural lesions of the central nervous system
5. Sensory handicap association—deafness, blindness
6. Double syndromes (autism plus another syndrome in the same child)
7. Idiopathic

Of course, regarding any syndrome, the best approach of all is to prevent it in the first place. Two forms of autism are currently able to be totally prevented.

The first is *rubella autism*, caused when a pregnant mother is infected with rubella—or German measles—at the beginning of the second trimester of pregnancy. If all the girls in a society are vaccinated against rubella before they reach the child—bearing years, this form of autism disappears. This is now what is happening in many countries and needs to be extended to every country in the world.

The second preventable form of autism is phenylketonuria autism or *PKU autism* for short. PKU is a metabolic disease that can be detected by newborn screening of all infants. For all newborns in many countries, a bit of blood is removed from the heel and submitted to special testing. Today, children with PKU can be identified in the first week of life and then placed on a special infant formula which prevents both the other—wise inevitable mental retardation and the autistic behaviors. The children must stay on the special food, which is missing the amino acid, phenylalanine, throughout their childhood. But is certainly worth it because they become normal adults instead of severely impaired and handicapped retarded and autistic individuals.

We may soon have additional preventable forms of autism. There are a several metabolic disease entities where research therapies are under intense investigation at present. If this research leads to an established medical therapy which reverses symptoms, then it is possible that testing for these additional diseases might be added to routine newborn screening test.

One of these diseases in *purine autism*. Purine autism is diagnosed when a child with autism is found to have too much uric acid in his urine. Purines are very important in brain function—they are involved in neurotransmissions, information processing on DNA, energy production and antioxidation. Three studies have shown that many children with autism excrete too much uric acid. The figures in Italy are 26% of children with autism who excrete excessive uric acid; in France they are 28%; and

in the United States, they are 22%. So far, two enzymes of the purine pathway (adenylsuccinate lyase and PRPP synthetase) have been found to be abnormal in children with autism and current research is demonstrating additional enzymes. Because there are overproducing, rather than underproducing, enzymes, it is likely that a treatment may be found for purine autism, and soon.

A rare form of autism is known as *hyperlactatemia autism*. Here the error is in the carbohydrate pathway affecting the brain and the treatments under study are the ketogenic diet and vitamin B1 (thiamine).

Another disease causing autism recently identified is *infantile manic—depressive disease* which is manic—depressive disease in the parents expressing itself in the child at an infantile age. The treatment under investigation is lithium, a classic treatment used in adult manic—depressive disease.

Some children with autism have food faddism resulting in very poor diets and a common result is that they have inadequate amounts of calcium in their brains. Low levels of calcium, as measured in their urines, can be associated with a prevention of language development and/or self—abuse of their eyes. This is something easy to check and easy to correct by calcium diet supplements in such an autistic child. This raises the important point that if an individual with autism is self—abusing, a biochemical evaluation of the person is always in order.

Seizures are often a problem in children with autism—in fact, they are more likely than retarded children to have a seizure disorder. Recent research has shown that if a baby has a EEG focus for infantile spasms on both sides of his brain, that child is more likely to develop autistic symptoms afterwards. Seizures should always be aggressively treated and suppressed in any individual with autism; sometimes the behavior symptoms also improve with the drug treatments. Certain underlying disease entities are more likely to be associated with seizures in autistic children— they are tuberous sclerosis and neurofibromatosis, which can be

diagnosed by imaging studies; PKU and purine autism, which can be diagnosed by blood and urine studies; the fragile X syndrome which can be diagnosed by chromosomal studies; and Rett syndrome—a form of autism seen only in girls—which can be diagnosed only by clinical observation.

This discussion of seizure reminds us that many children with other syndromes have autistic features; in fact, they may have two syndromes—autism plus another syndrome. Some examples of these double syndromes are:
1. deLange syndrome
2. Fetal alcohol syndrome
3. Hypomelanosis of Ito
4. Infantile spasms sequelae syndrome
5. Joubert syndrome
6. Lyan—Fryan syndrome
7. Moebius syndrome
8. Neurofibromatosis
9. Rett syndrome
10. Sotos syndrome
11. Tourette syndrome
12. Tuberous sclerosis
13. Williams syndrome

As noted above, some patients have autism as a result of infections either in utero or early in infancy—rubella, CMV and herpes virus are the best established at this time. Bacterial infections, such as Haemophilis influenza meningitis, also have led to the development of autism. As if one tragedy were not enough, children who are blind or deaf are at higher risk of having autistic features.

One heart-breaking cause that has been documented occurs when mothers are exposed during pregnancy to toxic substances. Benzodiazepine, excessive alcohol and thalidomide have all been indicted in some cases of autism. Also, there are cases where the most extensive examinations fail to reveal the etiology of the autism—these children are said to have "idiopathic" autism, which is the doctors' way of saying that "we simply don't know."

Finally, I wish to draw attention to the sufferings of the parents of children who have autism. These children have a type of handicap that often does not allow them to show affection to their attentive parents. In contrast to Down syndrome children, for example, who often are very loving to parents, some children with autism actually experience pain when the mother looks at them or when she hugs them. Children with severe forms of autism may use the mother's hand as an object to turn the doorknob rather than relate to her as a person. In our work to help children with autism, we must include support for their heroic parents. Thank you.

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GIAN LUIGI GIGLI

The Unfinished Project:
Ethical Problems and Strategies for Action
on Mental Retardation

A Word on Terminology

The term "mental retardation", which belongs to North American nosography, often has negative connotations and can be offensive in some cultures, as indeed is the case in Great Britain. The terminology which is employed in relation to this whole area varies from country to country. Mental retardation, intellectual disability, learning disability, development disability, and mental handicap are terms which can refer to the same thing or to things which are very different. An obvious confusion can thus occur when the results of epidemiological surveys are assessed and when precise reference is made to the results of different strategies of intervention to resolve certain problems.

It would be very useful to have a terminology which had the same meaning for everybody and which involved a positive vision of disabled people. From research conducted in English-speaking countries (Fernald, 1995) it seems that there is a certain degree of consensus about the suitability of "intellectual disability"—a term which is seen as understandable, sufficiently clear in its meaning, and not offensive in its implications. In this paper I will often use the concept of intellectual disability, interchanging it with the term "mental retardation," and this latter phrase will be employed without any negative connotation.

Introduction

Although the phenomenon occurs repeatedly without any apparent effort during the period of growth, its miraculous character never ceases to surprise us: nothing is more amazing than to observe the progressive intellectual development of a child to the point where it begins to acquire the characteristics of adult rational intelligence—that stage described by Piaget as being operative-formal thought.

In large measure this process is the outcome of a project far greater than ourselves which is written into our inner selves and over which we have only a marginal influence. Our influence is only able to render this process more evident when its impact is negative.

At times, however, this delicate process can become interrupted. We see the child continue on his path of physical growth until he reaches adulthood but his behavior and his intelligence remain rooted in childhood. We realize that we are faced with a strange individual whose chronological age does not correspond to his mental age. The process has stopped or advances with frustrating slowness and the project of man remains unfinished. We realize that we are dealing with a person who is afflicted by the condition of mental retardation. Quite apart from its negative connotations, the term suggests a general intellectual performance well below the average which begins before the age of eighteen and which is characterized by substantial limitations in the individual's capacity to adapt to the needs and requirements of the environment which surrounds him.

**The Causes
of Mental Retardation**

The causes which can lie behind this check to development are manifold. In a certain sense mental retardation can be seen as a sort of cumulative joint outcome of a large number of pathological conditions which affect the central nervous system before birth or in the first early years of life outside the mother's womb.

Amongst the biological causes which are at work there are such chromosome malfunctions as trisomy 21 syndrome or Down's syndrome and weak X syndrome (which are the two most frequent causes of mental retardation caused by genetic factors); other forms caused by localized mutations of chromosome X; and other conditions found more rarely amongst the population such as Prader-Willi's syndrome and Angelman's syndrome (caused by the deletion of chromosome 15 by paternal or maternal paths). There are, in addition, many congenital alterations of the metabolism usually inherited through autosomic recessive transmission (such as phenylpyruvic oligophrenia, Taysach's disease or Niemann-Pick's disease) but also linked to chromosome X (such as the sphingolipidosis of Fabry's disease, the mucoplysaccaridosis of Hunter's disease, and adrenoleucodystrophy). Obviously enough, diseases which cause metabolic alterations do not cause specific encephalopathies—that is, conditions where mental retardation is a permanent consequence—but progressive forms of encephalopathy where the intellectual defect becomes worse over time.

There are also hereditary forms transmitted by dominant autosomic paths which express themselves in a variety of ways (such as Bourneville's disease and neurofibromatosis). We also encounter alterations in the development of the embryo or foetus caused by maternal

infections (such as toxoplasmosis, the rubella syndrome or herpes simplex), by ectogenic toxicants such as alcohol, drugs or environmental pollution, by pre- or post-natal hypoxia, by malnutrition, or by traumas experienced during the course of the pregnancy. The dangers for the intellectual development of the child are, however, also present after birth. Indeed, traumas, infections, malnutrition, poisoning, and the toxic effects of drugs can all have devastating effects during childhood even though on the whole these damage the brain less severely than those factors which interfere with the development and growth of the embryo.

In addition to these biological causes it should be pointed out that psychosocial factors can also bring about mental retardation. The lack of suitable forms of stimulus during the first stages of the relationship with the mother (especially if the mother is absent, incapable or negative); the lack of social forms of stimulus; the poverty of linguistic forms of stimulus; sensorial deprivation (something which also takes place when there is natural blindness or deafness)—all these are elements which can help to bring about a state of mental retardation. To conclude this section on the origins of intellectual disability, it should be pointed out that mental retardation can also be caused by forms of serious mental disturbance which can interfere with the development of the cognitive functions.

Despite the important advances in our knowledge about mental retardation which have been brought about by scientific research, it should be observed that even in the most expert and up-to-date centers of study a goodly proportion of individuals (at least 30% of the total) do not lend themselves to a clear etiological diagnosis.

Even though the causes of mental retardation, its pathogenesis and the set of symptoms by which it expresses itself, can vary from case to case, there is an element common to all forms of mental retardation which permits a clear diagnosis of this condition. An assessment of overall intellectual functioning and performance carried out by IQ tests always shows the presence of deficits in those individuals suffering from mental retardation. The intelligence quotient is calculated by means of the use of a scale of assessment which explores the subject's intelligence in very general terms. The most commonly used kinds of test are the WISC, the Standford-Binet test and the Kaufman test. There is always a certain margin of error in the employment of these IQ tests. In the same way, they cannot be applied to individuals who suffer from chronic forms of mental retardation.

The other criterion of assessment which is used in the diagnosis of mental retardation is that of functional adaptation. Indeed, it is the problems of adaptation to the environment which first raise the possibility of the presence of mental retardation. The parents become aware that their child is not able to live at the levels of independence which are normal for his age. On the whole doctors and educators come to the same conclusion, and the same may be said of the results of suitable assessment tests. In cases where other independent observers and assessment tests on a broad scale detect the same problems of functional adaptation, it is very probable that one is in the presence of a case of mental retardation.

However, it should always be realized and kept in mind that other factors can artificially aggravate or reduce the detection of adaptation problems. For example, the presence of physical handicaps or connected forms of mental disturbance, or the impact of a culturally under-developed environment, can impinge on the perception of the presence of difficulties of functional adaptation in a child. On the other hand when a child is institutionalized even such forms of behavior as passiveness and dependence can come to be seen in a favorable light, elements which in other contexts would be seen as expressions of problems of adaptation. The concept of the reversibility of a diagnosis is implicit in any analysis of functional adaptation. If the adaptation improves, the individual concerned may well no longer come within the diagnostic definition of mental retardation.

As the American Association on Mental Retardation (1992) correctly points out, adaptation must be understood and assessed within the context of the environment of the child concerned and with reference to the linguistic and cultural frame of reference of his contemporaries—one is referring here to such elements as the home background, the school and the district where the child lives.

The measuring of intelligence through the use of IQ tests involves a number of difficulties. The IQ result is not able to give an adequate description of the abilities of the individual who has been tested when the results obtained through different tests vary a great deal and when there is a marked divergence between the results obtained in the oral section and those which emerge from the tests on performance.

In addition, there are conceptual criticisms relating to the numerical assessments of IQ tests. They must take account of the linguistic aspects of the case, possible neurosensorial deficits, and the general sociocultural background of the person who is tested.

But with all these problems which are latent in this kind of approach—problems which cannot be fully explored here—the definition of intelligence quotient enables us to define individuals in relation to their effective levels of mental retardation. The concept of intelligence quotient means that we can categorize individuals in terms of light, moderate, serious or very serious levels of mental retardation. These four categories differ greatly from each other with regard to numerical importance and correspond in practical terms to very different levels of performance even though, obviously enough, distinctions tend to become rather blurred when the intelligence quotient is on the borderline between one category of retardation and another.

The vast majority of forms of mental retardation (about 85%) fortunately enough belong to the category of light deficit—we are dealing here with an intelligence quotient of between 50-55 and 70. Precisely because their problems are not very great, children belonging to this category are often not perceived as being retarded until they reach the school-going age because even with this deficit they are able to acquire sufficient levels of communication and socialization. Fittingly enough, these children are often seen as being teachable given that they able to reach the standard of a child of the fifth year of elementary school even though they do so rather late in their educational careers. On the whole,

and especially if the environment can give them some form of supervision and support during difficult moments, they manage to perform socially useful work, achieve a measure of economic income, and live independently.

The category of children who have a moderate level of retardation—that is, those who have an intelligence quotient of between 35-40 and 50-55—make up about 10% of all cases of mental retardation. Although it is very rare for such children to go beyond the second year of middle school, they can look after themselves with a minimal amount of supervision, move independently within their family environments such as a village or small urban district, and carry out general forms of work albeit in protected environments where an especial respect for social conventions is not required.

Those children with a serious level of retardation constitute about 3-4% of all cases. It is only after a marked period of time that they acquire the capacity for oral communication and independence in managing their own basic bodily needs. Although such children are not able to reach the standards of normal schooling they can acquire the most basic elements of mathematics, reading and writing (one is referring here to certain key words). Despite their limitations, such children are able to carry out simple and repetitive tasks in environments which are intensely supervised and controlled. In the same way they can be integrated into community life within a family or protected groups, as long, that is, as these children with serious levels of retardation do not suffer from other forms of serious disability or handicap.

Most of the children suffering from very serious levels of intellectual disability (about 1-2% of all cases) are afflicted by serious neurological deficits which in conjunction with intelligence deficits compromise their neurosensorial performance or motorial capacity. Such children need an environment which is specially constructed for their needs and they require individualized forms of treatment and care which alone are capable of enabling them to achieve progress in terms of motorial capacity or communication skills.

Lack of Interest on the Part of Psychiatry

For a long period the discipline of psychiatry displayed a marked lack of interest in the phenomenon of intellectual disability. The problem was that intelligence was considered a prerequisite of humanity. In more specific terms, the discipline of psychiatry employed a concept of mind which attributed a leading role to intelligence in the decisional process, in behavior, in the development of the ego, and based a great deal of its action on individual psychotherapy—a process for which a capacity for introspection and verbal expression are more than necessary.

In addition, and perhaps for the same reasons, until a few years ago there was no recognition of the presence of psychiatric illness in those afflicted by intellectual disability. It was only with great difficulty that the symptoms of classic psychiatric illnesses such as depression or obsessive-compulsive disturbance were recognized as being present within mentally retarded people, and as a result it was very unlikely that people suffering from intellectual disability had the right to receive specific treatment for these kinds of mental illness in the same way as every other psychiatric patient. Only recently have researchers begun to direct their attention to carrying out inquiries into how psychopathological problems can be diagnosed and treated in the case of people suffering from intellectual disability, and into establishing what biological, psychological and social factors might lie behind the psychopathology of mentally retarded people. In other words, only in recent times have psychiatrists begun to study the question of psychiatric illness experienced by those who are already afflicted by the handicap of intellectual disability.

Psychiatric Illness in Mentally Retarded People

The incidence of psychiatric disturbance associated with intellectual disability varies greatly, ranging between 10% and 65%. Obviously enough, this high level of variability is a result of problems of definition, different criteria of definition and detection, and different ways of expressing the problem arising from the different criteria employed in admitting people to institutions and programs of rehabilitation. This phenomenon is also the outcome of the employment of diagnostic methods and instruments which vary greatly in their levels of sensitivity and monitoring.

Although it is clear that intellectually disabled people are more vulnerable to psychiatric disturbance in comparison with those who do not suffer from mental retardation, it is nonetheless evident that such forms of disturbance continue to be difficult to diagnose. The criteria employed in the diagnosis of psychiatric illness in mentally retarded individuals are difficult to establish and those suggested by the usual textbooks on classification are difficult to apply. One problem which remains very evident is that relating to the kinds of service which should be offered to mentally handicapped people who also suffer from connected psychiatric illness.

At this point special reference must be made to *problem behavior*, something which is frequent and persistent in those who suffer from mental retardation and is a factor which greatly disturbs the environment of the individual concerned. Antagonism, lack of co-operation, aggression, self-wounding, hyperactivity—all these are forms of behavior which may be seen as a challenge to a family, to a school, or to a health care institution. In addition to the damage which is done to the possible provision of personal affection and other factors, and to the subsequent risk of further disability, forms of problem behavior greatly increase the burdens of care which the family must bear. This raises the risk that the family nucleus will become severely disrupted, reduces the prospects for school integration, promotes the likelihood of the need to institutionalize the child, and as a general result increases the general economic costs that society will have to bear.

A large number of theories have been advanced to explain the high incidence of forms of problem behavior in those who suffer from mental retardation (Matson and Sevin, 1994). Most of these theories are based on ideas about learning. Indeed, in many cases of intellectual disability deviant behavior has a

functional origin. This means that the reaction of the mentally retarded person's environment reinforces the symptom and helps to promote the continued presence of pathological forms of behavior. For example, the mentally retarded person may learn that certain forms of behavior lead to certain kinds of attention being paid to that individual or that certain situations which the environment requires but which the mentally retarded person dislikes can be avoided. On other occasions it is the sensorial or neurochemical consequences of the deviant behavior which can lead to an automatic reinforcement of pathological kinds of conduct. The fact that these are more frequent in individuals with demonstrable neuropathological alterations, in conjunction with the results of pharmacological research (a subject which will be discussed later in this paper), gives great weight to the theory that these forms of behavioral disturbance have a biological basis and origin. Some authorities believe that it is very probable that in the future many of these forms of problem behavior will be shown to be of a physical nature (Reid, 1994). It is also very likely that the behavioral and biological elements overlap and interact and that they will require dual forms of treatment.

**An Integral View
of Mental Retardation**

Hitherto I have sought to outline and analyze the clinical difficulties and problems of the person suffering from the condition of mental retardation. It is more than clear that care for mentally retarded people involves a heavy burden for their families, for schools, for health care institutions, and for society as a whole. This burden is not only economic in nature but also involves time, dedication, humiliation, psychological disquiet, and difficulties in the formation and maintenance of personal relationships.

The commitment and the energy which families, institutions and society are able to give to people suffering from intellectual disability depends upon the conception of man that lies behind their actions and in particular on the value that is bestowed upon the person who is af-

flicted by the condition of mental retardation.

In Western societies, whether they are industrial or post-industrial, great emphasis is placed upon the production of goods. In this way the value and worth of a man is often identified with his social function. He is valued not for what he is but for what he does. In this framework of reference the value and dignity of man no longer constitute an absolute but are heavily influenced and molded, in particular by economic factors and considerations. The person suffering from mental retardation thus ends up by being perceived as a useless burden, involving very high costs, and the great aim then becomes to ensure that further cases of such a condition do not come to oppress the social body.

There are also other forms of cultural influence and direction which have a negative effect on how people afflicted by mental retardation are perceived and treated. The models subscribed to by the young people of this society of material prosperity are those of success and immediate satisfaction. Any kind of sacrifice whatsoever is understood and accepted with marked difficulty. For this reason it is with even greater difficulty that an intellectual disability can be accepted, a disability which from the very outset presents a family with the prospect of a long-lasting period of sacrifice which will have to be dealt with in a spirit of total giving and without any possible advantage being gained. Most of the time this sacrifice is asked of families which are often in a state of difficulty and for whom the birth of a mentally retarded child can constitute a potent factor of disintegration. Furthermore, these kinds of families are not helped by the character of the economic organization of society in giving space to a new child even when that child is healthy.

In addition, more than is the case with any other kind of disability, a child afflicted by intellectual disability wounds the expectations of the family it is born into and damages the self-image of the parents themselves. This disability compels the family and society as a whole to pose questions about the weakness of our existence, about what could happen to all of our children, and about what only by pure chance has not befallen

us. A society which wants to remove suffering and death from its field of vision, although rationally aware of the fact that such elements in the end touch us all, is led towards hiding the problem of mental retardation within health care institutions or through a policy of eliminating the problem at its roots through a denial of the right to existence.

This mentality has corrupted the very meaning of words, not least in the field of medicine and scientific research. By this route the prevention of mental retardation has ended up by meaning in current language a mere ability to identify the problem during the stage of prenatal life and then to resolve it through a policy of abortion.

In order to justify the results of eugenic selection, authoritative reviews on epidemiology have been used to link the incidence of abortion with levels of infant mortality and levels of maternal deaths caused by childbirth. The author of such an article (Puffer, 1993) draws attention to the decrease in infant and maternal mortality and an accompanying rise in the incidence of abortion in the United States of America after the Supreme Court decision of 1974 which legalized abortion. This article is a clear example of an ideological use of scientific information. In reality, the same graph shows how the decrease in infantile and maternal mortality began well before the legalization of abortion and continued after the number of legal abortions reached its peak in 1980. In addition, there is no attempt to take into consideration the fact that the decrease in levels of mortality could have been caused by an increase in the quality of obstetric and neonatal care.

**The Ethical Problems
of Mass Screening**

For certain causes of the condition of intellectual disability we now have systems of screening which enable us to identify the healthy carriers of genetic alterations. These systems have margins of imprecision according to the disease which is being investigated. In cases of recessive autosomic transmission, the diagnosis of healthy carriers can be used to positive effect for pre-mar-

riage and pre-conception counselling. But in cases where the transmission of the illness is linked to chromosome X, the screening of the genetic make-up of mothers who are healthy carriers is used in deciding whether to carry out an amniocentesis. When this leads to the presence of illness being diagnosed in the foetus the mother becomes placed in a sort of perverse spiral which leads almost inevitably to abortion, in part because at the present time there are no means by which this condition can be treated in the womb.

The weak X syndrome occurs at a rate of about 1/1200 in men and 1/2500 in women and is the most common cause of intellectual disability rooted in genetically inherited factors. Recently a rapid antibody test for the purposes of diagnosis has been brought into being (Willemsen *et al.,* 1995). Its application is envisaged in terms of mass screening and this fact has raised a large number of objections. The almost inevitable result of a positive diagnosis achieved by this test would be a policy of abortion, and this even when there are difficulties in predicting the seriousness of the illness in female foetuses subject to chromosome alteration. Phenotypical conditions of less clinical relevance are also possible in such cases. It has also been suggested that if such screening was carried out on a large scale it would be impossible to ensure that all women interested in obtaining genetic counselling support would receive such support. As a result states of anxiety and worry would arise to which nobody would be able to supply an effective remedy.

Forms of screening for Down's syndrome also now exist which enable a possible diagnosis of such a condition to be made when the pregnancy is already underway. This too leads to a policy of amniocentesis and abortion. One of these methods involves three biological tests (alphafoetoprotein, chorionic gonadotropin, and unjoined estriol) and this method seems to be especially reliable. The large-scale use of this form of screening also seems to involve paradoxical consequences. Fletcher and others have calculated that the offer of serological screening to all women in a city of half a million inhabitants would only lead to the birth of one less Down child than

would be the case in a screening of all women over the age of thirty. The achievement of this meager result would mean that in addition to the death by abortion of children diagnosed as suffering from the Down syndrome, there would be the cost of 4,500 useless tests, the anxiety involved in 200 false positive results, the distress caused by an equal number of amniocenteses, the loss of 1-2 normal children through amniocentesis, and the cost of these amniocenteses and of the personnel involved in counselling (a figure estimated at 90,000 pounds sterling).

It is more than clear there should be a correspondence between the resources that are allocated and the value that is attributed to a human being. Perhaps with sufficient economic support it would be possible to ensure that the Down child is accepted and that 1-2 normal children are not rejected in error, and this is a situation where the economic costs would be no higher than if such screening were carried out.

A More Human Perspective

The "Declaration on the Rights of the Mentally Handicapped" proclaimed by the United Nations on Dec. 20, 1971 lays down that "the mentally handicapped person must have the same rights as other human beings *to the greatest degree possible.*" Amongst these rights are certainly to be found the right to life, the right to be recognized as a person and treated as an individual rather than as a member of a category, the right to have a family, the right to the best possible forms of care and assistance (whether medical, involving rehabilitation, or through an institution), the right to schooling, the right to work, and the right to participate in the life of the community (at a religious, recreational and political level, to name the most obvious).

These rights imply corresponding duties unless, that is, we want them to remain mere rhetorical declarations. For example, when we recognize that the mentally retarded person has the right to have a family this means that there must be support for those families which have a mentally retarded member. Through the usual mechanisms of social solidarity there must be a lightening of the heavy

burden which the presence of the needs of mentally retarded person implies, and the tendencies towards disintegration which such a presence involves must be converted into an impulse towards unity. In this way less use will be made of the policy of institutionalization. Obviously enough, the enjoyment of the above mentioned rights must take place, as is made clear by the declaration of the United Nations, "to the greatest degree possible." Only by being able to offer the mentally retarded person services which are in line with his capacities will it be possible to avoid school or work becoming elements which act to underline his diversity even further rather than promoting his well-being. However, the diversity implicit in mental retardation should be respected and recognized as a right, the right to fragility and infirmity, in order to avoid falling into the trap of eugenic temptations reminiscent of previous sad racist experiences.

All modern research into mental retardation is an invitation to embrace this more human perspective. Indeed, in the light of present-day scientific knowledge a mentally retarded person is not only an individual with a development deficit but is also a human being with certain abilities and capacities which enable him to live, to love, and to learn. He is first and foremost a person whose potential for development should be recognized. This means that families, health care workers, and society as a whole have a clear task before them—they should not resign themselves to what they see as unavoidable. They should refuse not only to say but also to think that nothing can be done. They should for once and all stop seeing mental retardation as a condition of subhuman life, a source of terror, a defenseless object to be pitied, or an innocent witness to the presence of the sacred. On the contrary. Efforts should be made in favor of every kind of action and initiative which can promote and favor the potential of development and growth outlined above—and all this notwithstanding the evident difficulties which lie in the way of performing this important task.

Today we must and we can act—at the level of prevention, diagnosis, treatment, education, health care institutions, the family, the social envi-

ronment, the relationships between the individual and that environment, the physical environment, and the economy.

Action at the Level of Prevention

We need to emphasize with great force that true prevention takes place with reference to genetic illnesses through the diffusion of counselling in relation to genetic inheritance both before marriage and before conception. For all forms of illness, on the other hand, such prevention needs to take place through an expansion in prenatal medicine (help during pregnancy and perhaps in the future the surgical correction of malformations), perinatal medicine (improvement in forms of assistance during actual childbirth), and postnatal medicine (correction of metabolic deficits, vaccinations, early forms of rehabilitation, and the prevention of the postnatal causes of mental retardation and their consequences).

Certain examples serve to give us an idea of the great potential to be found in a policy of prevention in relation to mental retardation. They also enable us to dwell on what the future will bring for us in this area.

I think it would be a good idea to begin with the by now historic example of phenylketonuria. This involves a congenital error in the metabolism which is transmitted by recessive autosomic channels caused by a deficit in the hydroxylase phenylanin enzyme. This illness affects about one birth in every thousand. If this condition is not treated it inevitably leads to moderate or serious mental retardation. Knowledge about the enzyme deficit has led to the introduction of methods of screening which are now carried out at birth on a broad scale. Children who are seen to suffer from this condition have to undergo a diet involving phenylanin which is an aminoacid which constitutes a normal part of our food intake. This treatment has led to a dramatic reduction in the number of cases of mental retardation caused by phenylketonuria.

A more recent example of screening for a congenital alteration of the metabolism involves Tay-Sach's disease which can now be identified in healthy carriers. A mass application of this method of screening was used on young members of the Ashkenazi members of Israeli society. This is an ultra-orthodox group which only allows marriages between its own members and for this reason it is especially affected by genetic illnesses. The identification of couples who wish to marry who are both heterozygous at the level of their genetic make-up—and may thus have children affected by Tay-Sach's disease—wisely leads to the breaking of the engagement. This is something which occurs without great difficulty because on the whole the marriages within this ethnic group are arranged by the parents of the future marriage partners. The program of screening has led to the identification of tens of couples at risk and in this way the birth of many children suffering from a form of mental retardation which gets progressively worse has been avoided (Brodie *et al.,* 1993).

An example of metabolic correction which will perhaps be possible in the near future involves treatment of the Smith-Lemli-Opitz syndrome, a genetic condition which was identified some thirty years ago. This is an illness which is characterized by mental retardation, growth deficit, microcephaly, cranial-facial dimorphisms, and other malformations. This syndrome is present in about one in every twenty thousand births in the United States of America and is considered the second most common disturbance caused by recessive autosomatic transmission, second only to cystic fibrosis. The incidence of this illness is understated, at least in Italy, because hitherto diagnosis has been based upon clinical data. The recent discovery of low levels of cholesterol accompanied by high levels of a precursor of cholesterol has enabled us to classify this illness as arising from one of the congenital errors of the metabolism (Tint *et al.,* 1994). It is more than obvious that in the future this discovery will lead to an early identification of new-born children affected by this illness and to their treatment with supplementary cholesterol.

But prevention is not solely a question of the congenital errors of the metabolism. Infectious diseases can also cause mental retardation and this is something which can be prevented as well. An example which by now is of historical renown in this field is that of Dawson's subacute in-clusion-body encephalitis. This is a relatively rare illness which survives for many years after a measles attack. It brings about changes in personality, an intellectual deficit, paralysis and finally death. An association with the measles virus began to be noticed in the middle 1960s. Over the following ten years a vaccine against measles began to be introduced. At the beginning of this program of vaccination there was the fear that the weakened virus which was employed in the vaccine could itself be the cause of this illness. But some twenty years hence it now appears clear that this policy of vaccination has led to a progressive diminution of new cases of Dawson's disease which indeed now appears to be an illness whose days are numbered.

More recently we have learnt about the prevention of damage caused by Gonda toxoplasma. The maternal infection caused by toxoplasma can cause a visual deficit in the child and more rarely certain forms of intellectual disability. Today we can use methods of screening in the fight against this condition and it has been demonstrated that the identification of newly-born children who are infected but do not show clinical symptoms can be achieved through the use of the same blood sample employed for the screening of forms of metabolic disturbance (Guerina *et al.,* 1994). Although the diagnosis achieved by this method has to be corroborated by other tests, and despite the fact that false negatives are possible, early identification can allow the application of treatment during the first year of life. In this way the deficit and the disability can both be significantly reduced.

The prevention of mental retardation is also possible through the use of suitable dietary treatment. Research of the last few years presents a number of powerful arguments in favor of the idea that folic acid can play an important part in the prevention of binding defects within the neural tube. We are dealing here with such important illnesses as spina bifida, meningocele and anencephalia (this last condition leads inevitably to the death of the new-born child within the space of a few days). It seems that the introduction of 0.4g of folic acid every day can lead to a reduc-

tion of at least 60% in the binding deficit of the neural tube (Werler *et al.,* 1993; Czeizel, 1993). As a result, women in child-bearing age should increase their consumption of folates both through the consumption of additional vitamins and by means of a special diet, and in particular when they decide to become pregnant.

To conclude this section, it should be observed that there is also a secondary form of prevention. For example, it is well known that children suffering from the condition of mental retardation have very many more accidents than normal children of the same age. Although this difference tends to diminish as these children grow older, it is nonetheless true that we need to place greater emphasis upon the prevention of secondary cerebral damage caused by trauma in children who suffer from the handicap of intellectual disability.

Intervention at the Level of Diagnosis

When faced with a patient suffering from mental retardation the medical doctor and health care institutions should improve the diagnosis through an identification of the causes and the pathogenesis of mental retardation. A mentality directed towards such an improvement will encourage an indirect advance in research, guarantee the prevention of further forms of deficit (as in the case for example of metabolic or deficiency illnesses), and help in the identification of those areas of behavior which are most affected and influenced by the condition of mental retardation. In this way greater precision will be achieved in deciding upon individualized policies of intervention and greater success will be obtained with regard to treatment and rehabilitation. The ability to produce precise forms of diagnosis has undergone major leaps forward in recent years. We need only think here of advances which have been made in molecular biology or in the techniques of neuroimaging. Health care institutions should match this need to improve the character of diagnoses by guaranteeing access to services and especially to hospital services, and without committing those acts of discrimination which at the present time make the mentally retarded person an unwelcome guest.

Intervention at the Level of Treatment

It is not possible in this paper to dwell in detail upon all the methods and forms of treatment and rehabilitation which are now available to us in relation to the condition of mental retardation. I will not therefore discuss the field of physiotherapy, language rehabilitation, psychomotricity, the various forms of psychotherapy, and so forth. I will instead limit myself to outlining the advances which have been achieved in the field of psychopharmacology and will refer to the prospects that are now being opened up in the whole field of gene therapy.

Pharmacological Treatment

Although the prestige of pharmacological treatment has undergone a decline over recent years as is the case with all forms of medical action—something which corresponds to the crisis of the institutional model—the myth of drugs as a miraculous solution to the problems of mental disability continues to hold sway in the collective imagination. This is underpinned by the greater prestige enjoyed by the medical profession than that bestowed upon psychologists and educators. The indiscriminate use of drugs is very widely practiced because it is seen as the most convenient solution available to solve behavioral problems in patients where staff are not trained in methods of behavioral treatment or where the system is unwilling to invest time and human and economic resources in changing the attitudes and conduct of the staff and their patients. In reality many behavioral problems are messages which can be understood in rational terms.

The pharmacological treatment of mentally retarded people remains an extremely difficult course of action. This is the result in particular of a lack of precise diagnostic criteria in the assessment of the psychopathological expressions and symptoms of mental retardation. In addition there is a conspicuous absence of controlled clinical studies of this whole field, not least in relation to the most commonly used drugs such as the neurolytes. Although there are obvious limitations in their application, it is nevertheless true that recent research seems to offer a number of new forms of treatment which appear to be promising.

We are gaining ever greater information and knowledge on the use of atypical antipsychotic drugs such as clozapine and risperidon. This is a category of drugs which, unlike traditional neuroleptics, have the advantage of fewer extrapyramidal symptoms and a lower likelihood of inducing tardive dyskinesia.

Despite certain contrary results, the antagonists of the meconics—and in particular naltrexon—seem to play an important part on controlling self-wounding forms of behavior. Furthermore, drugs such as buspiron and the inhibitors of serotonin re-uptake have displayed a promising effectiveness in the treatment of the problem forms of behavior connected to mental retardation. This suggests that the behavioral disorders associated with the condition of intellectual disability may be caused by alterations in the serotoninergic metabolism as is the case with obsessive/compulsive forms of disturbance and panic attacks even though the sets of symptoms which are displayed may well be different.

The use of certain anti-epileptic drugs to control mood swings or as instruments in the control of behavioral disorder is a practice which is by now well consolidated. The effects of psychostimulants such as methylphenidate in the control of attention deficits or hyperactivity also seem to offer hopes for the future.

Mentally disabled patients have a biological and psychological vulnerability and this means that the negative side-effects of neuroleptic drugs are of especial importance and significance. In addition to the negative effects on the patient's cognitive functions, and in order to act in harmony with the principles of risks and benefits, attention should always be paid to the high frequency of side-effects of a Parkinsonian nature, dyskinesian or dystonic elements, and tardive dyskinesia. The malign neuroleptic syndrome, which can lead to death, fortunately enough is rare but in these patients it is more frequent and more serious than in other categories (Boyd, 1993). In recent years the toxic effects of drugs which alter the serotonin have been noticed and this also is something which is probably more common and serious in patients who suffer from mental re-

tardation (Sternbach, 1991).

Given all these elements and the limited effectiveness of psychopharmacological treatment we should perhaps dwell upon the ethical correctness of an indiscriminate use of psychotropic drugs. More than 50% of mentally retarded people are treated with psychopharmaceuticals, often receiving more than one drug and in large doses (Deb and Fraser, 1994). In this field we must seek to avoid possible abuses and we should respect the personality of the mentally retarded person. In particular we should make sure that the neuroleptics which are employed do not become a sort of chemical strait-jacket.

The future improvement in this condition will lie in a more frequent use of action at the level of behavior, in the identification of guidelines in relation to tried and tested forms of treatment, in a constant monitoring of the effectiveness and the negative effects of psychopharmacological forms of treatment, and in the ability to distinguish groups of responders from groups of non-responders.

Pharmacological Testing

The improvements in standards of medical practice cannot be separated from scientific research and thus from the ability to test new drugs and medicines. However, each testing raises ethical questions and problems, as indeed in borne out by a spreading tendency within centers of research and study to examine the ethical bases of every new initiative. The questions raised are even more pressing and the necessary examinations must be even more detailed where one is dealing with individuals who suffer from a condition of mental retardation. Without entering too deeply into this whole subject, here reference can be made to the question of what constitutes real consensus and to the need to assess the benefits which the individual participating in the experiment might be able to gain.

Gene Therapy

In this area today one often hears talk of the hope that a deficit can be corrected through the introduction of normal genetic sequences into the genetic code of a patient. It is probable that in the future such forms of therapy will be highly beneficial more in relation to alterations which

affect a sole gene and which cause serious forms of mental retardation than in relation to light conditions of intellectual disability where the environment often plays an important role. However, like the much lamented Professor Lejeune, I also believe that the prospects for gene therapy in relation to mental retardation rooted in genetic factors is an answer which is far too simple, indeed of a schoolboy level, which will probably be preceded and rendered useless by other more effective methods. In order to give an example of his position, Professor Lejeune argued that in his opinion before juvenile diabetes could be corrected by gene therapy a method would be discovered by which transplants of pancreas membrane cells from animals would allow the passage of insulin from the transplant without there being any attack on the transplanted cells by the host body's anti-body system.

Intervention at the Level of Education

At the beginning of this paper it was observed that the definition of mental retardation includes the presence of a deficit in relation to general intellectual functioning (measured by intelligence quotient) and the demonstration of limits to the individual's ability to adapt to the needs and requirements of his environment. Although it is true that the concept of intelligence quotient is rightly seen as something which is rigid and rather unyielding, it is also evident that it is possible to act upon the difficulties that an individual experiences in his adaptation to the environment. An improvement in this maladjustment can even lead to an individual no longer being classified as being mentally retarded.

Specialized forms of education, programs involving the development of how to use various kinds of instruments and tools, and a behavioral approach are only a few examples of the large number of opportunities we have to act at the level of education in order to help those who suffer from the condition of mental retardation. If I wanted to capture the salient features of contemporary developments in this sphere, I think I would say that emphasis is now being directed more towards the deficit of the

person, that is, towards his maladjusted behavior, and towards the environmental and social supports that he needs in order to be able to live with success in a given environment.

This tendency is to be found in the 1992 version of the definition offered by the American Association on Mental Deficiency. In approaching the question of capacity for adaptation this definition employs the concept of social intelligence rather than maladjusted behavior, a notion which previously held sway.

The ability to recognize that the mentally retarded person is an individual in the full sense of the term necessarily means that attention should also be paid to his opinions. This is especially so when action is taken in relation to his body. We also have to accept the suffering and the frustration that we feel when we are unable to understand him or when we are unable to communicate with him.

Schooling

Traditional schooling requires a section all of its own. In discussing this subject I will only refer to the Italian experience which is nevertheless seen in other countries as being very advanced. Until the 1970s the schooling of the mentally retarded child in Italy took place within the health care institutions themselves or in the case of children who had not been institutionalized within special schools or in special classes. However, a movement grew up which was based upon clauses 34 and 38 of the Italian constitution which campaigned in favor of the social integration of handicapped people. This met with a response on the part of parliament which passed laws 30.3.1971 n. 118 and 4.8.1977 n. 517. Subsequent ministerial circulars (n. 199 of 28.7.1979, n. 258 of 22.9.1983, n. 250 of 3.9.1985 and n. 262 of 22.9.1988) developed and improved upon this legislation and led to the closure of special schools for handicapped children, the abolition of special classes, and the creation of forms of support and school integration which employed a clinical diagnosis to promote an approach based upon the profiles and functional diagnosis of each individual child.

At the present time, and despite notable resistance, handicapped children are present in nearly every Italian school of whatever level or char-

acter. Many children suffering from mental retardation are in the classroom, at least until the school-leaving age.

The scholastic integration of mentally retarded children is undoubtedly a highly civilized goal even though from an ethical point of view we should ask ourselves whether attempts to place such children is normal classes is necessarily always a sound policy.

Although a normal class can well act as a factor of stimulus for the child suffering from a light or moderate form of mental retardation, it can nonetheless prove rather disturbing for children suffering from serious or very serious kinds of intellectual disability. Indeed, they may be prevented from acquiring that minimum of instruction which they would otherwise gain in a protected environment. Furthermore such integration often takes place in an uncontrolled and unregulated way and without the suitable training and instruction of pupils and teachers. In this way further rejection and stigmatizing can take place.

It should also be observed, in conclusion, that a policy of integration at all costs in normal classes often acts to deprive children suffering from serious mental retardation from receiving a precise diagnosis and the benefits of specifically aimed forms of rehabilitation. In normal schools such diagnosis and rehabilitation are generally impossible because the low number of mentally retarded children means that there can be no justification for the costs involved in providing a service of diagnosis and rehabilitation which is really effective. Furthermore, and without taking the whole question of costs into account, it should be pointed out that in the non-specialized context of the normal school people who are specifically trained for such initiatives and who really want to carry them out are usually far and few between.

Intervention at the Level of Health Care Institutions

It has already been observed in this paper that there is a right to live within one's own family and a right to receive the highest possible standard of care and assistance. With these rights in mind it is advisable,

when considering cases of mental retardation, to reflect at length upon whether it is a good idea to institutionalize such people. The decision will depend upon the seriousness of the case, the levels of behavioral disorder of the intellectually disabled person, the condition of his family, and the nature of the institution.

The best solution, obviously enough, would be to provide all the necessary forms of assistance and care within the family itself. However, we must recognize in a spirit of true realism that in certain cases (because of cultural deficiencies, economic constraints, or the age or health of those who would have to provide such help), the family is not able to deal with the very real problem of a member who is afflicted with mental retardation. Society for its part has the moral duty to pursue a policy of solidarity towards families which have such members, and this duty should involve the provision of economic support and services which can lighten the burden borne by the family. Society should also guarantee those suffering from mental retardation who live outside institutions, sufficient standards of medical care and forms of rehabilitation within clinics or where necessary within the home.

Even in those cases of mental retardation where a policy of institutionalization is obligatory, society has the duty to ensure that within long-term institutions health care and forms of educational rehabilitation are guaranteed to mentally retarded people and that the internal conditions which are offered to them respect the dignity of man. Only constant vigilance can prevent the frequent degeneration of such institutions into places of segregation and violence. The use of institutions can be gradual and flexible in line with the original situation of the patient and the local cultural and economic resources which are available.

The move from the old closed institutions which could hold thousands of individuals to open and stimulating institutions allows the overcoming of segregation and the creation of ways of life which are less artificial. The establishment of small centers in an urban context where community models of life are in operation, in conjunction with the support of voluntary organizations,

can facilitate social integration and the acceptance on the part of the community of people afflicted by intellectual disability. Steps towards greater levels of independence can also be encouraged. Staying within the family for as long as is possible or residence within self-managing homes (with various levels of external professional support) are certainly more suited to ensuring the dignity and the normalization of these people than traditional forms of institutionalization, at least as regards those who suffer from light or moderate forms of mental retardation.

Like all revolutions, the antisegregationist movement has also had its innocent victims, and gradual, thought-through and assimilated changes would have been more appropriate and positive in their effects, not least in order to avoid the risks of reaction and hostility. However, we should in all honesty recognize that often it was only the extremist campaign in favor of the closing of these old institutions which led to legislative or judicial initiatives which moved in that direction and redirected financial resources towards the creation of places with lifestyles similar—in so much as this was possible—to those of other members of the community.

The debate on the merits or demerits of institutionalization is now over. At the present time discussion centers around how to guarantee or improve the social integration of intellectually disabled people during a period of financial stringency. One solution to this problem could lie in moving emphasis from the provision of services to the strengthening of the supports provided by the natural environment.

Intervention at the Level of the Family

The family is the most important and fragile link in the chain of help provided to the mentally retarded. The birth of a child who is mentally retarded gives rise to different kinds of reaction which range from rebellion to aggression, from isolation to apathy, and from feeling different to feeling marginalized. This disquiet and disturbance affects all members of the family including the disabled child. He himself feels that he is the cause of these difficulties, that he is

to blame, and as a result he does not live in a state of tranquility or calm.

The humanization of caring for the mentally retarded becomes more possible when the solidity of the family itself is greater and when the assistance that the state offers that family in the way of legal and economic help and in the form of services is more pronounced. One cannot in schizophrenic fashion ask families to take care of their mentally retarded members in the home and then at the same time undermine the solidity of the family itself.

Action must involve families above all else when long-term programs of stimulation are being applied or when very early intervention is required. The involvement of the parents also ensures that action takes place within the normal life environment of the child and gives the health care worker the opportunity to observe the child indirectly for a long time and from close at hand, and this is something which can be of vital importance in any assessment of the case. However, efforts should be made to ensure that the parents are not overburdened with responsibilities and work, both to avoid a condition of burn-out and to reduce the risk of the married couple entering into a state of crisis.

Intervention at the Level of Social Environment

The environment is the factor which makes all the difference to many people who suffer from light intellectual disability. An interaction with a welcoming and stimulating environment can place such individuals within the range of normal performance and functioning. For this reason improvements to the environment in which poor children grow up can help to reduce the incidence of light mental retardation within such sections of society and thereby diminish the need to engage in institutionalization (Zigler, 1995).

The importance of social factors is stressed by the commonly noticed presence of higher levels of intellectual disability in the less privileged social classes. Even when racial factors seem to be at work (Murphy *et al.,* 1995), it is possible to demonstrate that the higher incidence of mental retardation amongst the black community of the United States of America is in reality the outcome of economic factors and conditions and connected to the educational level of the mother and the age of the mother at the moment of birth. To put it more simply, black children are more likely to be exposed to a variety of harmful factors both before and after birth. These negative factors are cumulative in their impact and involve a condition of disadvantage in relation to the forms of cognitive stimulus and early educational experiences which black children have to endure (Yeargin-Allsopp *et al.,* 1995).

Intervention at the Level of the Relationship between the Individual and his Environment

In dealing with the whole question of the relationship between the mentally retarded person and his life environment we should strive to reduce the potential conflicts which can break out and to overcome the forms of experience which are marked by isolation and anonymity. The condition of mental retardation would gain much from the creation of an environment which promotes human relationships and the feeling that the mentally retarded person has of belonging to a distinct community. We also need to work towards the acceptance of the movement towards social integration without which there would be no opportunities for acceptance in the local area, no offers of work, and no pressure upon the legislature to pass suitable measures involving legal and economic support.

Intervention at the Level of the Physical Environment

Unfortunately, year after year toxic elements in food and in the environment, and other polluting forces, are becoming ever more important in causing conditions of mental retardation. As an example of environmental pollution I would like to refer here to a recent article which refers to a cluster, that is, to an outbreak of new cases, of children suffering from Down's syndrome in the city of Berlin. This took place nine months after the tragedy of Chernobyl (Sperling *et al.,* 1994). It is very unlikely that the connection is merely one of chance given the very close tie between the two events in terms of time. Although a causal relationship between the two phenomena cannot be demonstrated beyond all doubt it seems clear that such a connection really does exist. The lessons to be drawn from all this in terms of changes which are needed in political and economic terms to bring about alterations in attitudes and behavior which will be more respectful of the environment are more than evident.

An increasing interest in the role of lead and other metals such as cadmium, chromium, cobalt, mercury and nickel in provoking mental retardation is also to be observed at the present time. Such metals are used in many building materials, in petrol, and in such discarded products as worn-out batteries. We are beginning to receive solid information on the presence of these substances in the amniotic liquid extracted during amniocentesis (Lewis *et al.,* 1992). The subject is still very much open to discussion but it seems that there is indeed an inverse relationship between the hemal level of some of these toxic substances and the intellectual level of the child. This is also the case when other possible causal factors have been eliminated.

In discussing the impact of toxic substances present within food and drink I will only refer here to the role of alcohol. Exposure of the embryo and unborn child to alcohol while still in the womb is linked to a syndrome marked by delayed pre-birth and after-birth growth, by craniofacial dysmorphism, and by alterations in the functioning of the central nervous system which can include mental retardation. Although there are wide geographical variations in the incidence of the alcoholic foetal syndrome which are themselves linked to different dietary habits, it is estimated that at a worldwide level the incidence of this syndrome is of 1.9 cases every 1,000 births. The alcoholic foetal syndrome may thus be considered as constituting one of the most important causes of mental retardation. Alcoholism is in a state of constant diffusion and requires a careful policy of prevention in order to avoid mental retardation in the form of the alcoholic foetal syndrome (Spohr *et al.,* 1993).

A work of education in relation to future mothers should also be embarked upon and developed, espe-

cially where a moderate consumption of alcohol is encouraged in social terms. Alcohol can in addition be linked to growth retardation and to a reduction in the circumference of the cranium (Geva *et al.,* 1993).

To conclude this section on the physical environment, it should be observed that the environment can also cause forms of intellectual disability by natural routes. Somewhat later in this paper I will dwell upon the question of the impact of a lack of iodine in drinking water.

Intervention at the Level of the Economy

Any action or initiative in relation to intellectual disability cannot be separated from the economy. Without the necessary economic resources such work would not be possible. Some experts believe that towards the end of this century the impulse in certain European countries towards allocating resources to support projects of integrated assistance for the mentally retarded will come to an end. These experts believe that in Western Europe and in the United States of America we are moving towards the end of a policy of support for the mentally retarded. Individuals suffering from forms of intellectual disability will be crushed by other competitors for these precious resources in a process which will disturb the whole relationship between the suppliers and the users of services (Boston, 1994).

For some years now a debate has been in progress regarding the provision of services to people suffering from mental retardation in terms of costs and benefits. Authoritative British obstetricians reject this kind of approach and call upon the medical classes to resist the appeals to become "suppliers of technological services obsessed by costs" (Elkins and Brown, 1993). After declaring that the idea that a person suffering from the Down syndrome costs society about $196,000 is absurd and out-of-place, Elkins and Brown go on to ask themselves and to ask us in provocative fashion: "What is the cost for a family and a society to bring up a "normal" person and to educate him to the point of his becoming a doctor? What is the cost of a person who spends a number of years in prison? How much do we

spend today in bringing up a "normal" boy who eats American-style fast food and spends his days in front of the television?"

There is a very short step from denying the economic basis of the birth of a mentally retarded child to denying that child the necessary care and treatment in periods of economic hardship. There is also a very short step from this position to that of sterilization—a policy proposed in a very recent resolution of the European parliament.

A recent research carried out in Chicago (Fujiura and others, 1994) sought to quantify the costs to a family of having an adult member afflicted by mental retardation. This investigation showed that the costs of maintenance were no higher than those involved in the maintenance of a member not suffering from mental retardation. The problems arise when the family receives a low contribution (whether from work or state welfare) from its mentally retarded member. For this reason the costs of his maintenance falls largely on the shoulders of the family itself. Important policy decisions follow from this state of affairs because supplying the family with the complete costs of maintenance constitutes a mere fraction of what it would cost to put its mentally retarded member in an institution.

A redistribution of wealth is also called for at a planetary level. We need only think here of how endemic cretinism can be caused by a lack of iodine. This lack is in absolute terms the most frequent cause of serious mental retardation in the world. Its pathogenesis is still very imperfectly known but its prevention through the supply of iodine is simple and very cheap. And yet the developed world forgets about this problem, a problem which is of immense importance in many developing countries. A remedial policy would cost very little but would give the peoples of developing countries many less burdens and a much more marked degree of intellectual capital.

The Necessary Aspects of Action

Hitherto attention has been paid to the different areas where action in favor of helping the mentally retarded is called for and can take place. In a

break with the past, such initiatives are based upon objective methods of assessment and appraisal which enable us to direct our efforts with greater precision,and to control and monitor the effectiveness of the action that we take.

Today action and initiatives in this sphere must become more individualized in character. Forms of standardized intervention are no longer feasible because they do not take account of the special needs of each individual. What we need to do is to develop plans of individual action which can involve very high levels of social competence and models of life which are ever more similar to those of the daily lives within the community of normal people. In seeking to achieve the adaptation of the mentally retarded person to society, we also achieve the adaptation of society to the disabled person and appreciate and promote his social role.

The complexity of the problems involved means that action in relation to mental retardation should be effected through the mechanism of multidisciplinary teams. But this very fact also means that there is the risk that information will be distributed wrongly, that the parents will have to endure excessive stress (deprived as they are of points of reference and forced to engage in the life of a sort of therapeutic nomad, wandering among a large number of different health workers), that there will be an operative and cultural fragmentation of the individual, and that there will be conflicts and tensions between health professionals and themselves.

It should be added here that at the present time action can be taken in relation to all ages and with different approaches and methods from the prenatal stage to the stage of pathological aging. On the one hand, the action taken must indeed be early on in the patient's life. Any service at all can only be offered if the problem is recognized. The role of pediatricians is of fundamental importance in this area and, as has already been pointed out, the same may be said of the role of parents. Indeed, the earlier the condition is diagnosed and the path of treatment and rehabilitation is begun, the greater are the hopes of recovery.

At the other extreme, the action

which is now performed must continue and take on different forms because of the constant increase in the number of mentally retarded adults. The elderly population is on a constant increase. At the same time the improvement in medical treatment has led to an increase in the number of elderly people who are mentally retarded. It is estimated that at the present time in the United States of America the number of adults who are over the age of sixty and suffer from mental retardation is about 173,000. Projections for the future suggest that these will increase and reach a figure of 333,000 in the year 2025. The phenomenon certainly has a number of important consequences. The aging of the population involves an increase in senile dementia. It is thought that at the end of the second millennium the number of Americans afflicted by Alzheimer's disease will be on the order of ten million.

A large number of studies have suggested that a sizeable proportion of adults suffering from Down's syndrome who are over forty years of age develop clinical signs of Alzheimer's disease even though in levels lower than those who display the neuropathological alterations which are characteristic of Alzheimer's. Such characteristics are to be found in the brains of nearly all elderly Down patients. Something similar, even though this has been little studied, seems to occur in other forms of mental retardation.

At the present time there are strategies by which to treat Alzheimer's disease, but nothing or little is available in relation to mentally retarded people who display symptoms of Alzheimer's. It is probably necessary to alter the character of the programs of such treatment and to adapt them to the changes in the behavior and the capacities of the patient. However, we lack general guidelines on how to achieve an early and effective diagnosis of Alzheimer's disease in mentally retarded people and on what kind of treatment and care to provide. The public authorities in the field of health and social services lack the necessary experience to deal with this problem and fall into crisis when they have to draw up programs to help this kind of citizen. The result of this is that patients affected by mental retardation who become victims of dementia end up by being placed in long-term institutions before they should be, and in such places the unfamiliarity of the staff with their specific problems leads to inadequate forms of care and assistance and to an accelerating decline in functional capacity.

To conclude this section, it should be pointed out that action requires guarantees that the individual will be respected. Such action must not be interference; it should not take the form of excessive intervention or uncontrolled experimentation. Excesses of zeal and extremist positions must be avoided. The disabled person's right to be different should also be recognized.

Before going on to the conclusion of this paper I would like to emphasize that action in favor of the person suffering from mental retardation and the involved and careful study of intellectual disability is not only an act of justice towards mentally retarded persons themselves but also has very great significance for human society.

The study of intellectual disability has led to advances in our knowledge of the mechanisms of mental development, and this in turn has enabled us to create better ways of dealing with the needs of mentally disabled people and at the same time to promote the mental and physiological development of normal children and the achievement of correct education within the family.

An example of this is to be found in a recent study (Brunner et al., 1993) which has led to the identification of the gene locus of a disturbance connected with chromosome X. This disturbance involves notable levels of aggression and a defect in the metabolism of type A monoaminissidases. The results of this study can be used for the more general study of aggressive behavior.

Knowledge about the mechanisms which lead to mental disability and pathological forms of behavior which are connected with such disability can offer information about the biological bases of the cognitive functions and behavior in people not affected by mental retardation.

Conclusion

In this paper I have sought to define the possible forms of action which can be taken to help individuals suffering from intellectual disability and to emphasize the ethical implications of the different courses of action. However, certain general observations are also possible. The attitude of society in general and the medical classes in particular towards mental retardation has oscillated between behavior which involves a sort of resigned approach and an attitude which we could define as being "liberal." As is always the case, the extremes of these two positions meet. For example, the failure to engage in more in-depth diagnosis which marked the experienced of many segregationist institutions was the perhaps unintended cause of the campaign to place mentally retarded children in normal schools at any cost. The same may be said at a practical level of those who fail to develop the diagnosis and choose instead to minimize the problem and to ignore the individual by referring only to the label placed on him by social stigma.

It seems to me that the best way to deal with the problems of mental retardation is to be found in action rooted in the categories of realism and hope. Hope deprived of realism ends up by ignoring what the individual is capable of and means that he will not receive the necessary support. Realism without hope involves an inability to recognize what the most recent research into the human brain tells us in clear terms - that cognitive potential is never static and that the brain is endowed with a certain plasticity whose intensity increases when stimulus is applied at a very early age. Recovery, therefore, is always possible and its extent depends both upon biological facts and upon how early the diagnosis is made and the rehabilitation is attempted.

If there is a sincere wish to avoid neglect or the concentration camp, the policy of placing a mentally retarded person in an institution is not longer possible. What we need is constant and competent social control and direction. In the same way, no action is possible in this sphere (not least of an economic character) unless it is based upon solidarity - solidarity within society should thus be inculcated as a value.

A sound vision of the whole problem means that we should develop a

feeling of love towards the mentally retarded person, and that such an individual should be seen as a person and not as a mere member of a category. "A love which opens to the other person in his unique individuality and speaks to him with the following decisive words: 'I want you to be'. If there is not this acceptance of the other person from the outset, whoever he may be, recognizing in him a real albeit obscured vision of Christ, then it cannot be said that there is real love... Every authentic love restates in a certain fashion the initial evaluation of God, repeating with the Creator in relation to *every* real human *individual* that his existence is a 'very good thing' (Genesis I, 31)" (John Paul II to the 'Cottolengo' of Turin, 13.4.1980).

"A very good thing." Instead of being a burden the mentally disabled person is a teaching chair. He teaches us that nobody is perfect. He teaches the right to diversity, the respect for differences, the true basis of every possible form of social integration. To employ the words of Elkins and Brown (1993), he teaches us that "the value of a civilized community founded upon welcome rather competition. He teaches us the philosophical ideal of unconditional love, the theological concept of grace" (the freely given).

It was with this belief in his heart that E.Mounier wrote these following words to his wife about their daughter who was immobilized and dumb because of the effects of a very serious attack of encephalitis: "I have undoubtedly never experienced the state of prayer so intensely as when my hand said things to that face which failed to reply, when my eyes were directed towards that empty look which spoke far away." This dimension of the contemplation of God in the face of a person who has been severely compromised in his intelligence touches the very highest points of mystical exaltation, requires a total acceptance of the cross, and cannot be asked of anyone. However, it becomes much easier when the love of God enables us to meet the mentally disabled person and his family through the freely-given love of people who can bear witness to Him.

Some years ago I was very struck by a letter which a young mother of a seriously mentally retarded child wrote to a simple quarterly review of the Faith and Light Community associated with Jean Vanier. In her encounter with the members of this community who work so splendidly for the disabled, this mother discovered a new meaning in her suffering and in that of her child.

A Letter

Not all of us receive a contemplation of the suffering which surrounds us, but all of us will be called to account for our reply. Last Sunday, the Feast of Christ the King, we listened during the liturgy of the Mass to the terrible destiny which awaits those who are not able to perceive the face of Christ in the smallest, in the poorest, and in the most suffering. We will also be held to account for how we have treated the mentally disabled, and it is our hope that our judgment will conclude with the blessed judgment—"Come, O blessed of my Father, come to the kingdom that I have prepared for you."

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BRUNO SILVESTRINI

Aberrations in the Natural Order of Things

The term aberration is used here to refer to human beings whose characteristics distinctly differ from those of others belonging to the same species or social community. The difference can regard various somatic or mental traits, but here we shall mainly discuss its psychic reflections. We shall begin by recalling certain personal experiences and then pass on to more general reflections.

My first encounter with aberrations occurred when, as a child, my parents took me to visit a home for disabled persons. Many had severe handicaps that had reduced them to a purely vegetative existence. Most of them were children, but some were adults. For the first time I found myself face to face with a stark reality that I had never even dreamt possible. It made me feel upset and frightened. My first instinct was to run away, to go outside into the open air and to erase those images from my memory as soon as I could. Then, my mind became gradually taken up with comparing the condition of those beings to the life of a healthy child surrounded by family affection, a child who lacked nothing. Until then I had never realized how lucky I was. Nor would I ever have understood had it not been for my parents' wish to teach me in this traumatic manner. Those deformed bodies and those suffering, half-witted faces often returned to my mind in later years, helping me to remain calm even in the face of adversity that to others seemed unsurmountable. Compared to those distant images, even death seemed to me a lesser evil. When my children were born and later when they reached the crisis of puberty,

an event that so often reveals erstwhile latent mental disturbances, my only concern was that they might have normal bodies and minds.

As the years went by these memories gave way to other experiences and reflections. I later encountered severe mental illnesses that caused a person's departure from the reality we all know. One day with a group of friends we found ourselves having to deal with an emergency, a drowning boy. Instinctively, we jumped into the water and brought the boy to safety. Only one boy stayed behind watching the scene, motionless, apparently paralyzed with emotion. But he was actually blocked not by emotion but by a lucid thought that he later expressed in these terms: "What right have we to intervene in another person's life? Whatever do we know about their inner suffer-

ings?" At the time, we stared at him incredulously, without understanding what he wanted to say— so absurd did his words sound that we thought we were dreaming. We tried reasoning with him. One of us spent hours and hours trying to make him see sense, all to no avail. Only years later did I learn to recognize in this lucid thought the first signs of schizophrenia. Despite being rationally irrefutable, these thoughts split off from the instincts and emotions that normally imbue us. Later I also came to know schizophrenics in a fit of psychosis who asked desperately for help to protect them from their hallucinations. Despite realizing the inconsistency of these intrusions, they seemed unable to free themselves. I also came to know the endogenous depression that can transform a person's life into unbearable, burning suffering ending in suicide. People suffering from depression rarely ask for help because they believe that their difficulties come not from within themselves but from reality. Hence, they look askance at those who propose treatment, wondering whoever could be foolish enough to fail to understand that what needs putting right is not themselves, but the rest of the world around.

Through these experiences I have come to appreciate the need to distinguish between how we perceive aberrations and how those who live through these aberrations from within perceive them. In contrast to the schizophrenic who begs to be freed from his hallucinations, others take part in their illness, have made illness their way of being, and know no

other ways. They ask for nothing more than to live in peace in accord with what they are.

In this connection, I would like to cite another personal experience. When I was a child and antipsychotic drugs had yet to be discovered, in the small town where I grew up one often encountered people who wandered around the streets talking nonsense but otherwise behaved normally. I had to resign myself to accepting the sneering they occasionally had to bear. But those who suffered most were their relatives, for they suffered the disgrace of having a mentally ill person in the family.

Depression also appears different according to whether it is viewed from within, or from without. Some forms of depression arise from an external cause—for example, a physical illness, a family quarrel, trouble at work, or the loss of a dearly loved person. The sick persons suffer desperately until they plunge into an overwhelming state of despair from which they cannot escape. Yet these same problems cause apparently analogous suffering in other persons, without precipitating depression. What matters, then, is not so much the cause of suffering or the suffering itself but how sufferings are perceived in the inner self. The subjective component becomes even more prominent in endogenous depressions, which arise without apparent external causes.

Hence, in facing up to aberrations, we should endeavor to put ourselves in the place of the protagonist. In thinking back over those far-off childhood experiences, I have often wondered, then, how much of the problem lay with the persons who had deformities and how much lay rather with me, the onlooker. It is a difficult and possibly misleading reflection, but one we have to make. Let me restate it in other terms, referring to a case that involved me directly.

A dear friend suffered a stroke that irreversibly damaged her physical and mental faculties. For some months afterwards she utterly lost her appetite, reaching the point of obstinately spitting out the food put into her mouth. So she was parenterally fed until she

eventually became completely apathetic. Once that had happened, she began to feed herself again normally and survived for some years in a disabled state, depending upon others even for her simplest needs. She was a humble person, yet endowed with an extraordinary sense of dignity. It seemed to me that refusing food may have been her way of asking to die in peace, following the natural course of events. Probably, when having to cope with the same situation again, I would still opt to prolong her survival. But whether this decision is right remains an unanswered question.

Yet another aberration that I have often needed to cope with is drug abuse (Silvestrini, 1995). It usually originates from a mental discomfort that the affected person tries to relieve through drugs. This discomfort may consist of a real disease, of the depressive or schizophrenic type. It may also arise in otherwise normal persons who are incapable of accepting the rules that chiefly govern living together. Whereas these individuals would like to follow their own natural inclinations and their own talents, they find themselves compelled to do boring, repetitive activities, to keep pre-arranged time schedules and to obey rules that they simply do not understand. They would be content merely with the fundamentals of life—food, health, and liberty—whereas they live in a society that believes in success, in

accumulating ever more power and wealth, even when these goods become useless and counterproductive. I was greatly impressed by the members of a small community who have settled into a ruined convent they have restored and turned into a garden. Their way of life reminds me of the cloistered monks of old. Some community members have withdrawn from drugs; others still struggle to do so. Many come from rich families from which they received everything, from complex toys when they were children to cars and expensive clothes as they grew up. And they were sent to famous schools reputed to ensure qualifications and suitable career openings. The only gift they never received was the one they really needed: the ability to accept their diversity.

I have used these concrete cases as a way of entering into the problem, but this has left too many questions unanswered. For example, what are the confines between normality and aberration? And, in addition, supposing that an aberration is actually a deviance from normality, to what extent are we authorized to consider it a dangerous oddity, to combat and to correct it. These are concrete questions; they demand concrete answers. Parents have to answer such questions when their children ask to lead a way of life that will to some degree make them social outcasts. So does a mother faced with the agonizing dilemma of whether to bear a pregnancy to full term when the foetus is deformed. And so does a physician who has to decide whether to start aggressive therapeutic efforts to sustain life or rather to let life take its own course. Finding an answer to these and other questions means embarking upon reflections of a more general order. In trying to discuss them I shall exclusively use the biological point of view to which I am accustomed.

One normally makes a distinction between the spontaneous flow of life that comes about without human intervention, and the changes that human beings introduce into life by exploiting their special intellectual and manual abilities. The former is also called

the natural order of things; the latter, progress. Both terms subtend scientific and technological developments pursued by humanity. The Church, too, accepts that life began with relatively undifferentiated primordial organisms that evolved into multicellular organisms comprising specialized and differentiated tissues, organs, and apparatuses. Despite their differences, these multicellular organisms belonged to a single system into which they integrated, sustaining one another. Biological evolution, therefore, continued under the form of social evolution, represented by living beings who gathered together into communities made up of individuals and subdivided into categories. Each category dedicated itself to a specific activity. And as they became better and better at doing it, it made their lives worth living. With mankind we passed gradually from the primitive society, made up of small family or tribal groups, within which there already existed a subdivision of roles and tasks, to ever more ordered societies in which biological and social evolution drew a further impulse from scientific and technological progress. The advancement of knowledge, along with the ability to translate knowledge into practical applications, is one of the prerogatives of humankind. At this point knowledge is no longer entrusted to traditional skill {dotto}, but to a community whose members all participate in exploiting instruments and machines that multiply out of all proportion the intellectual and manual forces of the individual. In this way, man has gone way beyond the dominion of his senses, penetrating into the microscopic, ultramicroscopic, molecular, atomic, and subatomic world to reach the point where material and energy merge. Humanity has also looked out to the origins of the universe, using the force of thought sustained by ever more powerful instruments to overcome the laws of physics of the universe and the speed of light. Thus we have succeeded in deciphering the genetic code, which contains the past, the present, and the future of life, and can now even manipulate it. In this process, cognition and its

applications have become entwined, as have the intellectual and manual abilities in our organism.

Hence, we are faced with two distinct moments of life: the biological moment, which belongs to the natural order of things, and progress, which depends on human intervention. Both cause life to evolve in a direction opposed to that taken by the rest of the known world. In other words, life has evolved not towards disorganization and division, but towards increasingly organized and structured material and abstract configurations. In this way, life has defended its own identity. It has protected its identity from adverse natural forces and improved, perpetuated, and transmitted it to other configurations capable in turn of pursuing the same pathway. To do so, living beings had to become distinctly aware of their own identity, at first unwittingly, and then, once they had reached the stage of mankind, through conscious self-criticism.

Philosophically speaking, it is hard to distinguish between biological evolution, in which man also participates, and progress.

For progress is linked to the intellectual faculties inherent in human nature; just as flight is innate in the bird. Both also share two distinct yet nonetheless complementary elements: similarity and diversity. Similarity is the intermediate evolutionary stage, the pause necessary to consolidate the

route so far followed. It is the pause when human beings group together into species endowed with a fundamentally common identity recognizable to all, despite individual dissimilarities. It is an identity made up of somatic, functional and intellectual characteristics as well as rules of behavior and cohabitation. In contrast, diversity implies resuming an interrupted journey, in an unceasing attempt to pursue it thus perfecting ever more the identity of life. From a strictly biological viewpoint, diversity, understood as aberration or deviance from the path thus far followed, consists chiefly though not exclusively in genetic mutations. Whether the change introduced is deemed good or bad depends not on the mutation itself, but on the advantages the mutation offers for the survival, evolution, and progress of life. This is the fundamental criterion that establishes whether an aberration is good or bad, whether it should be preserved or rejected.

For this reason, every aberrant form of life, whether vegetable, animal, or another type, disappears from the face of the earth if it is useless or harmful; but is preserved if it is useful in an absolute sense or only in specific, contingent conditions. For example, an abnormal capacity to retain salt in the organism is essential for survival in arid climates. But in places where water abounds and survival is prolonged it transforms into hypertensive disease. The constitutional traits linked to depression, in itself a feared disease, seem identical to those that in different circumstances sustain the creativity of the artist and the scientist.

In the so-called natural order of things, aberrations are maintained or eliminated according to the apparently ruthless criterion of their utility. On closer inspection, however, this criterion is also a corollary of the general law of solidarity. What actually sustains life, allowing the individual components of a living organism or the individuals that make up the community to survive and live together, is the ability to satisfy their needs mutually. The organs of the human body have the ability to satisfy the needs of the organism to which

they belong; the organism has the ability to satisfy the needs of its constituent organs. Both survive, grow, and develop as long as they respect this rule, first enunciated by Menenius Agrippa. A tissue that breaks this rule transforms itself into a cancer, thus dragging to ruin itself and its host organism. Conversely, an organism that cannot supply its organs with what they need destroys not only its organs but also itself.

In the same way, aberrations remain or disappear according to whether or not they favor the development of life. This is a simple but illuminating concept. It is the common good that transforms itself into the individual good. And it is solidarity that coincides with looking after oneself. Hence the commandment "Thou shalt love thy neighbor as thyself" becomes a biological as well as an ethical and religious rule of life.

Compared to their impact on the natural order of things, aberrations raise more complex problems in the civilization of man. Even though the criterion understood as reciprocal utility remains, aberrations without an immediate usefulness are not eliminated. In persons who are weak, deformed, atypical, suffering, and incapable of surviving on their own, normal persons envisage a condition that will sooner or later concern them, too, in illness, aging, or adverse circumstances. Normal persons endowed with wisdom will therefore assist the less fortunate, because they realize that this is the way to support and help themselves.

Respect for aberrations arises, therefore, not only from religious or ethical principles, but also depends on strictly biological reasoning that foresees both the essential evolution of life towards configurations of growing organization and complexity and at the same time expresses the strength of solidarity, without which life would break up. Yet again, at the end of his tormented and twisted peregrinations, the scientist discovers with amazement that he has simply arrived at the point which others following the main road reached long before.

My paper has remained so far on abstract levels that are hardly suitable to the dramatic urgency of the daily problems that forms of aberration pose. Let me therefore offer a concrete proposal, namely a Statute on Aberrations. To my mind, this should spring from religious, secular, ethical, and philosophical contributions, as well as contributions from those who have firsthand experience of aberrations in their various forms. Apart from defining aberrations, we need to establish rights and duties, not only on the part of society as a whole, which at times asks for protection, but also on the part of the individuals whom society rejects and outcasts who claim only their roles and their rights. It is a difficult task, yet one that we can no longer put off. For we who proclaim normality are accumulating a debt to others. Should we fail to honor this debt, it will ultimately crush us. In my opinion, the most suitable place for planning our action could be the National Committee for Bioethics (Il Comitato Nazionale per la Bioetica).

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CARLO LORENZO CAZZULLO

The Acceptance of Mental Illness

First part

1. Introduction

Since ancient times mental illness has prompted intense emotion among the uneducated, as well as among the learned. The reasons for feelings such as curiosity, fear, and fascination still exist, even if more tenuously, and are constantly stimulated by the mass media, movies, and books. The primary motivation for such an interest resides most of all in the incomprehensibleness of the mentally ill and their presumed inability to communicate, together with the constellation of "strange" events surrounding them.

Such events are not limited to the ill, but in the end concern all the members of their families, gradually expanding into the social context. It thus seems evident—and this will be the object of our specific attention—that those suffering most profoundly from the changes brought about by mental illness are, first of all, patients themselves, but the changes in their mind and behavior soon "contaminate" their immediate environment.

The acceptance of mental illness and its unpredictable complexity arises, therefore, in the family initially—often left alone to face this terrible dilemma—and only through the family can it be broadened to society as a whole, with an improvement in the quality of life of patients.

The Stigmatization of Mental Illness

The following question is posed: Is what happens to the patient just a result of poor information, a bad disposition, or is it the effect of the ancient fears we all have regarding the sly demon of mental illness?

The individual suffering and the collective distress related to mental illness are in reality amplified, often substantially, by two elements constantly found—and perhaps inherent—in such a condition: *stigma*, with the consequent *social isolation* to which the ill are subjected during their existential experience. Here the stigma is quite different from and much harsher than what happens with other diseases—perhaps comparable to what happened in the past with transmissible diseases (or, in some respects, with AIDS at present).

Some psychic disturbances—such as schizophrenia, mental handicap, or drug addiction—trigger a certain stigmatization, which may, in turn, greatly affect the quality of life of all involved, the sick and often their families as well.

The most evident case is *schizophrenia*, the most severe of all mental illnesses. The symptoms of schizophrenia, especially at the outset, represent a subtle discrepancy between the subject and the surrounding world. Such discrepancies are connected with the subject's inability to follow a goal coherently—that is, a lack of finality in behavior. People in contact with schizophrenics—the family, first of all—therefore face an ambiguous, sometimes elusive problem, multifaceted forms of behavior which may admit different, often discordant interpretations. The primary issue is whether or not we should believe in the patient's behavior?

The crux of the matter therefore becomes a correlation between the patient's past and present behavior, with the consequent risk of criticizing pathological symptoms or, on the contrary, of not recognizing them and to linger over misleading elements so as to posit a person's "peculiarity" while thus delaying therapeutic action.

This is where the stigma comes from, the idea that the mentally ill are dangerous—still so widespread in society and hard to eradicate.

This situation is reproduced, in an even more radical fashion, with *drug addiction*, although today a scientific proof exists of the fact that the drug addict has, in the majority of cases, not made a free choice, but manifests a pathology; however, society still disapproves of the addict and reproaches the family for not predicting or preventing the behavior of addiction. These aspects grow in importance when the drug addict is also "contaminated," when such persons self-destructively encounter a death-dealing virus, HIV, for which science and medicine have no remedy. These subjects then become guilty twice over—guilty of being unable to accept the pains and joys of life in the world and seeking escape in the sedative effects of substance abuse and guilty of bearing a new pestilence.

These dynamics of stigma and isolation are not, however, inescapable, as demonstrated by an-

other illness that is well known to-day and that may accompany different stages of life: *depression*, a severe pathology in itself, even more common than HIV in the general population.

Today depression is socially recognized as an illness which, even if severe, is *curable*, and this idea in turn affects society's conception of this illness: depressed persons are no longer stigmatized and may be accepted by any member of society without being treated as schizophrenics. Their symptoms are well-known, and the clinical features are described without fear on the mass media, and, most of all, this suffering is understood by most people and increasingly accepted on a family and social level. This awareness is a great advantage for the ill and fosters early treatment of relapses, facilitating needed therapeutic action.

The Family and Mental Illness

In considering the problem of mental pathology and of the mentally ill, it is convenient not to forget the third protagonist, directly in contact with them on a short- and long-term basis—the patient's family.

Within the family a series of dynamic phenomena occur, linked to the suffering of the ill member, with the alteration of responses of other family members and negative attitudes causing individual and collective distress and even triggering pre-existing personality disturbances. Physicians are frequently the first to encounter such situations, and their professional and ethical stance is decisive for managing them.

FIG. 1 EXPRESSED EMOTIVITY	
Negative factors (rejection)	Positive factors (acceptance)
• Excessive emotional involvment	• Emotional warmth
• Hostility	• Positive remarks
• Criticism	

(Fig. 1) Family tension—so-called "emotional temperature"—is recognized and measured today by using a methodologically consistent scientific construct which is multifaceted and with broad clinical and therapeutic applications—the analysis of *Expressed Emotion* (EE). Its components are, on the one hand, represented by *excessive emotional involvement, hostility*, and *criticism*, which produce high EE, and, on the other, by *warmth* in the relationship with the patient and by *positive remarks* concerning his behavior.

(Fig. 2) High Expressed Emo-

FIG. 2
SYMPTOMATOLOGICAL RELAPSES
DURING SCHIZOPHRENIA

Chi Square = 4.10 p <0.05
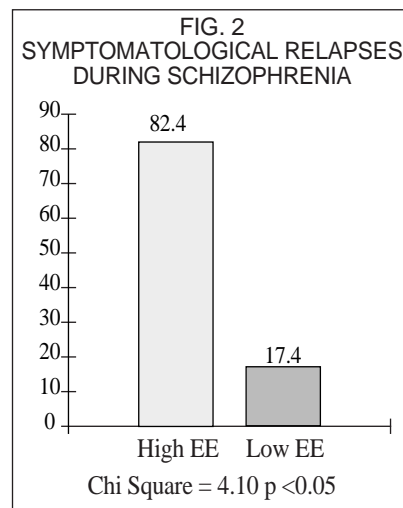
tion conditions usually produce relapse rates of up to 80% in cases of schizophrenia; such rates are halved when warmth or empathy towards patients are elevated.

(Fig. 3) In *depression*, high Ex-

FIG. 3
SYMPTOMATOLOGICAL RELAPSES
DURING MOOD DISTURBANCES

Chi Square = 4.15 p <0.05
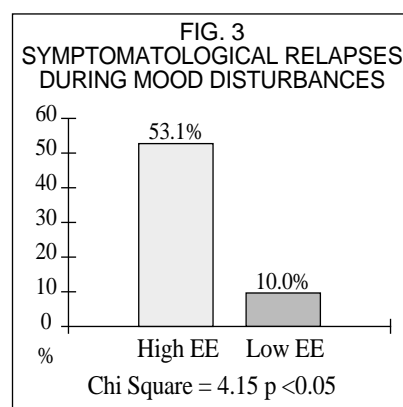
pressed Emotion rates for hostile or overinvolved relatives' attitudes (in this case, usually spouses) produce a mean relapse rate higher than with low EE results. The wives of depressed patients appear to be more critical than their husbands towards them and female siblings.

Attempted suicide, prevalent in female subjects (21-22 years of age), is related in over 80% of the cases to high expressed emotion responses.

The results in *drug addicts* indicate a high frequency of high EE profiles, similar to those observed for schizophrenics, and a direct correlation between a lowering of Expressed Emotion and better adherence to therapeutic programs, including the various forms of treatment beginning with therapeutic communities.

In contrast, in families with moderate and severe cases of *mental retardation*, a situation signifying heavy family burdens, emotional over-involvement is seldom accompanied by hostility, and Expressed Emotion tends to be low. Relatives of such patients seem to take advantage of the chance to explain disorders—their symptoms and behavioral manifestations—with an easy interpretation of them as an organic pathology. Such an understanding diminishes the mystery of the causes of the illness and eases acceptance of treatment programs.

Where the etiologic mystery remains, however, as in *multiple sclerosis*, EE is high in 46% of the cases and requires special attention to the family and its emotional response.

Second part

What has been said until now may be somewhat pessimistically interpreted as the negative side of the initial proposition in this brief paper. Its *positive aspect* brings us to the basic questions of *availability* and the *ability to know*.

Availability is linked to a basic acceptance of the dignity and autonomy of any human being. If any one of us accepts an essential truth *a priori*—the limitations, by virtue of our human nature itself, of the extent of our knowledge and of its temporality; we must be grateful for the half of the vessel of knowledge which is full and not despair over the other half, which is empty.

In knowledge today we may find precious information enabling us to understand the pathogenesis of some mental illnesses more and better and, most importantly, the

means for *early* treatment.

It is essential to recognize illness in its initial stages. The sooner an illness, any illness, is recognized, the more chance there is to control—and sometimes eradicate—it, while at the same time preventing its spread in the family environment. The family can, as I suggested, limit its emotional response, maintaining it at levels more useful for itself and for the ill.

Family members find themselves on a two-way street: they are *active subjects* of psychological support for the ill member. They are *passive subjects* needing direct, targeted support, as well as truthful information on their relative's illness. They are people suffering, then, alongside the ill who suffer, and the more the ill move towards a chronic state, the more they, too, suffer.

All observers agree on one issue: often we arrive too late at the families of schizophrenics—as well as the families of other patients—and treatment thus requires a long period of preparation.

From such considerations there arise certain principles for the action of all seeking to contribute to a better acceptance of mental illness and at the same time to a better public image of it.

1. *To provide information* on this illness—to know it and be defended against it. An important activity in this regard, related to the core problem of schizophrenia, has been—and is still being—carried out by the Association for Research on Schizophrenia. This moral body, with altruistic and scientific aims, has developed a family intervention program tailored to the specific needs of Italian families and based on information.

Information is essential to working on schizophrenia because it is the central core of the *stigma*, the terrible visage of a plague. None can accept this for themselves or their families.

2. *To control emotion*, fostering cognition and intelligence. I have already talked about the importance of emotion in the family, especially in the form of Expressed Emotion, as regards mental illness. I want to emphasize that a proper reduction of such emotional inten-

sity, together with a reorganizing of cognitive processes and modalities, can lead to a real improvement of the illness itself.

The possibility of developing more rational emotional dynamics, in the family and outside it, can be implemented, according to the most recent orientations, through proper *psychoeducational interventions*, which I will mention later on.

3. *To facilitate interpersonal communication*. The patient and his social environment influence each other, in a circular, diachronic manner, negatively as well as positively. On the one hand, patients may respond to ambiguous or negative relational feedbacks with a reduction in self-esteem and a feeling of refusal. In a certain number of cases, patients live through isolated experiences of *guilt induction and overt refusal*: this is often due to an ill-founded attempt by relatives and of other emotionally significant persons at struggling against self-directed guilt feelings, the most important of which centers on the inability to *communicate properly* and thus manage to help the patient. *Inadequate communication* reduces patients' emotional adaptation and, as a result, the acceptance of what happens to them, too.

A proper communicative relationship involves a) decoding messages; b) helping the concerns of others to emerge (maieutics); and c) becoming aware of complexity, without trivializing any message, even if expressed with special locutions.

4. *To free the ill from loneliness*, isolation, and abandonment. Suffering induces isolation, a reduction of social contact, a feeling of being "different": such feelings may generate mechanisms of revolt and aggression, or, on the contrary, of closing oneself off and detaching oneself from the community.

The family, thus left alone, cannot assimilate the loss, but falls into complex mechanisms of guilt induction and intolerance, making the ill person a *scapegoat*, an attitude that alleviates the underlying distress only temporarily.

5. *To accept the language of the ill* and try to understand the deep roots of it through interpretation. One should, in other words, understand the ill and their feelings, without losing respect for them, helping them to understand themselves better. The influence of the family group is, once again, essential.

If the behavior of the ill is constantly influenced in a positive way by the family reality, we can see real clinical improvement, with a freeing of individual and collective energies which have been lost or blocked for some time, along with an unexpected evolution of convalescence, and, finally, an increase in the strength also needed to endure the deficiencies induced by illness, which sometimes cannot be remedied.

When adequate mechanisms of social support and consensus are offered to the family, it can recover a strong, positive role in the best manner.

8. *To disseminate information on mental illness in society*. Although mental illness is still not perfectly known in its causal and pathogenic mechanisms, it is also true that scientific knowledge has progressed to the point where the facts relating to mental illness are now better understood. Proper information among citizens of the "state of the art" in psychiatric

knowledge it essential today for all action intended to create better acceptance of mental illness.

Psychoeducational Action

Aside from the therapeutic potential residing in information, family psychoeducational action sets in motion other positive factors, with enduring positive effects on families.

* *Hope is instilled.*

* *Common problems are shared.* Often family members believe they are alone in facing these kinds of problems, but once they participate in groups, they discover they are not alone and can share anxieties and fears.

* *Catharsis.* Intense expression of emotion within the group is important since it reduces tensions in the family and helps to develop group cohesion.

* *Learning.* Family members may acquire a knowledge of important aspects of their own behavior, confronting their opinions with those of other participants, as well

as group leaders.

The best result of psychoeducational work is not the disappearance of the symptoms of mental illness, which may be achieved through proper psychiatric treatment, but rather the attainment of certain key goals.

* *Understanding* the psychological needs lying behind the symptoms and disturbed behavior.

* *Realistic acceptance* of one another's needs.

* *Reduction of excessive expectations* which may crush the patient, with the development—if they are lacking entirely—of realistic, balanced expectations.

* *Reduction of the tendency to judge* and of contradictory behavior, often due to a lack of legitimization of the illness.

* *Improvement of communication channels*, which need constant reinforcement.

Any psychic disturbance can lead to positive results.

Depression, therefore, is always a critical experience; in working through depression, people may grow, mature, reconsider their

plans, and refocus their energies towards them (M. Klein).

According to Aristotle, a tendency towards depression is a characteristic of genius. And genius and lunacy, as far as schizophrenia is concerned, often follow a common way: artistic, as in van Gogh, or philosophical, as in Nietzsche.

Finally, the acceptance of mental illness is essentially compromised by a ghost of the deep—fear. Fear can be defeated by a wider knowledge, but also by the trust of those working with the ill, as well as those close to them. For all of them, exposed to the burden of a hard task, the words of Pope John Paul II will be helpful: "Do not fear, and cross the threshold of hope."

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Round Table

The Mentally Ill in Different Social Models

ELIOT SOREL

Health: an Invaluable Asset for a Robust Economy and Democracy

The health of nations is the wealth of nations.
—William J. Durant

Health is an invaluable asset for developing robust economies and democracies. The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity... (and advises that)... (t)he health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and states." Against a multifaceted backdrop of increasingly globalized national economies, frequent reliance on child labor, worker marginalization by virtue of rapid and pervasive technological advances in production, and the recurrence of old diseases (tuberculosis) and emergence of new ones (Ebola virus, AIDS), increasing percentages of gross national products are now devoted to health and health-related expenditures, particularly in the first few and last remaining years of life. The health status of individuals, families, communities, and nations is determined by environmental, biological, psychosocial, sociocultural, spiritual, economic, and policy variables, in transaction with each other.

Economic factors affect health planning and implementation as well as access to health care, accountability of providers, quality and outcomes of treatments, and the depth and breadth of research and training. In turn, the public health of a country affects its economic productivity, effectiveness, and efficiency. The health sector is a major employer, representing 10%-15% of the economy in some countries.

National health plans are presently under crippling financial pressures, resulting in personnel cutbacks, cost reduction (e.g.: the least expensive, not most effective, medications prescribed; hospital stays arbitrarily limited), and planning largely driven by economic considerations. But the pursuit of short term gains are likely to lead to long terms losses that have a negative impact on the health of the population and increase rather than reduce costs (e.g.: 24-hour hospitalization for labor and delivery increases post-partum risk and treatment expense for mothers and infants).

We are living in an era in which cost/benefit analyses are focusing on cost-reduction and profit enhancement. Some cost-reduction measures have been valuable insofar as they prompted a re-examination of health care systems. In some cases the re-examination has led to giving prevention high priority and to creating incentives for prevention, early detection, and intervention, as well as disincentives for over-utilization of services and late interventions. Consumers have been stimulated to participate in the health decision-making processes. Providers are forming new networks, have initiated new treatment guidelines across specialties, are developing outcome studies of benefit to consumers, providers, and payors by enhancing accountability.

Health promotion, illness prevention, and risk-sharing, in the broadest sense, are all the joint responsibilities of national health care plans, businesses, governments, health care providers, workers, and their families. Sound waste disposal practices, responsibly managed food processing, and attending to employee well-being benefit not only corporate stockholders but also society's stakeholders. Sharing health-related risks (environmental, high-risk behaviors, violence, and illnesses) among governments, businesses, other payors, providers, and consumers of health care services is an essential part of a revised social contract that emphasizes shared responsibilities, and both moral and ethical imperatives. Thus, the availability of accessible, quality health care services is an essential stabilizing force in the matrix of society. Health care models which emphasize prevention at primary, secondary, and tertiary levels, as

well as ensure access, accountability, and quality outcomes are required, along with a partnership between public and private sectors.

Business that have become increasingly global in nature need to recognize that their success depends, in large measure, as much upon their multi-national labor force as on strategic planning, capitalization, innovation, and expanding markets. The health of the labor force is an invaluable asset. An unhealthy labor force severely limits productivity, quality, competitiveness, and profitability. Billions of dollars each year are lost as a result of environmental conditions (toxic waste exposure, "sick building" syndrome, "mad cow" disease) or events (natural disasters, massive national and regional development projects, with their accompanying population dislocation, ethnic conflicts and "cleansing"); undiagnosed and/or insufficiently treated worker and/or worker family illnesses (AIDS, infectious disorders, high blood pressure, cancer, depression, other psychiatric disorders); high-risk behaviors (including smoking, sexually transmitted diseases, substance abuse and dependence); ethnic, domestic, and workplace violence. Investing in the health of workers and their families will not only reduce these losses, but will result in significant tangible returns to workers, their families, businesses, and governments. The state of health of the labor force is not only important for its intrinsic value, but also for its value added.

Although the patient-physician relationship is the cornerstone of the healing process, in recent years it has become hostage to professional biological reductionism and political and commercial economic reductionism. The patient is not the illness; cost alone cannot exclusively determine choices for patients and physicians. Patients and physicians need to free their relationship from reductionistic forces and engage in a redefined and reinvigorated partnership characterized by mutual respect, trust, caring, and guided by scientific excellence and humanistic considerations. Patients need to approach this task with assertive-

ness, participation, and commitment to their own healing. Physicians need to approach with humility, caring, and high standard of excellence. They must be at ease not only as clinicians, researchers, and educators, but also as advocates for their patients. This partnership extends beyond the patient to include the patient's family, and beyond the physician to include the entire health team of professionals, paraprofessionals, and health care workers. Together, they need to develop a new health language intelligible to people and professionals alike.[1] The newly emergent language and concepts will facilitate joint participation and risk sharing in clinical, economic, and ethical decision-making processes pertaining to health care.

Policy makers have an unprecedented leadership opportunity to make health a leading component of their initiatives. Doing so will benefit not only health systems, but also education, justice, commerce, and labor sectors. Their failure to consider the importance of health undermines economic strength and political stability at national and international levels as illnesses spread across borders, create enormous and possibly disastrous expenses of an economic, social, and political nature.

When they are responsive to their constituents' wishes and

mindful of changing global conditions, policy makers can harness multiple environmental, biological, psychosocial, sociocultural, spiritual, and economic factors. They can rely on professional and technical assistance based upon the most recent scientific innovations and discoveries to develop integrated economic and health models in the new millennium. Policy makers must

– emphasize the importance of health across sectors;

– promote systemic cross-sector cooperation;

– encourage risk-sharing among patients, families, pshysicians, and payors in the context of medical, financial, ethical, and legal decisions;

– balance the allocation of resources among prevention, treatment, training, and research;

– develop flexible multi-sectoral reforms, restructuring, and retraining;

– promote public ad private sector cooperation, nationally and internationally;

– foster complementarity between job creation, social protection, and health for all.

Patients and their families, physicians, nurses, and other health care team members have the challenging task of going beyond their traditional roles and as partners develop a new language of health that informs, educates, and advocates health and economic policies that are buttressed by solid scientific evidence and humane, ethical considerations.

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Note

[1] Prior terminology was professionally derived: the physician/patient (relationship). Recently, market forces have given rise to "new" terminology: the consumer/provider (relationship). Neither adequately reflects the complexity of the relationship and the forces influencing it.

TONY ANATRELLA

The Depressive Society

In this paper I would like to examine and analyze those elements which foster a climate of depression, and I would like to discuss this subject with special reference to France. Our society is afflicted by a sense of sadness whose causes go beyond the simple fact of unemployment and extend beyond an economic crisis which marginalizes an ever-increasing number of people.

In a recent study the World Health Organization defined depression as the malady of the rich countries of the world.[1] The WHO estimates that by the year 2020 mental afflictions and nontransmissible illnesses will have increased by 15%. The illnesses which are the greatest danger are not those which are commonly believed to be so—this study calculates that deaths linked to the smoking of tobacco will increase threefold over the next twenty-five years to reach a level of 8.4 million deaths a year in the world. The death rate caused by AIDS should pass from one to 1.7 million over the same period. These statistics bear out the ever-more perceptible state of malaise which is present in the rich countries of the world and bear witness to the conditions of life which foster the emergence of new kinds of illness or psychic troubles linked to changes in living conditions.

Indeed, despite the conditions of prosperity which prevail in our developed societies we often hear individuals complain about feeling bad. One of the reasons for these complaints is asthenia and a feeling of depression—that is, tiredness and the idea that the realities of existence cannot be dealt with

and tackled. Paradoxically, at the same time we can perceive that mental disorders have not increased in France over the last thirty years but that our patients, when they consult us, display a growing tendency to complain of an existential void. We have before us forms of psychic suffering whose causes people cannot explain but which nonetheless clearly damage their lives. Although individuals can always avail themselves of a psychotherapist in an attempt to alleviate their suffering and treat what is causing their condition, this malaise, which is characteristic of civilized societies and which can be observed in our patients and in society more generally, cannot be approached solely from a medical point of view. Very often it involves questions about the meaning of an individual's existence which lead to a concentration upon the problems of existence itself. This environmental depression has become a mass phenomenon and involves a very real social problem which economic growth and dynamism will not be able to solve in automatic fashion. In addition, it is often masked by the optimism of the models engendered by the mass media.

1. The Lack of Internal Resources

A certain diffidence, marked by the idea that solutions do not exist to our existential problems, is becoming ever more widespread. This sense of powerlessness creates a damaging environment and the belief that reality is beyond our control. We are encouraged to

think that not much can be done and that events do not depend upon what we do at a personal level or upon our own lives. Plans for the future are lacking; the experiences of previous generations no longer seem relevant and are forgotten; and moral and religious traditions no longer appear to be resources with which it is possible to construct meaning and establish links with the new realities of contemporary conditions.

In this context depression appears as a loss of instruments and tools. Men find themselves alone and without resources. They go to look for them at a pharmacy, in the gamut of psychopharmaceuticals. It is certainly true that the usefulness of these drugs in cases of need cannot be denied—however, there is a great risk that we will abuse them.

Originally seen as instruments by which to treat and deal with mental illness, they have become much sought-after products because of the comfort they bestow upon their users. This form of drug addiction expresses the emptiness and the fragility of the contemporary inner man. Today people drug themselves to be more prominent and effective at the workplace, in relationships, and in their personal lives, whereas only recently drugs were first and foremost a means by which to escape from reality. Existential problems and our states of mind have now become unbearable because we are unable to face up to them and to tackle them effectively.

At the back of these phenomena is the demand for self-help by individuals who have become vulnerable because they are alone in life.

Persons increasingly become a problem for themselves. Medicines and drugs falsely seem to be means by which to increase personal potential or by which to govern and manage emotions and behavior—individuals do not know the governing principles or the points of departure by which to organize their own existence. Moreover, they do not always know the boundary between changes in mood which herald a pathology and existential questions. A large number of people find themselves in a black and confused state, and the problem is whether they are ill or whether they are unable to bear or to give a meaning to their lives.

At the present time we tend to understand and approach most problems in psychological terms. Genes express their problems with a psychological or psychopathological code although the answer in terms of a product is a tie which enables the suffering to be alleviated. The product is sought after so that the people can insert themselves more successfully into society and become more available within the community, achieving thereby a state where they are no longer affected by sensations or perceptions which they do not know how to manage and which cannot become thoughts because they lack suitable words. Thus it is that individuals enclose themselves within their own subjectivity without being able to occupy their own inner space and without wanting to be confronted by objective laws and realities, which by definition exist independently of the individual.

Contemporary men tend to live like sick people and to direct their attention towards medicines which they believe can deal with the problems of their existence—problems which are in fact caused by a lack of personal resources. Our society does not trust itself and at times one can well ask whether one knows why one lives, why one works, and why one loves.

In my book[2] I described society as being "depressive" because I wanted to underline the crisis and the suffering of the psychic structure of the ideal in the psychoanalytical sense of the term and which

social psychiatry measures with reference to the social ties of an individual. This structure is constructed during childhood because it is the outcome of narcissism and parental identification. It allows an inner debate between what children are and what they want to become. It becomes a moment of evaluation and programming of the psychic destiny. It should be stated that human life is not possible if there is no commitment to a project to which such essential psychological functions as identification, the ego ideal and the super-ego ideal can be bonded. These functions enable the individual to act if the social environment communicates the symbolic materials which are necessary for such an operation. But nowadays this transmission is defective in a serious fashion and provokes absences in the field of ideals, interiorization, and sexuality.

Depression has a precise medical meaning which must not be confused with a transient feeling of sadness and suffering which individuals experience when they undergo difficulties. This sadness—which is often provisional in character—does not cancel the capacities of individuals. Indeed, they remain able to act and to find solutions by which to manage the adversities they come up against.

Depression, in contrary fashion, is an illness and is a state of profound and painful sadness which has repercussions in the daily life of the sufferer to such a point as to alter the ability of individuals to live and to function. Disgust, lack of interest—that is, despair—take possession of them and they become blocked and able to live only in the present. They are oblivious of the past and are unable to project themselves into the future—individuals are unable to detect ways out of their crisis—unless, that is, they face up to their relationship with reality.

The intensity of this sadness gives the impression that individuals' resources are exhausted and their capacities destroyed. But this sadness—where love for life and delight in it are no longer active—can also be masked by the individuals' production of different forms of activity and of euphoric behav-

ior in order to give themselves the impression that everything is going well. In reality certain questions have been put to one side whose return will be paid for later at a very high price. Faced with events, modern men live alone and without a historical consciousness as if the world and the universe had been born with them. In these conditions it is very difficult for an individual's personality to achieve maturity in relation to time and to engage in long-lasting commitments, not to mention the achievement of the perception of objective values.

We find ourselves in societies which forget their own pasts and the role of their own pasts. The narcissism of contemporary models which convert the individual into the reference point and the purpose of everything is rather tragic because in such conditions the social bond can no longer be lived out and fails to be a source of projects. Life stops at individuals and there can be no life before them or, indeed, after them. This is especially true if we become locked into a mentality of the "strike" in relation to births or the transmission of the cultural inheritance.

The asthenia we are dealing with here is not caused by a physical factor, but, on the whole, is the product of an inner paralysis. Men gradually encounter difficulties in achieving the real as they grow old. This undoubtedly arises from the fact that our conditions of life do not foster inner development, but keep it at a superficial level. From a psychological point of view individuals lack—from childhood onwards—those guiding images by which they can learn to live out and to act upon external realities. In wanting to turn the past into a clean slate, and in withdrawing from the duty to bring up their children, individuals engage in activity whereby their offspring are constantly left to themselves because adults do not know what to say to them or what to transmit to them. By such a route we have promoted a counter-identification in relation to our history and our origins. A widespread feeling levels our contemporaries as if there were an attempt to erad-

icate the shame which we feel over our origins and our past. This prevents us from thinking positively about the future. However, it is now clear that without a past it is difficult to construct a history! If modern man encounters difficulties in achieving the real, this is without doubt because he lacks reasons for living.

It is, therefore, not so much society which is depressive as individuals. In coming into contact with society they experience an imbalance and are unable to deal with reality; they have the impression that they are unable to act upon events. Individuals find themselves with themselves alone; they lack the support of a society which lives without a future. The ephemeral becomes king. Individuals have to rely upon their own will, not least because modern conditions of life promote a shortening of time. The state of depressed persons is expressed in a feeling of not being able to exist for others or for an ideal; they remain marked by existential boredom.

2. The Crisis
   of the Inner Man
   and of the Ego Ideal

The contemporary crisis attacks the working of the psychic apparatus, and in my book I demonstrated how the structure of the ego ideal can be made ill by this process.

It has been stressed that the ego ideal which is created, taking narcissism as its point of departure, is one example of the evaluation of projects which derives from parental and social identification but also from cultural ideals. The individual can engage in an interiorization of these latter elements only in proportion to society's evaluation of them.

Contemporary mentalities are concerned with the individual dimension and live out a feeling of social belonging which is much lower than that of previous generations. This is because the social environment is uncertain and devalued. Indeed, when individuals have a historical consciousness they achieve their existence over the long term through institutions.

At the present time identity and institutional bonds are neglected out of simple disinterest or because of a fear of being deprived and limited, not to speak of being castrated. Nowadays people plant, cultivate, and build for the moment. This is not done for future generations, but with materials which grow old badly and which are without an inner dimension—such as glass and metal.

Although the independence and freedom of the individual are priceless achievements, inherited from Christianity, the risk we run is that of wanting to look after ourselves and to believe that we are the purpose and measure of everything. According to the mood we find ourselves in, our relationships with values, for example, can be relative. In this way we forget that they constitute an objective dimension which goes beyond what we are, as occurs, for instance, in the case of the prohibition of incest. We are not the founders and the judges of the law.

Our social expressions and the dominant models presently in circulation produce narcissistic men who worry about themselves in a positive sense. But they can also close them up within, and lead they to their own subjectivity, and to that alone. Indeed, external reality is poorly integrated and the processes of interiorization become impoverished.

It is often thought that the depressed express a lack of interest in reality. It would be more accurate to assert that they are unable to reach reality. They find themselves blocked within a structural powerlessness and thus turn to strategies which involve expedients. The lack of the ego ideal leaves individuals in a situation and set of circumstances where they lack resources.

The psychic structure of the ego ideal—which has often been referred to in this paper—is constructed during childhood when individuals realize that they themselves are not enough and that the universe is not at their mercy. They accept the idea of giving up a part of their narcissism and project it as an ideal which then becomes laden with personal interests, their parental identifications, and the

projects which they intend to bestow upon their psychic destiny. *In other words, it is through the intermediation of this action that individuals establish a relationship with the outside world; by the same route reality is able to enter their inner self.*

But in order for this operation to be possible—I would like to observe once again—the environment must provide values. Otherwise individuals risk losing their ego for an ideal. This usually corresponds to a phase of development in early childhood which is reactivated during puberty or adolescence. Because the ego ideal becomes a process of evaluation, the difference between what individuals are and what they want to become creates a gap. It is from this point that a subjectivity develops within which inner debate will be possible and the work of the interiorization of elements collected within them can be carried out.

It is precisely this operation which a large number of young people are unable to achieve because of a lack of the materials of identification and of culture by which to fill their inner selves. Their interiority remains flat and superficial. When the inner self is poor, it leaves space available for the emergence of impulsiveness and the practical expression of primary instincts and inner orientations. Communication also becomes very problematic and difficult. This reality explains the increase in psychopathologies affecting the inner dimension of young people, such as drug addiction, anorexia, bulimia, and forms of behavior involving emotional dependence along the lines of the "baby-couple" model[3]—a situation where the relationship of conservation is more important than the feeling of love.

To conclude this section, it should also be observed that the collapse of political ideologies—after they had caused the economic and moral degradation of a large number of peoples—has given rise to the view that a life cannot be constructed without reference to an ideal. It is no longer illusions which appear as a deception but the very sense of the ideal as a psychic function which comes to be

altered. In most depressive states it is to be observed that the ego ideal suffers from not being able to impart dynamism to the personality. It is unable to include the personality within a project; it no longer knows how to innovate—in short, it lives without a future. If the ego ideal does not experience a continuity in social life supported by shared and universal ideals, then the social field, relationships with other people, and the consequences of the actions of individuals for society as a whole lose their value. Persons remain with themselves, alone, as though they were in a desert.

Although individuals are the subject of social life and not merely a social effect or product, as has been proposed by Marxism, they can only become such at the price of education and transmission which awakens them to themselves and to reality through a life project. This life project is bound up with the will—that is, with rational research and a humanizing conception of existence.

One of the purposes of the inner self, it should be remembered, is to promote association between subjectivity and truth, between subjectivity and objective realities— that is, those realities which do not depend upon the individual. This internal process enables the individual to elaborate his impulses through secondary productions such as intellectual reflection, social, cultural and artistic relationships, the meaning of law, religious faith, or the upbringing of children and the formation of adults. It encourages the expansion and the development of an inner self, which means that a relationship with the outside world is both possible and beneficial for the individual and for society as a whole.

3. The Fragmented Society Neither Educates nor Builds

The essential problem of the crisis of interiority is to be found in upbringing. We have observed over the last twenty years that relationships involving upbringing have been increasingly neglected in a large number of contexts. Act-ing on the principle that children have all that they need for their development within themselves, adults have abandoned this role in favor of the autonomous upbringing of the children. These latter have to direct themselves and learn things on their own. These children cannot rely upon adults and thus develop a deficiency in support. They thereby come to look for dependency forms of behavior and for support during the stages of adolescence and post-adolescence. Indeed, early pseudo-independence weakens individuals who, in turn, look for alienating dependencies and seek to "lean" on others or on esoteric or magic activities and products because they lack internal resources.

However, the psychic function is always waiting for identification material in order to achieve development. It has to do its work in the face of a refusal: "Above all, do not identify with us—we do not have anything of value to propose!" This is what we can hear certain adults say who do not want to be objects by which children build themselves. And if everybody withdraws, psychism no longer has the objective material which it needs to advance. Without cultural material, personalities are left to the partial explosion of their impulses and draw upon objects which come from the archaic relationships of their childhood. Hence the international success of films such as *The Great Blue*, which symbolizes flight from others; *The Dead Poets' Society*, which is immersed in youthful idealism to the point of suicide; and *Wild Nights*, which asks the pathetic questions "How can others be found?" and "How can our emotions be identified in the confusion of feelings and psychic bisexuality?" Once again it is the elaboration of the inner self which is lacking. The fact that the life of the emotions and the senses prevails over thought is a telling comment on the state of contemporary subjectivity.

The formation of intelligence and awareness are two fields where we must work if we want to promote the process of interiorization. Reading, reflection on texts and on the thought of authors, is essential to this process. The images of comics and of television cartoons are unable to foster and promote this development. The written and spoken word develop the memory and mental images because they associate rationality, imagination, and feelings. The images of the screen are sensorial, factual, and without memory. When people watch them too often, they become depressed because of a feeling of not doing anything and of being empty.

In addition, the impoverishment of the inner self gives excessive space to externality. The notable importance attributed today to the body—which should thus bear the identity of the individual—is a good example of this. "I express myself with my body, but my head is unable to think!" When individuals no longer know what to do, they exhibit their own body and in some cases take off their clothes. Such rapidly revealed nakedness is more the expression of an incapacity to be ourselves than the manifestation of a new-found freedom. It is a way of canceling and distancing the anxiety caused by inner emptiness and uncertainty.

The bad working of the ego ideal is at the center of the life of men in the "depressive society" and expresses itself in a number of symptoms which can be observed through two principal phenomena. One is *drug addiction,* which is an expression of difficulties in occupying one's inner space and integrating the law. Because of a lack of resources transmitted by society, individuals come to lack guiding images and directives and thus become maintained in a condition of a body cut up into little pieces.

Suicide as an expression of despair (and not a symptom of anonymity, as described by Emile Durkheim) is constantly on the increase. Between 1975 and 1986 there was a 67% increase in the number of suicides committed by people between the ages of fifteen and thirty-four and a 42% increase in those over the age of fifty. The silence which surrounds suicide shows that it is difficult to ask questions about it and that people do not want to inquire into the motives which lead individuals to lose hope in themselves or in society.

At the same time young people become fragile because they have to look to themselves to solve their own personal problems and those of society, where previously they could look to such institutions as family, school, and Church for support and a place to grow.

The problems which we are faced with today are much more serious than those which constitute a crisis because a crisis is always limited in time and the outcome of particular difficulties and factors. Today we can see that all fields are affected and afflicted. For this reason, we can safely affirm that we are faced with a state of chaos where society is disintegrating and where there is a refusal to engage in the construction of symbols which are essential to the development and expression of individual and social life.

The depressive society is not a destiny, but a set of conditions which generate and maintain a cer-tain moral masochism. The same may be said of the derisive approach so loved by the mass media. It is as if the need to destroy were stronger than the need to live!

As a science of the unconscious, psychoanalysis, although it may not have a message of hope in relation to the meaning of human existence, has much to offer through its therapeutic methods—that is, psychotherapy and psychoanalytic treatments—and through its theory. It can promote an understanding of the individual and thereby enable him to deal with his own conflicts and live a better life. Psychoanalysis is a stance in favor of life and not a surrender in the face of the misfortunes and suffering of existence.

The seduction of despair is clearly present in the contemporary masochistic consciousness and constitutes a challenge which can be met only if we have the de-sire for truth and a desire to inquire into it in a spirit of love for life. But this hope also springs from another dimension which is both religious and moral. Here, however, we have a subject which is not the province of the psychoanalyst.

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Notes

[1] Impact Médecin Quotidien, Paris, n° 934, 16 septembre 1996: *Les prévisions de l'Oms pour 2020.*
[2] TONY ANATRELLA, *Non à la société dépressive,* Paris, Flammarion, 1993.
[3] TONY ANATRELLA, *Interminables Adolescences,* Paris, Cerf/Cujas, 1988.

MODEST KABANOV

Ideology, Politics, and Psychiatry

Psychiatry has been connected with ideology and politcs since distant times. This circumstance has found its reflection in the biblical parables, in the theological treatises of the Middle Ages, and in the more advanced periods of the evolution of society in its philosophy and morals. Psychiatry was not regarded as a medical science for a long time; it was more "within the competence" of the church, which interpreted it by proceeding from sacred positions. Care for the mentally ill was provided mainly by the representatives of religious confessions and their monastic services. The approaches to the mentally ill were dissimilar in different cultures and countries, and sometimes considerably varied. On the one hand, patients were revered as saints ("God's people") (for instance, the so-called "yurodivies," hysterical "prophesiers" in Russia); on the other hand, they were frequently treated as persons subject to demonic (Satanic) influences, as occurred in many countries of Western Europe, especially in the period of the Inquisition. Medicine, undeveloped at that time, practically did not give attention to them. The situation in psychiatry, its shaping into a special branch of medicine and science, began to change at the end of the 18th century (Pinel); and at the beginning of the 19th century psychiatry was recognized to be a sphere of medical activity, and it was agreed that "lunatics" ought to be treated and not morely supported by charity. It should be said, though, that in those already distant times, treatment often had a brutal character, which it maintained to a certain

degree for many patients up to the beginning of the fifties of our century, when the first psychotropic preparations appeared. However, at that time (at the beginning and in the middle of the last century), reformers appeared among the psychiatrists in some European countries who effectively began to apply the so-called non-restraint system when treating their patients. These were D.B. Tuke and D. Connoly in England, V. Chiarugi in Italy, W. Griesinger in Germany, I.F. Ruehl, A.U. Fraese and, later on, S.S. Korsakov in Russia. The influence of the "demonic forces" was replaced by the understanding of mental illness as a brain disease. This approach was vulgarized sometimes under the influence of philosophical schools (J. Moleschott, L. Buchner), but it was, however, a progressive phenomenon for that period in the de-

velopment of psychiatry. Though the emergence of the non-restraint concept had begun to complement the developing biological model of mental illness with its environmental "arrangement," still the changing of paradigm, i.e. comprehension of a mixed (biopsychosocial) disease model of a mentally ill person, did not take place at that time. Only today, in the light of the systemic approach, is this "model" finding more and more acceptance.

Strengthening the positions of biological psychiatry, in great measure under the influence of the German school of psychiatry, connected with the progress in the development of natural sciences, specifically physiology, biology and genetics. Political cataclysms in the epoch of Napoleon II and Bismarck, as well as of Russia under Nicholas I, called "the gendarme of Europe," led to reinforcement of state power. The ideological conception of "enlightened absolutism" and manifestations of intensified struggle between the materialistic and idealistic views in philosophy and the natural sciences have met with varying success to our day; all of this could fail to affect, directly or indirectly, the status of psychiatry both as science and the sphere of practical work. The first dissident appeared with the stigma of a madam (in Russia this was the philosopher Chaadayev, a friend of Pushkin). The latest achievements of biological sciences, chemistry and pharmacology in particular have led to development of an immense number of pharmacological (especially psychotropic) remedies; their number is

growing from year to year, nearly in geometric progression, and also represents, besides being a positive factor, a menace for the health of the population. At the same time, psychiatry remains almost incapsulated, fenced off from general medicine, society and human ecology. Stigmatization of the mentally ill person, as well as, to a certain degree, the psychiatrist (whose work is almost always surrounded by a haze of mysticism, of peculiar "magic"), still takes place, even though in different, softened forms, as compared to the times of Paracelsus. A mental patient remains in the opinion of many people a "loony," a kind of monster who ought to be pushed aside from the society of so-called normal people and only then treated by some medicines without penetrating into the core of his/her spiritual problems connected with attitudes towards his/her own self, disease, and the surrounding world (the family in the first place). And from the point of view of an average man (even a contemporary one), the psychiatrist "detects" "the insane," allegedly everywhere, and is himself a queer man, an eccentric. This viewpoint has been generally accepted by public opinion (including doctors with other specialities) and in various branches of art (in fiction and films, for instance). The biological approach to patients, which is still alive today (especially in the academic clinics), postulates a practically fatal genetic predisposition to mental disease, and this results in therapeutic nihilism and favours labelling (stigmatization) of the mentally ill. The dynamic psychiatric conception of Adolf Meyer and the psychoanalysis of Siegmund Freud failed to affect significantly these positions of classical psychiatry, especially in German and in Russian psychiatry, which followed ideology and politics for a long time. As a reaction to the "dehumanization" of psychiatry, which has an extremist character, we can see the emergence in Western Europe and the USA of so-called antipsychiatry (Cooper, Szasz and others), completely negating the medical model of mental illness.

This negation in a spirit of protest can also be attributed to the reform of the Italian psychiatrists who follow the ideology and policy of the Basaglia School in Trieste. The Italian reforms in the area of mental health services have their own pluses and minuses and are the object of differing judgements among Western psychiatrists, whereas they always met with a sharp rejection in totalitarian Russia. In our country, especially in the Stalin-Brezhnev period, all innovations which displayed, in the opinion of the authorities, an ideological colouring were ostracised. A purely biological approach to psychiatry reigned and was supported theoretically by the Pavlovian teaching on the "higher nervous activity," corrected "in the necessary direction" by the communist leadership and its scientific servants. Both in Hitlerian Germany and Stalinist Russia—the countries with markedly totalitarian regimes—the influence exerted by ideology and politics upon psychiatry manifested itself very distinctly, though there were also some differences in the approach to solving this "awkward" problem. In Germany, a considerable percentage of the mentally ill as well as the allegedly "inferior" Jews were subject to physical extermination. My acquaintance with the mental hospital in the town of Bernburg, in postwar Germany, where mental patients were being murdered with

gas in the basements of this establishment, produced a painful impression. These facts are less familiar to broad circles of the population, especially outside Germany, much less than the Nazi atrocities, for instance, in Oswiencim or Buchenwald. Luxenburger and Rudin were the psychiatrists of the Third Reich who defiled the role of the doctor and provided a theoretical basis for working out the racist laws of the Nazi ideologists. And it took place in enlightened Germany, where at the beginning of our century G. Simon laid in the Gutersloh Mental Hospital the foundations of contemporary social medicine based on the principles of humanism and respect for the diseased man's personality. However, not long before Simon and also in Germany, the well-known philosopher F. Nietzsche, who was seriously mentally ill himself at the end of his life, had made a considerable contribution to the *Ubermensch* (superman) ideology: his works, together with the works of M. Stirner and other philosophers, were used by the national socialists in shaping their ideology and policy. Some ideas of F.M. Dostoyevsky were also used by them in their politics for a certain period. The distortion of scientific, philosophical and even religious tenets for political manoeuvres in general policy, science, medicine and especially psychiatry as a branch of the latter to combat the "inferior" strata of society was also typical of other dictatorial regimes. The mentally ill in the Soviet Union during Stalin's time, though not exterminated directly, were kept under inhuman conditions. Instances can be mentioned when Russian psychiatrists in the thirties saved some persons ("the alien class element"), such as individual representatives of the clergy, nobility and even party functionaries, from imminent death by concealing them in mental hospitals. Later on, in the times of N. Khrushchev and L. Brezhnev, the psychiatric services were used for repressive purposes in the struggle against the differently minded (the so-called dissidents). But it occurred less frequently than is asserted today and not everywhere. It is well known to

me, since from 1960 to 1964 I worked as Chief Psychiatrist of St. Petersburg (still Leningrad at that time). The label of mentally ill ("madman," "loony") often pursued a person all his life. In the Soviet period, the attitude of the authorities as well as of scientific and medical ideologists towards psychiatrists was very negative.

Firstly, psychiatry was regarded as a minor science (as if not quite necessary) as distinct from therapeutics, surgery, obstetrics, gynaecology, etc. It was "consecrated" by the Pavlovian teaching and nearly tabooed due to the efforts of the ruling circles and their compliant scientific bureaucracy. It merely existed officially and was taught in an abridged form at medical institutes. There existed a network of mental hospitals (very neglected though, and quite often situated in former prisons, barracks for prisoners of war or convicts, in semi-downfallen monasteries) and psychoneurological dispensaries, which existed mainly in large cities. At the same time, prior to so-called *perestroika* (restructuring), psychiatry and psychiatrists were seldom mentioned in the general press. Some publications appeared solely in scientific literature, specifically in the only psychiatric journal. It is necessary to note that in the Tzar's era and early post-revolution years, up to the beginning of the thirties, many specialized journals were published in psychiatry and other related disciplines. Manuals for students and young therapists were also published in the Soviet years, but, beginning in the mid-thirties, they were studies lacking individuality and ignoring almost completely personal and environmental influences on the development of nervous and mental diseases. In our land of "triumphant" or "victorious" socialism it was generally accepted for a long time that psychiatry and the mentally ill compromised our ideology and our political systems leading towards communism, the latter being characterized as the "bright future of mankind." The advent of this future seemed imminent, even though nobody could describe its real form and content. Many illnesses, such as alcoholism, drug abuse, and other forms of self-destructive behaviour were called "birthmarks of capitalism" in those years or were explained by the "deleterious influence" of the "West." Mental diseases were mentioned, if at all, in the newspaper columns on "their morals" which referred to the "rotten" way of life of the West based on the merciless exploitation of man by man in capitalist society (one formulation was "mental diseases are ulcers of capitalism"). And since in the USSR there was not and there could not be any exploitation, psychiatry was in our country merely a "survival" of that society which must soon disappear. As a result of such "theories," a number of mental hospitals were even closed in many parts of our country (specifically in Leningrad), and new ones were not built as a rule. All, including medicine, was tendentiously ideologized in the structure of Russian society for many decades, and theoretically substantiated by the "immortal teaching of Marx-Engels-Lenin-Stalin" (even though Stalin disappeared from the number of above-mentioned "Fathers of the Church" after denunciation of his deeds by N. Khrushchev, yet the spirit of his conceptions and even nostalgia for his "wise leadership" are still alive in certain circles of the population). Psychiatry was not an exception; other anthropological sciences were ignored and even persecuted in Russia during the Soviet period. So, for instance, psychology was among those routed in the mid-thirties and dragged out a miserable existence for many years mainly in pedagogical institutes (as a kind of supplement to pedagogy). There were no psychological journals (until 1955); social psychology and sociology were declared to be bourgeois false science. The traces of this ideology remain to our day.

But, following the formal downfall of communism and collapse of the totalitarian system, the situation in Russian society represents a unique phenomenon in world history. A global crisis of post-communist and post-Soviet society ensued due to an absence of traditions and spiritual foundations in relation to politics, economics and psychology. Former ideals (false and utopian, though) have been lost as well as the "footings," whereas at the same time, liberty of speech, of the press, of the will, etc., lost decades ago and suddenly retrieved, fell on unprepared soil and turned into permissiveness accompanied by absenteeism, xenophobia and an even greater loss of spirituality. The number of cases due to stressful influences has increased sharply, first so-called borderline states, including neuroses, psychosomatic disorders and self-destructive behaviour. Interest in religion has awakened in society, due in particular to various crisis-related changes and accompanying stress factors, which we regard as a positive phenomenon. Unfortunately, this interest bears in many people a superficial and even feigned character (the 70-year rule of state-supported atheism has resulted in this miserable situation). Great preoccupation in all strata of society, specifically in psychiatrists, is caused by the emergence of an immense number of religious, semi-religious and overtly pathological sects, which are prophesying fantastic nonsense concerning the "end of the world," zealotry of various kinds and other dubious proposals (for instance, the so-called "White Fraternity," or Japanese Aum Shinrikyo Sect, which had many adherents in Russia). Many people mistrustful to-

wards all conventional institutions, official medicine, including psychiatry, among them, turn for advice to psychics (specialists in extra-sensory methods), parapsychologists and sorcerers and charlatans to not only get deliverance from their diseases, but also from "spoiling" and "bewitchment"; they believe in the reality of alcoholism treatment in the absence of patients by using their photos, and in deliverance from alcoholism "after one seance only," etc. Besides, these methods of healing cost a great deal of money.

Communism naturally suffered a fiasco; the totalitarian system collapsed, but survivals of both are alive, and much time is needed to get rid of them, especially in the spiritual sphere ("two or three unwhipped generations are needed," said A.I. Hertsen on one occasion). And here psychiatrists, in close unity with psychologists, social workers, teachers, lawyers,

journalists, and political scientists, must play an important role in solving a number of state problems connected with liquidation of consequences of the general crisis: for instance, training the cadres of modern-type specialists, participation in the so-called screening of leaders, rehabilitation of patients with manifestations of post-traumatic stresses, wide-scale psychoprophylactic measures, etc. We must not limit our activity only to solving traditional problems such as treatment and rehabilitation of already developed mental diseases, where considerable reforms are also necessary. But politicians and ideologists must understand us, the psychiatrists, first of all. They must not be afraid to get in touch with us, to establish contacts with us in every way for those problems where psychiatrists, psychotherapists, and social psychologists can be of help to them (to all of us, more precisely).

And this is perhaps the most difficult problem confronting contemporary psychiatry, which is changing its status. Psychiatrists, without losing face (i.e., their professional peculiarity), at the same time, paradoxical as it may sound, must undergo depsychiatrization to a certain degree; as a matter of fact, this problem has been discussed by many specialists, mainly social workers, for a long time (however, according to V.M. Bekhterev, the boundary between clinical and social psychiatry is a very relative one). But their voice remains a voice of one crying in the desert for both politicians and the public at large. Perhaps until some maniac "organizes" (God forbid!) another Chernobyl or something still worse.

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VINCENZO DI NICOLA

Culture and the Web of Meaning: Creating Family and Social Contexts for Human Predicaments

Introduction: Social Contexts

In order to understand the experience of mental illness in different societies, we need a vocabulary for those experiences and a method for understanding the "situated nature" of illness and suffering. This means that illness is situated in a given time and place, that is has a history and a geography, that it takes place in a network of relationships starting with the family and the social world. Together these particulars create and define culture as a "web of meaning" in the words of anthropologist Clifford Geertz (1983).

In this paper, which is based on my forthcoming book (Di Nicola, 1997), I define the notion of "predicament" to understand the human experience of mental illness and its expression in "idioms of distress" and "explanatory models of illness." The family and culture create social contexts for this understanding. As these social contexts are so crucial in shaping individual and family responses to illness experiences, I take stock of changes in Western societies and the accompanying trends in the human sciences, such as anthropology, family therapy, and cultural psychiatry.

Then, I review recent progress in two subdisciplines for the study of mental illness—family therapy and cultural psychiatry—to bring these changes together for a clinical model of cultural family therapy.

Defining Predicaments

Predicament is a concept that tries to grasp the human experience of illness in a meaningful context (Di Nicola, 1989):

predicaments are painful social situations or circumstances, complex, unstable, morally charged and varying in their import in time and place (Taylor, 1985, p. 130).

We can elucidate predicaments through the patients' personal histories and by understanding their "idioms of distress" and their "explanatory models of illness."

Idiom of distress (IDs) is a concept from medical anthropology to identify the ways people express their dilemmas and their pain in their local language and folkways (Nichter, 1982).

Explanatory models of illness (EMs) are what generates a person's answer to basic questions about their predicament: Why me? Why now? What is wrong? How long will it last and low serious is it? What problems does it create for me? How do I get rid of the problem? (Kleinman, 1988, p. 156).

Transcultural Psychiatry

The term "transcultural psychiatry" was coined in the 1950s by a group of psychiatrists at McGill University in Montreal. At the outset, according to Murphy (1986, p. 13), the field catered to three main target groups: 1) researchers interested in the influence of culture on mental health, 2) clinicians who found Western psychiatric teaching unsuited to practice in societies with very different cultural contexts, and 3) social psychiatrists seeking to add an international dimension to their concerns. The McGill group led by Wittkower and later the Transcultural Section of the World Psychiatric Association chaired by Murphy chose to bring together the first two concerns.

Raymond Prince (1983) offered a broad and practical definition: transcultural psychiatry is concerned with the comparison of mental disorder among different ethnic groups and/or cultures. In Prince's view, transcultural psychiatry deals with three areas:

1. Cultural variation in psychiatric symptomatology and diagnosis (comparative psychiatry),
2. The study of culture-bound syndromes,
3. How culture affects healing practices (such as indigenous healing practices).

One implication is that all explanations of mental illness arise from what anthropologist Clifford Geertz (1983) calls "local knowledge" and all therapies are what I call "cultural products," not just indigenous healing practices. Another implication is that all therapy needs to be culturally informed.

Emphasizing epidemiology (the study of the distribution of illness), Murphy (1982) called his landmark text, *Comparative Psychiatry* (the international and intercultural distribution of mental illness), which he defined as "the study of the relations between mental disorder and the psychological characteristics which differentiate nations, peoples, or cultures, whose main goals are to identify, verify, and explain the links between mental disorder and

these broad psychosocial characteristics" (p. 2). This important aspect of the field emphasizes objective population research using a comparative approach with little direct focus on or applicability to the problems of individuals or families who come for our help. With this objective stance, comparative psychiatry leans to the *etic* viewpoint which calls for the researcher to develop an analytic structure from the outside with concepts and criteria assumed to be "universal."

From the beginning, though, transcultural psychiatry was also interested in emic perspectives—generated within the specific culture in question. Questions from the "emic" viewpoint in transcultural psychiatry include: What is the experience of mental illness in a particular culture? How is it expressed by the members of that culture? How is it explained by them? and, What sorts of healing practices do they turn to for help?

"The New Cross-Cultural Psychiatry"

Arthur Kleinman (1977) of Harvard University criticized the "old transcultural psychiatry" as being preoccupied with "universals across cultures, notably externally-imposed Western psychiatric categories. In its place, Kleinman proposed a "new cross-cultural psychiatry," an interdisciplinary framework drawing on the rapidly expanding discipline of medical anthropology along with newer methods in psychiatric epidemiology. Kleinman emphasized a more "emic" approach, arguing that concepts of mental health and illness are culturally based and that concepts and therapies should be drawn from local cultures to be effective.

The view that emerges from cultural psychiatry in the 1990s is of a processual understanding of culture *situated in* and *created by* the social world of families and other interpretative communities.

With this growing emphasis on meaning-making and the social construction of reality, culture is a process "located not in the minds of individuals, but *between* people,

in the medium of intersubjective engagements" (Lewis-Fernandez & Kleinman, 1995, p. 434). This leads to the view of illness as embodied experiences based in biology *and* shaped by cultural processes. And cultural psychiatry emerges as the discipline that can examine the connections between social worlds and embodied illness.

Changes in Society and the Human Sciences

A number of significant developments in all Western societies are shaping the experience of mental illness ways that demand a socio-cultural approach.

In society:
* Diversity issues have become much more prominent in most Western societies; bilingualism and translation are common social concerns (Edwards, 1994).
* Racism has become more clearly identified as a *systemic* problem in society and in health-care professions (Fernando, 1988).
* Professional discourses have become politicized; for example, there is discussion of the political implications of psychiatric diagnoses and of professional practices.
* There has been a greater emphasis on understanding patients' perspectives, issues of advocacy, rights, and empowerment by professionals.
* The self-help movement, rep-

resented by the formation of the World Alliance of the Mentally Ill (by representatives of patient, consumer and self-help groups in many countries), has grown.

In the humanities:
* Postmodernism, born of the perpetual crisis of modernism including the diverse demands of multicultural societies, emerged as the dominant social theory (Harvey, 1989), undermining the foundation philosophy of the Western tradition (Rorty, 1989).
* With "text" emerging as a ubiquitous metaphor in social thought (Geertz, 1983), the field of semiotics (the study of signs and symbols) became the hot new social science, from literary and film theory, to narrative approaches in therapy (see Josselson, 1995).

In cultural studies:
* Transcultural psychiatry debates centered on the key themes of the universal and the particular, similarities across cultures versus differences and uniqueness, the "classic transcultural psychiatry" versus the "new cross-cultural psychiatry" (Kleinman, 1977).
* Pragmatically, much of the research in transcultural psychiatry focused more on clinical issues and introduced some valuable clinical ideas for diagnosis (on PTSD, see Marsella et al., 1996; on cross-cultural diagnosis, see Westermeyer, 1987), and treatment (on self-mutilation, see Favazza, 1996; on clinical methods in transcultural psychiatry, see Okpaku, 1996).
* "Cultural consultation is a collaborative effort" aimed at supporting rather than undermining local authority and expertise, relying on others as equals (Kirmayer, 1995, p. 168).
* Medical anthropology and cross-cultural psychology have become more mainstream, visible in undergraduate programs and in medical and other professional curricula.
* Psychology and other social studies have turned even more to questions about the construction of the self, identity, and family stories (Bruner, 1990; Gergen, 1991; Shweder, 1991).
* Sex-role studies have significantly rewritten the postmodern social landscape (Gilligan, 1982;

McDermott et al., 1983).

In the family therapy field:

* Attemps to integrate individual and family therapy.

* Increasing client-orientation is reflected in more visible techniques (open reflecting teams, instead of strategic messages a from a hidden team) and a more collaborative stance (interviewing as a conversation; therapy as a dialogue).

* More emphasis has been placed on pragmatic issues (how to resolve problems, how to empower clients) and brief therapy approaches.

* Constructivism and social constructionism have become the dominant conceptual models of family therapy, eclipsing systems theory (see Hoffman, 1990).

* Narrative has emerged as a new perspective in family therapy (echoing cultural anthropology's reviews of its own work) (see Paré, 1995).

In the light of all this, there have been a number of calls for paradigm changes—throughout the social sciences and among clinicians. We will examine two—one from cultural studies and another from family therapy.

"Paradigms Lost"—Changes in Social Theory

This catalogue of social changes has had its reciprocal impact on social theory. Here are three other related areas of the human sciences where new paradigms are being imagined.

1) Anthropology: In a brilliant essay that prefigured its impact on therapy, cultural anthropologist Clifford Geertz (1983) calls the text analogy "the broadest of recent refigurations of social theory" and "the most venturesome" (p. 30). Narrative thus emerges as a key idea for understanding human experience.

2) Psychology: Jerome Bruner (1990) and Richard Shweder (1991) call for the establishment of a "cultural psychology". Bruner, in response to the mechanistic features of the information-processing approach to cognitive psychology, wants to reinject meaning and narrative into psychology with a

focus on culture. Shweder rejects cross-cultural psychology, psychological anthropology, ethnopsychology, and other universalist approaches to a general psychology, arguing for cultural psychology as a study of the ways mind and culture jointly make each other up (p. 73).

3) Developmental Studies: Jaan Valsiner (1989) has conducted a trenchant critique of developmental psychology, calling for a "culture-inclusive developmental psychology." With Valsiner's work and others as a spring-board, I have called for a "transcultural child psychiatry" defined as "developmental questions about children's metal disorders in cultural context" (Di Nicola, 1992, p. 40).

Socio-Cultural Psychiatry: "A Relevant Viewpoint for Multicultural Societies"

In his critical book on race and culture in psychiatry in Britain, Suman Fernando (1988) defines a new approach to these issues. Fernando argues that psychiatry needs its own definition of its social and cultural tasks—not one imported from anthropology or family therapy. What Fernando thinks we need is:

a "socio-cultural psychiatry" that is sensitive to culture in a broad sense while maintaining a practical, perhaps pragmatic, stance in insisting on being relevant and useful to people that psy-

chiatry is supposed to deal with. Socio-cultural psychiatry is a means whereby psychiatrists, and other health workers who use psychiatry in a multicultural setting, can examine themselves, their institutional practices and their disciplines for social influences that produce and perpetuate bias. (p. 104).

In Fernando's view, socio-cultural psychiatry would incorporate sensitivity to cultural factors and extend psychiatry from individual concerns to family and cultural group, as I have argued. But above all, socio-cultural psychiatry is:

a viewpoint, as well as a way of working, that is relevant to the needs of a multicultural society, taking in social realities that affect cultural groups. (p. 104)

In his scholarly book on *Culture, Health and Illness,* Cecil Helman (1994) writes: "The relation of *culture* to family dynamics is complex, and to some extent controversial" (p. 288). Helman echoes some of the concerns voiced above about "the danger of stereotyping all Italian families," for example, in the "minietnographies of the family cultures of different ethnic groups in the USA" in the volume by McGoldrick and her associates (1982). Helman also registers the corollary concern of "ignoring major differences *between* families" based on other social and cultural variables (p. 299). He also articulates something that concerns me deeply—and is always treated dismissively when I raise it—that "family-oriented ethnic groups are sometimes described as if their differences from the Anglo-Saxon family type (with its emphasis on individual, rather than family goals were pathological by definition" (p. 288).

A New Story for Family Therapy: "The Family-as-Culture"

Bringing many of these threads together, David Paré (1995) calls for a new paradigm in family therapy, summed up in the following question and answer:

What would a family therapy look like that made no pretense of being value-free, that included a

temporal dimension, that included both persons and relations, that was contextual, that induced the reduction of power differentials between therapist and family, that hoped for, and promoted, the empowerment of families, that valued equality over authoritarianism, and that valued an education method as well as the therapeutic? (Erickson, 1988, p. 233)

Paré's answer is: "a therapy that views families as storying cultures) (Paré, 1995, p. 14). The narrative metaphor, a textual reading of life that sees lived experience as a text, "places persons in interpretative communities" (Paré, 1995, p. 14). By offering a model of therapy as "sense-making," searching for meaning, Paré argues that systems theory is an outdated story. The conceptual model he offers in its place is social constructionist epistemology. On the other hand, the postmodern stance moves away from either/or constructions to both/and juxtapositions. In this spirit, Paré reassures us that there is no need to reject useful ideas from the systems era of family therapy (see p. 15). But what is the truth? Where do we find bedrock? There is no final truth, only "preferred meanings" (Paré, 1995), "edifying discourses" (Rorty, 1989), and the "stories we live by" (Howard, 1991). I think it is time to stop calling for new paradigms and turn to *syntagm:*

Instead of bringing a working method with me into the session (paradigm), I try to capture a fresh, different discourse with every family, in every session (syntagm). (Di Nicola, 1993, p. 54).

There is no bedrock, only "final vocabularies," the irreducible language we use to make sense of the world, according to Richard Rorty (1989). When "stories go awry" (psychopathology, relational problems, human predicaments), the task of therapy may be best described as "story repair" (Howard, 1991). The best available tool for story repair may be the articulation of a new story in new words: what Michael White (1986) calls "redescription." As Paré aptly concludes: "by changing our meanings, we change our worlds" (1995, p. 15).

And what is the new metaphor for families, if they are not best seen as systems? In the "family-as-culture metaphor" (Paré 1995), families are interpretative communities, or storying cultures. In their book on "narrative therapy in the postmodern world," Parry and Doan (1994) invite clients to become authors, telling the stories of their own lives and recruiting an audience for their stories.

All the changes in society and in family theory that have coalesced into the emergence of a new paradigm for family therapy—based on narrative metaphors and social constructionist approaches— "families as storying cultures"— come together with my proposal for a synthesis of family therapy and cultural psychiatry as "cultural family therapy."

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ANDREA CALVO PRIETO

Family Reality in Regard to Mental Patients in African Countries

1. Introduction

There is no healing process in Africa that can be undertaken without the involvement of the family, which is viewed as a group that gives meaning to the individual, and as something that concerns everyone and can only function well with the participation of all, without exception.

The notion of health to the Bantus (peoples of the Central African Region) is a stage of complete well-being based on a way of living, good conduct and abilities in relation to the other members of the family group.

In black Africa, the family is considered to be made up of the entire clan, which is a collection of individuals who share a common ancestor, as far removed as possible. It is therefore a vast family system with no clear limits, and which reduces the individual member to his most basic state in the interest of the group.

The life of a person (his health, socio-professional fulfillment, etc) can only be conceived in relation to his family, within which his real value really depends only on his position as grandfather, father, son or grandson.

The obligations towards the family lead to an exaggerated influence of the powers of the group or of its members on the individual and, on the other hand, to a tactical withdrawal of the individual from personal responsibility.

Thus the happiness or misfortune of the black African always seems to be the business of others. The individual owes his material success of the community which, in turn, is as much entitled to enjoy that success as himself. His failures, for example, by falling ill, are considered to be caused by others with whom matters have to be settled before any return to prosperity can be expected.

This strongly paternalistic conception of the family is at the origin of the legendary African solidarity which, in theory, constitutes a counterweight to the rejection of the members of the family system. The individual receives from the group material support and protection against external economic, physical and mystical aggressions. Hence, traditionally speaking, the mental patient is never disqualified with regard to his contribution towards the cohesion of the family group; he simply changes his role, and assumes the one in which he is most useful. The African "madman" is a clear symptom of a problem within the group, and thus makes it possible to resolve unsettling conflicts that had so far been hidden or ignored.

Life in the towns, far away from the family to which people are inextricably linked by blood and by the land, compels individuals to group themselves into "neo-families" on the basis of their hailing from a common village, region of the country, or even a given neighbourhood. Under these circumstances, people come together as a matter of necessity; their rights and obligations are not rigidly binding, and their ties are not very strong given that, when all is said and done, these ties are based essentially on material considerations. In this type of "family", any member of the group who strays away is quickly excluded, especially if he behaves in an anti-social manner, which is the case with mental patients.

2. Material and methods

The study concerns 40 patients of Bantu origin who are chronic psychotics treated as out-patients in the "TELEMA" mental health centres in Kinshasa, Zaire, and in Yaounde, Cameroun, during the year 1995.

A personal history analysis which is as detailed as possible was carried out for each patient in order to determine the role of his family entourage in providing support to him.

We tried to determine not only the presence or lack of material support to the patient from his family group (shelter, purchase of psychotropic drugs, food, etc...), but also the availability and concern of the family in the face of behavioural disorders afflicting on of theirs.

In the observations, we try to interpret the type of support which sometimes goes as far as the rejection of the patient.

3. Data concerning the patients and their entourage

The study involves 40 patients, including 25 women and 15 men, all unmarried although 7 of them had had apparently unwanted children before or during the course of their mental illness. Their average age is 27.5 years,

with the extremes being 17 and 48 years.

None of the patients had attained a high level of education, and only 5 of them had been gainfully employed before the onset of their mental disorders.

The main family support is a close relative in 75% of the cases (30 patients); he is at least a family member of one of the parents in 20% of the cases (8 patients); he has a salaried job in 25% of the cases (10 patients); or he never showed up at all in 5% of the cases.

In the case of the guardians who presented themselves, consultations with soothsayers-traditional doctors had been arranged in 80% of the cases. And in all these consultations, the culprits had been pinpointed within the family except in one case where the patient was found to have personally involved himself in magical practices.

4. Observations on information concerning the patients

The ages of the patients involved in the study are consistent with those of psychiatric patients in black Africa.

The patients are relatively uneducated and do not have any income that could have made it possible to found a stable and respectable home in the negro-African context.

In reality, Africans recognize children who are valuable mostly for the future; active parents, that is, those who are still capable of producing children; and the elderly who are depositaries and guarantors of the wisdom to pacify or destabilize the group.

Bachelors remain "children" irrespective of their chronological age, and are thus trapped in the position of irresponsible, vulnerable and eternally protected members of the African family in its broadest sense. Under these circumstances, a mentally ill bachelor is quickly marginalized where there is no support from a large group, which is the case in towns.

In 80% of the cases, the mental illness would have been referred to a soothsayer/healer who identifies the external cause of the disorder, apportions blame, clears others of the charges, and reintegrates the patient in the family circle. All traditional birth and conflict resolution practices are used or exploited to explain the significance of a mental illness and to determine the healing process. Even the charismatic Christian movements quite often go through the family unit within which evildoers known as witches or evil spirits are hiding. Moreover, it is not enough to identify the demon or devil in person to reassure everybody, especially the patient himself.

In the final analysis, projection onto others, a favoured defence mechanism of Africans, helps to foster family solidarity Unconsciously, the African (Bantu) relinquishes his responsibilities in favour of the group or the family which alone is important. The individual who is only worth something as a member of the family cannot afford to assume any responsibility likely to upset the harmony and unity of the family. On the other hand, the family feels "obliged" to find the culprit responsible for any misfortune that befalls a member of the group. The family considers itself as one and indivisible, with the consequence the the suffering of one member is automatically shared by all the members of the group. In short, the most pathetic, miserable or sick member of the group becomes the concern of everybody.

As a result, the treatment of an individual must be based on a collective approach both in form (healing takes place within the group, and in public) and in substance (the entire group feels sick, or at least indisposed).

The healer, in order to reassured the patient and his family entourage, must not only relieve the visible symptoms plaguing the group, but must also, and especially, battle or give the impression of having conquered the inevitable occult or invisible forces which are responsible for all behavioral disorders. The fact is that any deviant behaviour is alien to the person concerned and, hence, can only have been induced by invisible forces. These forces can only be fought by those who are capable of returning what is visible to its normal state while uprooting the underlying evil accessible only to the initiated.

The doctor or healer must assume a double role, that of a "trained" practitioner (from a master or in a school), and that of an initiate (which requires the acquisition of powers that are incomprehensible or at least inaccessible to ordinary mortals).

The Central African Bantu Society may entrust its mental patients for peace of mind only to a person or an institution where visible physical treatment is supposed to be accompanied by a more-or-less supernatural know-how of the healers. This may represent an advantage for religious healers who have obviously been initiated, in their various orders, to fight against elusive forces through prayer and established discipline. After all, the social conventions which may have been trampled underfoot by the "madman" in question could be understood by others as divine transgressions or sins. Just like traditional taboos which can only be "corrected" through psycho-socio-cultural practices, sin can only be eradicated through a non-physical process and a psycho-affective medium.

The notion of "healing" in Black Africa leaves no room for relapse, recidivism or a mere attenuation or stabilisation of the problem. The family member, the patient who is not what he was before, even with respectable social behaviour, incites the family to look elsewhere. In the end, it is a frantic race towards the hypothetical doctor or healer who has the final solution: healing without the least unpleasantness in the future.

The mental patient's family can only understand the therapeutic framework of the psychiatric hospital as being the visible part of a process that must continue into the unprecedented, in an experience that is barely materialized by the collective memory supported by cultural beliefs (witches, ancestors, spirits, ghosts, living dead, evil genies, etc.).

In fact, the African "muntu" has two bodies, a visible one on which medicine works and an invisible one on which only a strategy that examines the invisible can work.

In modern diagnosis (psychiatric pathology) the African in general expects that, somehow, certainly not in western medicine, the real malady, the real etiology, of a behavioral disorder will be identified. For example, a guilty person practising witchcraft must be identified, even named (with the title or grade of witch). Thus the usual precautions will be taken to prevent the witch from harming the patient and his family.

The guilty party who is behind every illness in Africa, is in the end a necessary evil for society. He must exist; he must have "worked" in the dark so that there should be an "imbalance" within a family group. It is only after tracking down the guilty person and delivering the victim that the group can once more find peace. After all, one must know one's enemy to fight him well.

Habitually, the disease is transmitted by an incantation which must be revealed. Hence deliverance from the evil incantation can only be accomplished through a beneficent incantation, which must be public, and pronounced on a stage where the actors are the patient and his family.

The origin of mental illness in Africa is not exclusively linked to the group of living family members; ancestors or even invisible beings linked to the earth, the forest and rivers belonging to the family are also permanent dangers.

In the towns, where neighbours in a neighbourhood and colleagues at the workplace are the "family" of town dwellers, magical or occult practices are often incriminated as being at the root of mental disease. Paradoxically, these sources of harm bring people without natural family links closer to each other. They are unconsciously percieved as potential pathogenic links created by communal living which leads to a more or less close-knit group.

To the African, illness, like all other kinds of misfortune, naturally has a cause or at least an aspect that does not originate from the victim.

This extra-individuality of mental illness absolves the patient of all guilt and strengthens the unity of the family group. Here, the individual is what he is only thanks to, or due to the fault of the other members of the group.

Whoever touches the individual touches the family group; thus the witch-doctor is often seen as being sadomasochistic in the sense that, in harming another person, he is also harming himself as part of the family body, which is one and indivisible.

In rural areas, withdrawal from the family group (already rendered fragile because it is bigger and destabilized by the socio-economic crisis) on account of psychosis quickly triggers off self-protection and rejection mechanisms as a matter of necessity. Dependence on a usually small salary further limits the power to intervene, which is already weakened beyond the nuclear family (father, mother and children). By this very fact, the result is an abandonment of the traditional role of supporting others.

The mental patient is the first victim of this rejection (or, better still, of this lack of support). This is even more painful when there is a general lack of support structures at all levels. We are experiencing a kind of division between the unity of the family and the abandoning of the weakest member, who is thus exposed to the difficult socio-economic realities of the moment. In the end, we are confronted with a kind of fragmentation of the African family, resulting in the "marginalisation" of the mental patient.

In rural areas on the contrary, the family ends up accepting the special status of the mental patient who can calmly move unimpeded between his world of hallucinations and social reality, especially as the financial cost of this support is, in spite of everything, quite low in the villages.

In actual fact, the family can only be stable when all the members remain united in their way of thinking, their way of understanding, and their experiences of the vicissitudes of life. Unfortunately, in urban areas, solidarity is almost exclusively devoted to the economic survival of the family. Very little effort is devoted to the protection of individuals, especially psychotic ones.

In urban areas, the family group is characterized by its many latent or active conflicts due to the lack of unity between its members; thus is fosters the development or the manifestation of psychic disorders essentially based on the fundamental notion of conflict in relationships.

The future of the mental patient in Africa is inextricably linked to his family situation. The family must be sensitized and included in all stages of patient care, from the traditional understanding of the illness to the modern psychiatric care of patients.

It seems important to us to emphasize the need to create a social protection system for the mentally ill in order to restore the former role of the family in this respect.

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AMELIA MUSACCHIO DE ZAN

Society, Family, and Mental Health

The values of urban society have undergone very marked changes. As my generation well remembers, in economic matters one honored one's word, work was a positive value, the achievement of success through one's own efforts was logical, responsibility for and in one's actions was taken for granted and respect for older people, for one's father, one's teacher, one's priest, or for authority in general, was lived and experienced in a natural way.

Children are still seen by many parents as a blessing and families take care not only of their own children but also of the children belonging to other people—entirely as a matter of course.

There is still love and fundamental respect for parents. There is real affection between members of the family and there are also hospitality and a readiness to integrate the stranger or foreigner, forms of behavior which are a marked by a special warmth.

Increasingly influential circumstances rooted in different factors have had a negative influence on this kind of lifestyle. The practice of depending on a benefactor state has had a profound impact even though many people both in the past and at the present time have tried to eliminate the error of confusing the rights of the individual with an obligation which involves everything being obtained without personal effort. Furthermore, the culture of work has faded in almost unnoticed and imperceptible fashion.

This change in outlook has been so great that we are now faced with a situation where when a person does only what is in his own self-interest, receives money without doing anything to earn it, accepts bribes because it is the logical thing to do, engages in compromise because it is the only way to win, or behaves like an arrogant pupil who wants to be better, he is thought to be engaging in forms of behavior which are held up as values. The results of all this are a lack of personal responsibility—and an escape to the external is their common theme.

The vicissitudes which have taken place and a series of tiring sociopolitical struggles have caused immense damage to the achievement and practice of solidarity. The ordinary person observes all this and deludes himself into thinking that he is faced with positive changes. At the same time a constant "triumphalism" makes it difficult for him to remain loyal to his ideals.

Our society does not always cultivate its virtues, of which there are a great many, but gives great importance to the values of other societies in an attempt to give itself an identity of new youth.

Many people act and feel that they are the representatives of a clean, healthy, and dearly-loved country, and they do this at a very heartfelt level. At times it seems to be difficult to confess this love in public in the same way as it is difficult to admit love for God. Certain phenomena have the effect of inducing changes which obstruct the development of the best part of people and impede the belief that the family is something which must be defended and maintained.

For example, not so long ago psychiatrists like ourselves had to put up with the ideas about the family handed down by Cooper and Laing, the leaders of the anti-psychiatric movement. In his book *The Death of the Family* Cooper argues that it is "useless to talk about the death of God or the death of man.... We cannot directly expect the death of the family—this system assumes in the form of a social obligation the role of filtering in hidden fashion most of our experiences and emptying our actions of every kind of genuine and generous spontaneity." He also asserts that "the upbringing of a child in practice means the sinking, the submerging of a person. In the same way to educate someone means to lead him outside of and far away from himself."

These ideas and their proponents can exercise a certain seductive appeal on people who are not careful and cautious. However, their intrinsic deceit comes out when the author later goes on to say that "while writing the final parts of this book against the family I am afflicted by a very deep spiritual and physical crisis.... Those individuals who have accompanied me and looked after me with great care during the worst part of this crisis are my brother, my sister-in-law, and their young daughters." (5)

This deep psychology has been rendered superficial and has spread far and wide, and for this reason its ideas and concepts have had a major impact. As a result of this diffusion, we often hear the employment of such much-discussed terms as "liberation," "trauma," "complex," "assuming," and "accepting responsibility," used in ways which are completely divorced from their original con-

texts. These words, which are very detached from their roots, often bear latent or manifest criticisms against the stability of marriage, against the free and mature choice of the marriage partner, against the right to postpone gratification for the sake of a sound ideal, and against the decision to resist the dictates of an infantile impulse.

By way of example, we have heard it said over and over again to the point of boredom that repression is a source of various kinds of physical and psychic disturbance. But we do not hear it said with equal insistence that it gives rise to such negative effects as envy, hatred, and resentment, which employ the sexual impulse as a means of expression. The fact is that psychology in today's world is unable to deal with the subject of instinct in the same way as our society usually does in a variety of ways—that is, through the hypothesis that forces are at work which seek release. Instead, it relates instinct to the workings of the ego.

The ego distributes and connects in keeping with its structure, the nature of its relationship with the interior world, and the intimate and unrepeatable emotional situations of each and every person. (15)

Various writers refer to an area of the ego which is "free from conflict" and Kohut outlines to us the vicissitudes of the maturation of the "self" and its very delicate bio-psycho-social balance. He goes on to provide lessons on how that sophisticated being in a state of formation which is the human individual should be treated with care and tenderness. (13)

Other factors act together to upset mental health.

Advertising and the appeal of television are unrelenting. It is difficult to escape the charm exercised by the changes provoked by advertising. When the consumer mentality becomes established, not only can things be changed, but also one's marriage partner, friends, and even ideals. They all become mere consumer goods and are dependent upon the desires, the needs, and the whims of the moment.

In the same way as privations engender despair, irritate, oppress, disturb, or discourage, so material well-being weakens, softens, and prevents making serious decisions which involve the exercise of paternal or maternal authority and the acceptance of the natural phases of life which occur within the family.

On the other hand, given on the whole that it does not matter whether what advertising says is true or false, love for truth becomes alienated in favor of the desire to be able to buy—in this way the critical faculties of the individual become weakened. In this context, because the value of a man lies in what he has and not what he is, the individual ego yields and becomes submerged in an inhuman collective ego. At the same time, the achievement of this paradise on earth requires a hard and terrible effort.

The men and women who survive have a clinical profile which at first sight is contradictory—they are always very busy and at the same time passive; they strive to earn money and gain prestige but cannot enjoy them; they have an acute critical spirit towards privations but are themselves without a human and social sensibility; they seem to have strong characters, but they are weak in spirit. (15)

As we can see, society is permanently convinced by the mass media of the inevitability of divorce, marital betrayal, abortion, addiction, and the legalization of drug-taking. The superficiality and the corruption of the world complete this demoralization. On the other hand, it should be observed that corruption is the logical consequence of the elevation of money into an absolute value.

The constant supply of information in favor of the right to modify sexuality and the promotion of the naturalness of accepting alleged matrimonial unions between people of the same sex is followed by the logical conclusion that these unions should be allowed to adopt children.

Furthermore, we have witnessed a fall in the total number of marriages accompanied by an increase in *de facto* marriages, and this is especially true of the large cities. (1)

Families demonstrate a desire for stability but in many cases there are children looked after by only one parent. The absence, change or alternation of one of the parents is a common phenomenon. This is as true of poor families as of rich families. This reality provokes pathology.

At various international conferences and places of debate our country has defended the integrity of the family and promoted the defense of life from the moment of conception. However, those in favor of abortion now seem at times to be in the majority. The choice in favor of life is undermined in a whole variety of ways and forms.

We can detect attempts at deculturalization. The road signs in the cities and the billboards are written in English. The language of many people is debased and full of bad words—something which is taught them by the television. Good manners and good upbringing, elements which reflect charity and love towards one's neighbor, have been replaced by a certain dullness and anger in ways of behaving.

Our urban society is emptied of religion and the sacred. Cribs are hardly ever seen at Christmas. Father Christmas gives out presents and the Three Kings are forgotten. Holy Week for many people is a period of extended holiday which amounts to a good opportunity for rest and tourism.

Religious sects have proliferated among people without real values who have need of a spiritual life. Like healers and seers, they increasingly confuse people and distance them from more rigorous devotion and belief.

The mass media have an important role in all this because they offer as models adults who are not suitable. They are people with whom children cannot identify in the formation of a sound sexuality, who are not up to forming their characters, who do not inculcate joy in professional development, who do not inspire a sense of humanity and social responsibility within them, or direct them towards a transcendent projection of their personalities. Furthermore, this abandonment of duty has meant a retreat from initiative, and the schools have to perform a

number of roles with little or no help from the families of their pupils.

In some families things are given to children so that they will not disturb their parents, and when a great deal is given, in actual fact they disturb even more. So it is that they are left to search for leaders who appear to be more suitable than their parents, whoever these leaders may be, or they are pushed into an early independence or marriages at an early age with equally uncertain outcomes.

Henry Ey dwells upon other aspects of forms of mental pathology. (6) This great French psychiatrist, who recently left this world, demonstrates that mental illness is the pathology of freedom. Mental illnesses in various ways and degrees suffocate freedom and the ability to decide between different courses of action.

It should also be observed, however, that although patients can suffer the most serious forms of alteration, there nonetheless survives within them a hidden and lively personal life. This was well demonstrated by an episode I witnessed when I was a medical student and which I have never forgotten. A teacher who no longer loved his sick patients showed us a catatonic schizophrenic patient so that we could study the condition of "automatic obedience." The various positions which the patient adopted were a direct outcome of his condition.

In an unusual example of lack of respect, the teacher then grasped the patient by the hair and began to shake his head in order to bring out the point he was teaching. The sick man then gave him a sharp punch—without, however, displaying anger—and then proceeded to return to his autistic and catatonic stance and posture.

There can be no doubt that an inner life which is invisible to our eyes exists within people who suffer from very serious forms of mental illness. This is also the case when the intellect, the will, and the feelings are assaulted and kept down by the illness.

As the Fifth Lateran Council teaches us, (4) the soul is not only the form of the body—it is also immortal and is infused at its own specific time into the specific individual who receives it. The belief that the soul is created specifically for each individual compels the medical practitioner to adopt a very special attitude towards his patient—each form of treatment must be directed towards the human being even when that being is seriously weakened.

Visits to psychiatric hospitals have increased over recent years. If we consider the pediatric hospital of Tabar Garcia, we can see that the first visits numbered 2,783 in 1993 and rose to 14,641 in 1995. In the José T. Borda psychiatric hospital for men the number of visits in 1993 was 5,539 and 7,932 in 1995. In the Moyano psychiatric hospital for women the number of visits was 1,009 in 1993 and 1,768 in 1995. (2) Furthermore, 11.64% of patients admitted from January 1993 to March 1996 were psychopathic—that is, people who suffered from anti-social disturbances of their personalities. (3)

The OPS has demonstrated that the causes of death in Argentina between 1980 and 1990 were as follows: first, heart disease; second, malign tumors; third, cardiovascular illnesses; fourth, accidents; and fifth, arteriosclerosis. (17) In these statistics we can perceive the presence of conditions of a clear bio-psychosocial character and the consequences of the impact of illnesses involving social and psychosomatic adaptation.

Although the pathology of un-

derdevelopment is dramatic in its expression, and especially during childhood—deficiency illnesses, infections, diarrhoea, malnutrition, and the unemployment of both of the marriage partners—the pathology of development displays indicators of physical health which are undergoing rapid improvement, but which are paralleled by a worsening of psycho-social health which is expressed in sterility, suicide, divorce, and psychosomatic illness. (9)

At times one of the most brutal and unjust attacks which takes place and which people have to undergo is that of the spread of drugs. Many people adopt the impractical proposal that they should be made freely available. Among the many socioeconomic arguments which are waved about it is never made clear that this escape into a world of noncreative dreams and fantasies does not allow people to face up to, and to deal with, a life which however difficult at times is the only tie which allows the mental apparatus to function normally.

Cardinal López Trujillo has given very clear expression to one of the factors which is directly connected with the forms of social pathology which have been described in this paper. He argues that the phenomenon of drug-addiction is directly related in its incidence to levels of interior emptiness, lack of ideals, inner desolation, and a youth which has received nothing from the family or from society in the way of values by which to live in truth. Drugs are an escape, an unreal world by which an attempt is made to fill a gap. We have before us an existential void which leads to escape, to "journeys" of compensation, to a search for an elusive happiness. (14)

Nacht (16) reminds us that a strong ego has overcome fear and that it is only in this way that it will become free. A times this drug-taking of the young members of a family is an act of submission because they are afraid of both inner and outer reality. In this way fear makes them inferior, it standardizes the individual and leads the human being to delegate his powers of independent thought to other

people and thereby abandon his own self-determination.

In one way or another society creates conflict between the generations. The rootlessness and abyss between generations helps to generate—as, indeed, all psychiatrists have observed—schizoid and psychopathic symptoms, emotional coldness which hides a desperate need for love, and the search for substitute identifications in order to remedy by one way or another the torments of the super-ego. Contradiction itself becomes the sign of this damaging absence of care.

Contemporary forms of psychopathology include drug-addiction, alcoholism, dependence upon psychopharmaceuticals, work, and upon the attraction of television and computers. The alimentation pathologies such as anorexia and bulimia correspond to a bio-psycho-social correlate whose interiority is alienated because of the cult of beauty, being thin, and extreme values which involve both the family and society.

These pathologies of our time are connected with other very serious distortions of the personality.

The "borderline" personalities (10), (11), (8) have been described as "stable in their instability." The people suffering from this condition are impulsive, have profound difficulties with their personality identity, display irritability or unsuitable anger, and threaten suicide or actually carry it out. These are people who have intense relationships with others, but who swing between affection and idealization and hatred and devaluation. This provokes and involves emotional problems and difficulties in their human environment. Such people suffer from a feeling of chronic emptiness.

People who suffer from narcissistic disturbances of their personalities (19) are afflicted very early on by a lack of order in their affective tensions. Turned inwards in their desire to be admired and appreciated, they lack personal empathy, use other people for their own ends, have fantasies of grandeur, become easily offended, and usually engage in a kind of sexualization of their problems where they look for a way of releasing sexual charges through conflicts which are not sexual in origin.

Although these people have been described as individuals who display a permanent style of grandeur, it must be emphasized that they also suffer from a feeling of futility and emptiness when their defenses of grandeur begin to crack.

These forms of pathology are termed "deficit" pathologies because they involve personalities which in appearance are very solid but which from the outset lack a structured formation of the personality. Their egos remain very vulnerable for this reason. There are many causes behind these deficit pathologies, and one of the most important is to be found in the fact that such individuals, when they were young, were not suitably followed or appreciated to allow them to achieve a successful identification with the good aspects of their parents.

The lack of parents or tutors with clear ideas about what is good, bad, right, wrong, true, or false can give rise to a personality which has no moral criteria but which acts according to personal advantage, convenience, and need and without any moral contradiction between opposites.

It is more than evident that in a society the continuity of the traditional inheritance of ancestors is transmitted in a natural way only through the family, by means of

natural communication with those who are older—tales, anecdotes, ways of saying things, songs, friendship, and trust between the young and the old, certain warm intimacies between people of very different ages. All these elements, and many others, are priceless factors in building a sense of one's own value or identity.

How often we have seen in patients with problems of identity the phenomenon of the treatment beginning to work when they begin to stop rejecting what they have received from their parents and start engaging in a progressive understanding of those parents and in a process of reconciliation with many of the traditions which have been transmitted to them. This enables the patients to recover their own inner freedom and to start on other roads which are very different from those of their parents without, however, provoking a sharp break. On the contrary, this can constitute a step forward beginning with a fusion with the valuable elements of inherited ideals. This involves a recovery of the inner good of the individual; it means integrating the past with the present and constructing a harmonious base for the future.

This paper has involved a rather incomplete attempt to identify certain features of contemporary society—the reference to the demolishing theses of anti-psychiatry, the proud incomprehension of a widespread psychologism, the almost inescapable paternalism of propaganda which acts as a pathogenic element for vulnerable minds, the attack on children and young people caused by the weakness of adults and certain forms of aggression launched against their psychic structures which can be excused only with difficulty, and the convenience of seeing generational isolation as inevitable.

All this is often analyzed according to the cold criteria of sociopolitical bureaucracy and—I repeat the point—may have the character of an alarmist process of listing which, although it is true to life—as I indeed believe—is also only part of the picture. Here one might make reference to the research conducted in London into the emotional reactions of children

to the terrible bombing of the last war. It was discovered that the peace of mind and serenity with which the adults bore these bombings was the cause of the low number of children afflicted by traumatic shock. Furthermore, the level of infantile anxiety was proportionate not so much to a clear notion of danger as to the attitude and approach of the parents towards this danger. Moreover, when there was conflict within the family, the consequences were far more serious than those provoked by the bombings. (7)

This means that, notwithstanding the external violence, the real authors of harmony were the parents. Their children suffered the effects of the bombing only when the conflicts within the family rendered their parents the effective allies of the aggressors.

There is a great deal of hope, therefore, in the humble recognition of the fact that one's own erroneous behavior is what renders the family more vulnerable to the attacks of the external enemy. When the internal moral cohesion is intact, no form of destruction coming from the outside can cause serious injury to the children. (15)

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GISELA CRESPO

Anxiety: The Illness of All

Anxiety is a universal human experience, a vital force, with adaptive capacities, able to induce in the subject behaviour that will satisfy physical and psychic conditions necessary to the establishment of a biological, psychological or social equilibrium in a certain moment and context. Anxiety described in this way is normal anxiety.

We speak about pathological anxiety when the adaptative capacity is lost, exceeds the optimum limit for the harmonic functioning of the individual and reaches an intensity and persistence that is pathological.

Sobrad Cid (1959) has defined pathological anxiety as an "emotional state of painful affective tonality, accompanied by *sui generis* feelings of internal tension constantly regenerated and from which the patient cannot release himself." (8)

Anxiety disorders are the most common disease in psychiatry, and their disfunctional character, inducting great suffering, incapacity, and costs, makes them one of the most severe pathologies.

Among the more than a thousand million people in the world that suffer any kind of psychiatric disease, four hundred million have anxiety disturbances (Hiroshi Nakagima 1996).

Anxiety and depression, true "plagues of society," affect 30% of the general population in a certain moment of their lives, with evidence of an increase in this disease marking the Twentieth Century as the "Century of Anxiety and Depression" Stuart A. Montgomery 1993.(19)

W. H. Auden designated modern times as "The Anxiety Age." This anxiety has a sense of universality and it matters to all of us. It is related to a worldwide context of quick changes that force fast adaptive attitudes and impose new lifestyles that don't respect the traditional or familiar values. Before the Industrial Revolution, changes were slow, becoming swift after it. The scientific and technological advances exceeded man, without answers to the newly generated problems, and coming up sometimes with perverted solutions in the name of dignity and human rights.

Cities are growing in an anarchic way, erasing the memory of the old family spaces. Villages turn into a desert with the abandonment of the fields. The shortening distances supported radical transformations in rural life and impeded adaptation to new social standards. Unemployment rises in Europe and in the rest of the world and with it, insecurity and illegal activities. The big geopolitical spaces, the breakdown of the frontiers, brings new threats and reinforces the competition for survival.

We see the rush, the absence of time to have a good time; talking between people is lost, the ability to listen and be heard... even to look. War increases; people run away from fear, hunger and humiliation. The absence of integration programs aggravates the existing problems and exacerbates xenophobic behaviour. The adaptation problems patent in these populations can be severe, mainly in the weakest, in the presence of stress factors related to leaving their countries and families and confronting a new discouraging reality, sometimes even hostile. (3, 9)

Anxiety disturbances have been exhaustively studied recently; we now know that it is a very frequent pathology. Clinically, it can presents in three different categories of symptoms.

Subjective Manifestations – The intensity of the anxiety states ranges from some internal agitation to true panic: it can be accompanied by nonperception of phenomena.

Behavioural Manifestations – Very heterogeneous ranging from great agitation with self-aggression *raptus* to a deep inhibition. Appearance of avoiding conduct crucial to the life of the individual, usually with very invalidating personal and social consequences.

Somatic Manifestations – They are the neurovegetative *correlatus* of the anxiety disorders: digestive symptoms (diarrhoea, nausea or discomfort, abdominal pain), as well as respiratory (dyspnoea, suffocation, alkalosis that can put life in danger), cardiovascular (tachycardia, palpitations, chest pain, pre-cordial discomfort, hypertension), suduresis, trembling or shaking, hot-cold, urinary disorders.

These symptoms also have a cognitive component, which affects thoughts, perceptions and learning.

Independently of the intensity, the symptoms are felt as threatening (fear of dying, going mad or getting crippled). "Cognitive dis-

tortion" reinforces anxiety, adding more somatic symptoms and shaping true *ciclus-viciosus.* Anxiety acquires in this way characteristics of a true autonomy behaving as an "organising psychopathological nucleus" of the anxiety disorders. (14)

According to the international disease classification ICD-10, anxiety disorders are classified into: (7)

– Disorders of phobic anxiety:
– Agoraphobia
– Agoraphobia with panic disturbances
– Agoraphobia without panic disturbances
– Social phobia
– Specific phobias
– Other anxiety disorders
– Panic disorders
– Generalised anxiety disorders
– Mixed disorder of Anxiety and Depression
– Obcessive-Compulsive disorders
– Posttraumatic Stress disorder
– Somatoform disorders.

Epidemiology of Anxiety Disorders

Results vary very much among scientists, depending on the reference population and the way the data were collected. Nowadays we have more precise data as a result of more accurate methods, the use of standard equipment and multivariate statistic analysis.

In an American study (Mental Health Institute) and a Swiss one from Angst and Doble (Mikola 1985), the following prevalences were found (Table 1):

Risk Factors in Anxiety Disorders (12)

Social Demographic Factors

Sex: Preponderance in the female population; 66 to 90% according to Thorp and Burns, confirmed by others. In panic disorder the sex ratio varies between 1.5 and 6. In the single panic attacks and severe recurrent crises, the female preponderance is from 2 to 3 and 2.5 to 5, respectively. In panic disorders the female preponderance is questionable.

Age: Anxiety disorders have their beginning between twenty and thirty years old. The largest incidence is between 25 and 44 years old, dropping radically after 65. In social phobia the beginning is much earlier, between 11 and 15 years.

Marital Status: Panic crises are much more frequent in divorced and separated people than in married ones. This difference does not affect agoraphobia.

Social Cultural Factors

In panic disorder, especially in phobias (mainly the social phobia), there is a low social educational profile related to isolation, bad social-economic conditions and bad social functioning (avoiding behaviour).

Evolution and Prognosis: One of every two patients has an unfavourable evolution; a bad prognosis is connected with the unfavourable economic and social-cultural factors as well as a long period of disease (more than six years). Accentuated co-morbidity with somatic as well as psychic diseases. High mortality from cardiovascular diseases as well as suicides and consequences of alcohol abuse.

Precipitating and Predisposing Factors

Of organic nature: abusive of

substances and their privation. Alcohol (the most important), illicit drugs, coffee, benzodiazepins.

Life Episodes: Separation and loss are responsible for a great number of anxiety disturbances in the year, or most frequently the month, preceding their appearance.

Personality Factors

There are some individuals with a premorbid anxious personality than can be carriers of a stress adaptation mechanism deficit (Lepine et al). But in a general way the personality is perfectly normal. (15)

Familial Factors

We must consider genetic and environmental factors. Studies with twins revealed in 15 pairs a concordance for anxiety disorders in 41% of monozygotic and 4% in heterozygotes. Togersen (1983) found a very elevated concordance for panic disorders in monozygotic twins but not for generalised anxiety. (29) These studies confirm the strong genetic bond for panic disorders but not for generalised anxiety (Pauls D.L. *et al.*). (26)

Phobic Anxiety Disorders

Social Phobia (19,20)

One in every ten persons suffers from social phobia in a certain moment of his life.

There is a high risk of co-morbidity with different pathologies such as the major depression, agoraphobia and panic disorders, alcohol abuse and consumption of other substances.

Suicide is two times higher than in the general suicide population, independent from sex and social condition. It starts between 10 and 15 years with serious problems in the development of the child, education, professional preparation and also in the relationship with others. Social phobia, culturally, is more frequent in the West that in the East maybe because in these countries it is seen as a personality disturbances and therefore not curable. Nevertheless the clinical signs are identical.

It is usually sub-diagnosed or not

TABLE 1: EPIDEMIOLOGY OF ANXIETY DISORDERS		
	Masculine	Feminine
Panic Disorders	0.3 to 0.8 %	0.7 to 1.8 %
Agoraphobia	0.9 to 3.4 %	2 to 17.8 %
Anxiety Disorders	1 to 4 %	2 to 12.3 %

The results show a marked preponderance in the female population.

diagnosed at all, which makes the prognosis even worse. The social phobia has a malignant evolution, when not treated adequately.

The phobic person is characterised by "being afraid of being evaluated," which leads to behavior of dissimulation, rationalisation, avoiding. In this context he avoids medical help because he is afraid to face strange people, accepts his disease as normal, is afraid of the mental disease stigma, uses adaptive strategies (above described); disbelieve in the cure and in the doctor, and feels discouragement about the attitudes of the doctor.

When social phobia is not accompanied by co-morbidity recource to medical services is low, but with comorbidity, it is very important and superior to the non-phobic: 59% in ambulatory and 37% in psychiatry. Comorbidity varies between 75 and 90% of the cases (Table 2).

TABLE 2: CO-MORBIDITY IN SOCIAL PHOBIA	
Simple Phobia	59%
Agoraphobia	45%
Alcohol abuse	19%
Drug abuse	17%
Major Depression	17%

In social phobia there is no anticipatory anxiety, as in panic with or without agoraphobia.

The isolation in the social phobias is the pretext for depression, so common in the social phobics, and the idea of dying comes out as a solution: there is no desire to die but it is necessary! In this point it is different from agoraphobia.

Main Characteristics
in Social Phobia

• Fear of being watched by others
  in social events;
• Constant fear of being exposed
  to embarassing and humiliating
  situations;
• Avoiding of phobogenic situations

The social phobia responds well to treatment with RIMAs and SSRIs. Psychotherapy by itself is limited in results but it is of some value when associated with psychopharmaceuticals.

Panic Disorder

It is characterised by a sudden appearing and progresses very fast. It can be preceded by an *Aura* and duration is brief, disappearing after a maximum intensity period. The panic can appear in a spontaneous way or be unleashed by an ansiogenic situation that patients sometimes do not perceive.

It can result in two clinical patterns: psychological (discomfort with the feeling of imminent catastrophe, loss of control, fear of dying or going mad), and somatic (tachycardia, palpitations, sweating, dizziness with a great neurovegetative participation; dyspnoea, suffocation which can lead to alchalosis with dramatic medical consequences). Objectively the pulse is more or less 130b/min. with sistodiastolic hypertension (due to catecholamins) and hyperpirexia.

Associated with the anxious paraxistic manifestations some behavioural-cognitive responses arise, leading to the final clinical signs (uncontrollable agitation and/or escape to a "safe zone."

The disease progresses with repeated crises, between which there is an "anticipatory anxiety" because of fear of new crises. The drama in panic disorder is that the patient perpetuates and renovates his suffering (the frightening crises and the anticipation of the fear of new crises), and organizes his life around that fear. Avoiding behaviour regarding the supposed psychogenic situations appears, which leads to the isolation of the patient. There is a strong association with phobias, namely agoraphobia, depression, alcohol addiction. But the intensity of the anticipatory anxiety can be such that it dominates the clinical signs and is also a reinforcement to alcohol abuse. The neurobiological and behavioural changes linked to the alcohol metabolism aggravate the panic disorders, making the prognosis more severe (George *et coll.*, Chignon *et coll.*).

The mortality is high: toxic effects of ethanol, association with somatic diseases such as mitral prolapse, spasmophilia and the hyperventilation syndrome.

Panic responds well to a relaxation therapy and medicines like benzodiazepinesm RIMAs and SSRIs. There is need for a systematic diagnosis because treatment is possible and effective.

Biological Bases
Noradrenergic system, GABA-Benzodiazepinic receptor system, serotoninergic system, adenosine system, peptide systems.

Main Factors
in the Panic Disorders

• Sudden and dramatic beginning
  of the attack;
• Anticipatory anxiety;
• Strong genetic bonds.

Obsessive-Compulsive Disorders

The main points in this disturbance are obsessive thoughts (emerging against the will of the patient), or recurrent compulsive acts. The obsessive thoughts, ideas, images or impulses "introduce" themselves into the mind of the individual, repeatedly and distressingly because of their violent or obscene content and lack of any meaning to the individual, that tries at all costs to oppose them until he gives up. The compulsive acts are attitudes that repeat themselves and are not useful or pleasant to the patient. Usually they come along with autonomic symptoms of anxiety and anguish, internal or psychic tension.

Comorbidity in the Obsessive-Compulsive Disorders
With Depression it is very common. The depression symptoms can precede, accompany or follow the beginning of the obsessive compulsive disorders (OCD). The differential diagnosis bases itself on the early beginning and chronicity of the OCD, and the resistance to SSRIs and to the sismotherapy.
With other Anxiety Disorders... It is also very frequent: 47% with phobia, 18% with generalised anxiety, 14% with panic disorders. Alcohol abuse can be found in 24% of patients with

OCD. The panic disorders are present in 20%, agoraphobia with 11% and simple phobia with 10%.

With Panic Disorders... The clinical signs emerge sooner and alcohol consumption rises to 37% and depression to 89%. In these cases there is a heavy family history and the prognosis reserved with a bad response of the panic attacks to Aprazolan©.

With the Social Phobia... We see a drop in sensitivity to serotoninergic agents, and RIMAs are then indicated.

With Schizophrenia... In recent investigations it was found in 161 schizophrenics. Many authors corroborate the severity of the symptoms and reserved evolution in cases of double diagnosis (OCD+Schizophrenia). This fact has therapeutic implications, with the use of clomipramin, which improves the OCD...

With Motor Tics... The comorbidity is significant with the Gylles de la Tourette syndrome: 63% of the obsessive patients have tics and 50% of these have family backgrounds. Also in 25% of the tic carriers, there were familial antecedents of OCD. In another study, 22% of obsessive patients had a family background of tic carriers, against 2 to 3% in the general population. In the Gylles de la Tourette syndrome obsessions are frequently of great sexual violence. There is also a frequent association with bulimia and nervous anorexia with aggravation of the clinical signs and prognosis. The presence of disturbed personalities is also very frequent but OCD itself can be responsible for perturbations of the personality difficult to distinguish from primary, secondary or coexistent personality perturbations. (13)

Considered a rare disease, we know today that OCD is a high prevalence disease twice as frequent as schizophrenia or personality disturbances. Of high prevalence in teenagers and young adults it is frequently sub-diagnosed or not diagnosed at all, because of the lack of cooperation by patients. There is a higher prevalence in the poor population. In a general way, only when

there is need for hospitalization is the diagnosis of OCD made. In a group of students that were hospitalized during the school year, in 17% OCD has been diagnosed, against 1.5% of nonhospitalized students. These studies confirm the frequency of the disease, the incapacity it causes and the need to go through medical units. For this reason doctors must be alerted to OCD. The treatment consists of SSRIs, with very good results. The biological basis of OCD is related to a specific disturbance of serotonin.

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FERRUCCIO ANTONELLI

When Disquiet Invades the Body

1. The Reasons Behind the "Leap from the Psychic to the Somatic"

When disquiet invades the body: this phrase captures the whole concept of psychosomatic medicine, a current of thought which recognizes the strict interdependence between the mind and the body (the psyche and the soma) at all levels—from the physiological to the pathological, and from the preventive to the therapeutic.

"Disquiet" is the precursor to "disturbance"—disquiet precedes disturbance, it is an alarm bell which calls for immediate adaptive action. But if it persists it produces disturbance—that is, a state of illness.

Disquiet is an "emotion," a state of being characterized by ill-humor, dissatisfaction, the wish (or the need) to change something in order to return to a state of well-being. A banal example of disquiet may be found in the example of the tiredness of an arm after carrying a suitcase. Here the remedy is of an elementary nature—the suitcase is put down and picked up again with the other arm—that is, that the emotion of disquiet is "managed" in cognitive fashion, which means with rational methods, and thereby eliminated.

But this process is not always easy because some (indeed, many) emotions of disquiet are of such a character that they cannot be "managed," and this is for three reasons: 1) either because they are sudden and fleeting (for example, a feeling of fright hits us like a slap in the face; indeed, it strikes the heart and makes it beat—palpita-tions—without giving us time to reflect); 2) or because they are so complicated and intricate in nature as to prevent us from understanding their limits, identifying them clearly, or translating them into thoughts (in order to reflect upon them) or to express them orally (in order to talk about them and unburden ourselves); 3) or, to conclude, because they are evident and clear in character but we are aware that we do not have any practical means by which to deal with them and manage them.

In such cases emotions cannot be expressed through normal psychological channels—that is, through thoughts, words, behavioral adaptations (perhaps even through shouting or banging one's fist upon the table)—but take the route of the body and "speak" with the guts or the muscles. In technical terms one speaks here of "acting out," by which is meant a

process where a feeling becomes an action (acting) and comes out (out) from its true natural location (the psyche) and invades the soma. Typical examples of this are "breaking into tears" in order to interrupt a discussion which is pushing one to the very limit or a situation which we are not able to control. Or even an act of vomiting which symbolizes the "rejection" not of a gastric intake but of a situation which has become unbearable and intolerable to us. Or an attack of ejecting diarrhoea which symbolizes the passing of the danger—given that I cannot escape, I let a part of me run away.

2. Why Somatizations Are on the Increase

Disquiet somatizations—that is, psychosomatic manifestations—have always existed and taken place. Even Plato and Aristotle perceived their presence. But at the present time they are constantly on the increase, and are present in a good 80% of human beings, whether they are ill or not.

One of the first reasons for this state of affairs lies in the fact that the daily lifestyle of civil society (which is industrialized, culturally diversified, mechanized, electrified, computerized, and accelerated in its rhythms) is an endless source of disquiet. Progress seems to make everything much simpler but in reality it imposes frenetic rhythms upon us; it requires us to have a state of alertness which is so constant and intense that at an internal level it reaches unbearable and intolerable heights. It deprives us of those pauses to which
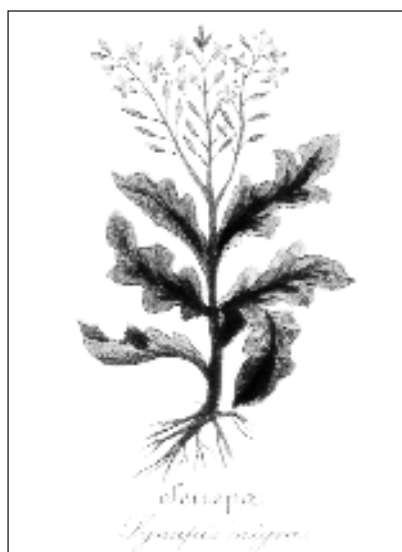
mankind was used and to which it was attached for centuries, such as going for a walk, a family meal, the pleasure of playing with children and grandchildren (as used to occur before the emergence of the baby sitter), or playing as an end in itself (before sport became unnatural and changed into a veritable form of commercial activity).

It is certainly true that stress (stressor and stressed) only afflicts those who allow themselves to be stressed: it is said that rain falls on everybody but only wets those who do not open their umbrellas. But, to continue with the metaphor, whereas once it rained every now and then, now we are faced with a deluge, and as a result everyone gets wet. Progress should certainly be welcomed, but it remains a fact that those who have not experienced it somatize much less, such as animals and the peoples of the third world, where the rate of psychosomatosis corresponds to the level of development.

A second reason for the increase in the presence of the somatization of disquiet is to be found in a new approach to the body promoted by contemporary culture. In Homer's Greece the "soma" was the body—the strong arm or swift foot of heroes were separated from their corpses. Until a century ago the body was a value only during youth. This was when one died too young, when at the age of forty one was in decline, at fifty obese, and at sixty on the way out. Today a large number of those aged seventy or over play tennis, and at all ages men and women take care of their looks through cosmetics, aesthetics, fitness, dieting, and so forth. It may be the outcome of a myth or of fashion, but such, indeed, is the situation. In the collective mind the body has become a constant and inflated value. To speak with the body at one time was the sole prerogative of young and beautiful women, and of Hollywood film stars. Today nearly everybody speaks with their bodies. We should not forget that psychosomatic disturbance is itself a matter of "speaking with the body."Alexander defines it as the "symbolic language of the bodily organs."In the frequent distur-

bances known by the term of panic attacks (the famous DAP) the organs even seem to explode in a great scream. In technical terms we speak about a "vegetative storm"—the storm is made up of a set of wind, thunder, lightning, inundations. In the DAP we encounter palpitations, sweating, tremors, pains everywhere, a feeling that one is about to faint, anxiety about death, the need for air, and disturbances of physical balance.

3. What Disquiet?

In this conference the term "disquiet" is employed with a very wide meaning. In the case of psychosomatosis, on the other hand, disquiet has a very specific connotation—the psyche of the sick psychosomatic person is *healthy* in its structure and functions (indeed the schizophrenic person or the individual suffering from the Down syndrome never somatize) but is *fragile* in the control of emotions.

The disquiet which involves somatization is existential—that is, there is something "which is wrong" in the existence of the individual. By this we mean in the way of existing, in the lifestyle, in the relationships with the family members, or at work, or with food, in bad habits, and in the anti-economic administration of such emotional potentialities as love, ambitions, values or morality.
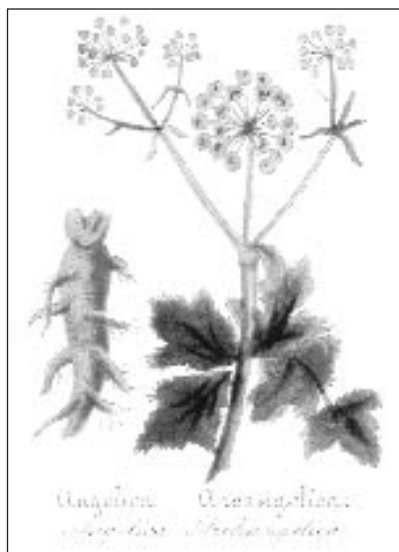
It is impossible to list the infinite number of aspects of the prism of disquiet. I will cite only one amongst the most common—loneliness. This does not mean the isolated life of hermits. It means feeling alone. Quasimodo wrote: "Everybody is alone in the heart of the earth." Various categories are as alone as hermits, alone in the spirit. The elderly, for example, despite the physical presence of children and grandchildren; old age pensioners who have invested too much in their working lives and not enough in their emotional lives or in pastimes or hobbies; the handicapped; the maladjusted; those who have fallen from wealth or from positions of prestige or power; and the wretched, those who have failed even in the supposed remedy of drugs or alcohol. So-called hypochondriacs are also alone, those people who go to the doctor because they feel that he is the only person still ready to offer them help.

Loneliness is a pathogenic factor which is as serious in its implications as any virus. It can double the probability of disease and of death. As can be seen in so many cases of widows and widowers who finish their statement with that horrible phrase "by now," a phrase which mental hygiene wants to cancel from every dictionary on the face of the planet. Never say, "by now"—this is a phrase which connotes suicide. And never say "I suffer from loneliness"— it is as unhealthy as going for a walk in the snow dressed in a swimming costume. The care of loneliness is very simple: one need only adhere to the so-called "safety agencies" such as the family, clubs, old people's centers, voluntary work, and so forth.

I referred above to hypochondriacs. It should not be thought that these are the prototype of the psychosomatic patient. There are psychosomatic disturbances—that is, illnesses caused by disquiet which at times are fatal in their impact, such as heart attacks or cancer. We are all well aware of famous people who have been destroyed by cancer after being destroyed psychologically by highly distressing events such as loss of dear ones, arrests, or failures. This should not

surprise us. Serious occurrences in life (so-called "life events") cause a lowering of the body's defenses, exactly that special malfunction of the immune system which is the primum movens of the process of cancerogenesis.

4. How to Defend Oneself

Some degree of somatization is inevitable, somewhat on the same scale as a head cold and, therefore, not difficult to bear. However, it is absolutely essential to keep the state of somatization from becoming chronic. In order to ensure this an attempt must be made to tackle the disquiet-emotion at its source. Tackle, not confront. A confrontation implies commitment, an effort, heroism—approaches which are not very useful and which are also very expensive in terms of the economy of the psyche. In contrary fashion, "tackling" means trying to find a solution with a certain calm, perhaps a solution which is only partial and temporary, but which nonetheless is reassuring or at least relaxing. The technical term employed here is the English word "coping." The English say "hope and cope." The technique of coping is a form of psychotherapy, on a par with counselling and problem solving, terms which do not correspond to the Italian phrases "to advise" and "to solve problems," but which are nevertheless very near. Not all problems can find a solution but they can, after a certain fashion, be tackled. The Chinese declare with wisdom, and have done so for centuries, that "if there is a remedy to a problem, why worry, and if there isn't a solution, why worry, anyway?"

The rules of mental hygiene to ensure a warding off of the risk of the somatization of disquiet are few in number, but essential. Perhaps at root there are only two:

1. *Adaptation.* There should be no rigid taking of positions, no "always" or "never." We must learn to be "walls made out of rubber." Adaptation does not mean passive acceptance, surrender, or humiliation—on the contrary, it means positive, productive and winning behavior. Under the weight of snow the branch of an oak tree may well break; the rush which bends, however, manages to survive.

2. *Good humor.* Putting things in their proper perspective and justifying are much more healthy than hatred and anger. Lorenz used to say: "The man who laughs does not shoot" at himself or at other people. This is a truth which we would do very well to reflect upon.

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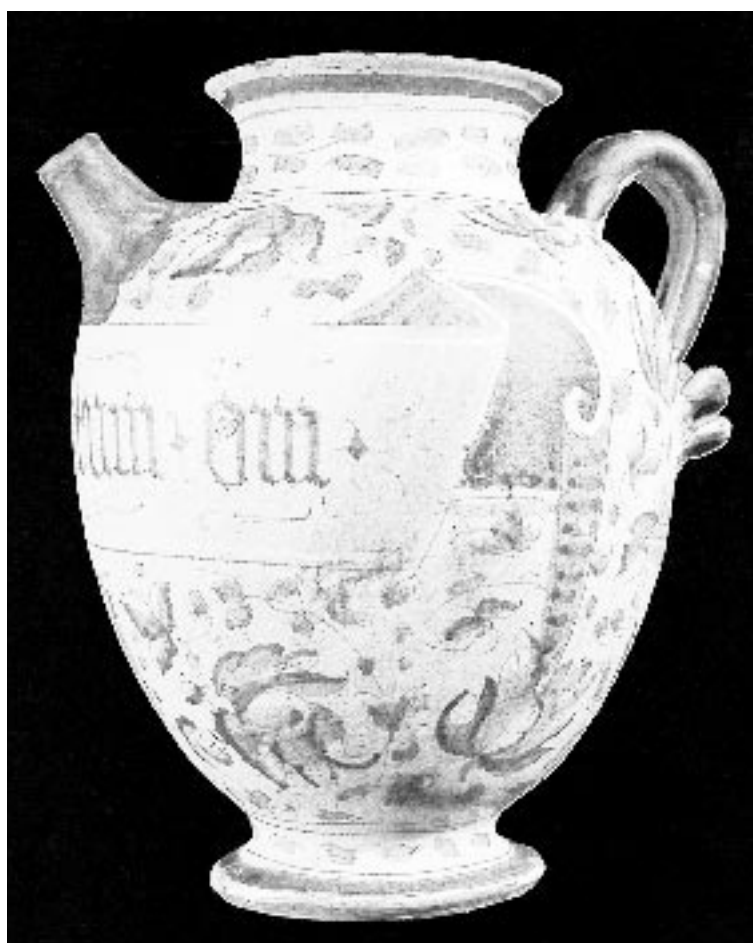
JULIO LICINIO

The Biology and Psychology of Depression

Introduction

Depression is a state that can be experienced by all human beings as a reaction to loss or deprivation. Depression is also a severe disease that affects the mind and the body. How does one differentiate feelings of depression experienced by all of us from the disease of major depression that affects only certain individuals? Feelings of depression that are part of the general human experience are not long lasting; they are not associated with severe symptoms, and they tend not to affect function. For a diagnosis of major depression to be made it is required that an individual feels depressed or has a general lack of interest for at least 15 consecutive days. Moreover, there should be associated symptoms affecting appetite, sleep, sexual activity, memory, concentration, hopelessness, and despair, most likely resulting in detrimental effects on performance of professional and personal duties.[1,2]

Can depression be caused by the modern world? That is an important and complex question. Depression has been reported since antiquity; therefore, it is not a "modern" disease. Nevertheless, many believe that the stress of life in the 20th century contributes to precipitate depression. That hypothesis is hard to test experimentally. Sociologists earlier in the century postulated that the industrial production process that alienated the worker from the product of his/her work might cause stress, hopelessness, and depression. Social research no longer focuses on stress as the result of the industrial production process, as it has not been demonstrated that assembly line workers are more de-pressed than the population at large. Social studies on stress are now testing the hypothesis that stress may be caused by administrative work involving decisions that affect job security. It is still unknown whether social factors cause clini-cally-relevant stress that contributes to depression.

Major depression is a universal experience that transcends cultural boundaries. It is among the most common forms of mental illness in the world. A recent population-based epidemiologic study assessed the rates of depression in 38,000 community subjects in 10 countries: the United States, Canada, Puerto Rico, France, Germany, Italy, Lebanon, Taiwan, Korea, and New Zealand. The results showed that lifetime rates for major depression vary widely across countries, rang-ing from 1.5 cases per 100 adults in the sample in Taiwan to 19.0 cases per 100 adults in Beirut. The annual rates ranged from 0.8 cases per 100 adults in Taiwan to 5.8 cases per 100 adults in New Zealand. The mean age at onset shows less varia-tion (range, 24.8-34.8 years). In every country, the rates of major de-pression were higher for women than men. Insomnia and loss of en-ergy occurred in most persons with major depression at each site. Indi-viduals suffering from major de-pression were also at increased risk for comorbidity with substance abuse and anxiety disorders at all sites. Persons who were separated or divorced had significantly higher rates of major depression than mar-ried persons in most of the coun-tries, and the risk was somewhat greater for divorced or separated men than women in most countries. These large datasets show striking similarities across countries in pat-terns of major depression; however, the differences in rates for major de-pression across countries suggest that cultural differences or different risk factors affect the expression of the disorder.[3]

The Psychology of Depression

Psychologically, melancholic major depression presents as a state of organized negativistic outlook, especially attached to one's sense of self: typically, the profoundly de-pressed individual feels either like a burden to others or the object of their disgust, and is hopeless about the prospects that this worthless self may have for future gratification in either love or work. Because these feelings rarely yield to the individ-ual's most carefully constructed ar-guments, the sense of helplessness is exacerbated. Consequently, shame deepens and a vicious cycle is initiated that can lead to suicide.

Major depression is also classi-cally associated with inhibition of physiological events that are associ-ated with restorative functions, in-cluding sleep, eating, growth, and reproduction. The response rate of melancholic depression to antide-pressant treatment is in the 60-80% range.[4]

Cognitive elements and vision of life contribute to personality struc-ture and to life experience. Al-though there are no standard cate-gories under which specific intel-lectual orientations towards life can be grouped, there is some conven-tion for assessing whether a particu-lar view corresponds more closely to a comic, romantic, tragic, or iron-ic vision of reality. These visions

differentially shape expectations in life and the sense of the place that disappointment, ambiguity, sadness, risk, and triumph play in human affairs. As such, they interact with other aspects of life experience, learning, temperament, and biological predisposition and are postulated to modulate the response to external reality and inner experience, and hence towards or away from the contingency of depressive despair.

We now believe that the burden of internal conflict and external stressors interacts with genetic susceptibility and other biological factors to influence the likelihood of the development of clinically relevant major depressive disorder.[1,2]

Depression and Stress

As the genetic basis of depression is still unknown, we have focused our research on the biological mechanisms of the stress response and their role in the biology of major depression. Moreover, by defining the biological basis of the stress response we can address the intersection of biology and psychology in major depressive disorder.

Specific circuits in the brain modulate the response to stress. Those include the autonomic nervous system, and neuroendocrine networks.[5] We have studied the hypothalamic-pituitary-adrenal (HPA) axis, and its role in the biology of depression, for several reasons. 1) Corticotropin-releasing hormone (CRH), a 41 amino acid neuropeptide that is synthesized in the hypothalamus, and extra-hypothalamic sites and that regulates the HPA axis, can cause a syndrome of behavioral and biological stress.[6,7] 2) Classical, melancholic major depression is associated with increased activity of the HPA axis, caused by high levels of CRH, and adrenal hyper-responsiveness to adrenocorticotropic hormone (ACTH).[8,9,10] 3) Drugs that treat depression lower CRH gene expression in the hypothalamus.[11,12]

Having ascertained that there is dysregulation of the HPA axis in depression, we have now expanded our concepts and propose that depression is not only a disease of the mind but that it affects the functioning and the structure of the human body. Thus, our group and others have looked at anatomical and functional alterations that can occur in depression as a result of increased activity of HPA function, caused by increased CRH production.

The somatic consequences of stress-system activation in depression

Decreased bone mineral density in women with depression.

Our group has recently found that pre-menopausal women with current or past major depression have clinically significant decrements in bone mineral density,[13] as assessed by dual X-ray absorptiometry (DEXA). Women with past or current depression were individually matched for age, height, weight, menstrual status, reproductive history, ethnicity, and for a variety of factors known to influence bone mineral density, such as smoking, alcohol consumption, etc. As compared with healthy women the mean ($\pm$SD) bone density in 25 women with past or current depression was 6.5% lower at the spine (depressed women 1.00 ± 0.15 g/cm^2, normal women 1.07 ± 0.09 g/cm^2, $p=0.02$), 15.7% lower at the femoral neck (0.76 ± 0.11 vs. 0.88 ± 0.11 g/cm^2, $p<0.001$), 13.5% lower at Ward's triangle (0.70 ± 0.14 vs. 0.81 ± 0.13 g/cm^2, $p<0.001$), and 10.8% lower at the trochanter (0.66 ± 0.11 vs. 0.74 ± 0.08 g/cm^2, $p<0.001$). In addition, women with past or current depression had higher urinary cortisol excretion (71 ± 29 vs. 51 ± 19 µg/d, $p=0.006$), lower serum osteocalcin levels ($p=0.04$), and lower urinary deoxypyridinoline excretion ($p=0.02$).[13] We have also shown that there are no differences in vitamin-D-receptor alleles (Aa, Bb, and Tt) in depressed women and control subjects that might explain these findings.[13,14] Thus, it is likely that humoral factors cause loss of bone mineral density in depressed pre-menopausal women.

Our group of 25 women, average age, 41 years, showed a mean bone mineral density at Ward's triangle of the hip that was similar to that seen in post-menopausal women at age 70. Because 35% of post-menopausal women at this age have one or more osteoporotic fractures, this finding is of clinical significance. Approximately 40% of the premenopausal women in our study showed bone mineral density determinations two or more standard deviations below peak bone density, a level which represents a loss in bone strength sufficient to render them at present risk for pathologic fracture.

Patients with depression have been shown to manifest several alterations in neuroendocrine regulation that could contribute to loss of bone mineral density. Approximately 50% of patients with depression manifest hypercortisolism,[1,2] and moderate hypercortisolism of the magnitude seen in depressed women manifesting decreased bone mineral density can accelerate bone loss.[15] However, the mean loss in trabecular bone we observed (e.g. 15% in Ward's triangle) far exceeds what could be expected on the basis of hypercortisolism alone, so that other factors must be implicated. Decreases in growth hormone (GH) secretion can also contribute to loss of bone mineral density;[16] however, the subjects with past or current depression showed no evidence of hyposomatotropism, as evidenced by normal insulin-like growth factor 1 (IGF-1) and IGF-binding protein 3 levels. Decreased sex steroid levels also contribute to loss of bone mineral density,[16] but our depressed subjects with bone mineral abnormalities did not have amenorrhea during depressive episodes. Thus, the causes of this dramatic decrease in bone mineral density in women with depression are not yet fully elucidated.

Hippocampal atrophy in depression

Interestingly, Sheline *et al.*, studying women with a mean age of 68 years, found hippocampal atrophy in patients with depression, when compared to sex- and age-matched controls.[17,18] The causes for this neuroanatomical finding are still undetermined. Cortisol causes neuronal loss and hippocampal atrophy in experimental animals. Hippocampal atrophy in depressed women was correlated with duration of illness, suggesting that expo-

sure to high levels of cortisol during episodes of depression contributes to this finding.[17, 18]

Molecular mechanisms for stress-related susceptibility to disease

We have also examined molecular mechanisms by which depression, through elevated CRH production, might contribute to physical illness. Living organisms are constantly exposed to stresses that threaten homeostasis. Several aspects of the response to stress potentially influence susceptibility to disease. CRH is one of several stress-responsive substances that influence the response to pathogens and susceptibility to disease. CRH participates simultaneously in the organism's response to stress and to inflammatory mediators;[6, 19, 20, 21] it is present in the hypothalamus, and it also acts directly as an immunomodulator.[22] Because of these actions, CRH is an important mediator of the interactions between the nervous system and the immune system.

The cellular response to CRH occurs after the ligand binds to specific G-protein coupled receptors,[23] initiating events leading to changes in gene transcription. CRH receptor binding leads to accumulation of cAMP and intracellular free Ca^{2+}, both of which stimulate proopiomelanocortin (POMC) gene transcription. The nuclear mechanisms involved in POMC transcription are not fully understood. Usually, cAMP and Ca^{2+} activate transcription by inducing transcription factors that bind to the promoter region of many genes at the DNA responsive elements CRE (cAMP responsive element) and CaRE (calcium responsive element), both of which are variants of the basic palindromic motif, TGACGTCA.[24] However, because the POMC promoter lacks those motifs,[25] research has been directed at finding other cAMP responsive elements in that promoter.

New factors have been isolated from CRH-treated pituitary cells, such as PCRH-REB-1, which binds to a region of the POMC promoter, known as PCRH-RE [CTGTGCGCGCAG], increasing transcription of that gene sevenfold.[25] PCRH-REB-1 is 90% homologous

to another POMC transcription factor, PO-GA, which binds to a different thirteen nucleotide sequence located further downstream in the POMC promoter and known as the PO-B site.[26, 27] The PO-B site [AGAAGAGTGACAG], corresponding to nucleotides -15/-3, is located between the TATA box and the cap site. This sequence is responsible for at least 70% of the basal POMC. We conducted Genbank searches for the nucleotide sequences of those two sites contained within the CRH-responsive element of the POMC promoter, namely the PCRH-RE and the PO-B site. We hypothesized that those two specific sequences of nucleotides might be contained in other genes whose transcriptional activation or inhibition by the CRH-related factors PCRH-REB-1 or PO-GA could increase susceptibility to human disease. We found homology between the PCRH-RE and the non-coding region of pathogenic viruses, such as HIV-1, cytomegalovirus, and malignant fibroma virus, and inflammatory mediators, such as interleukin 1ß converting enzyme, and homology between the PO-B site and the non-coding regions of two important human oncogenes, c-fes and MAT-1.[28] Based on those findings, we hypothesize a novel mechanism of hormone action by which CRH-related transcription factors, reflecting the molecular responsiveness to CRH, might affect disease susceptibility by binding to unexpected intracellular targets, such as viruses, oncogenes, or the genes encoding for inflammatory mediators. Infection, inflammation, and possibly neoplastic susceptibility would thus be facilitated.

Peripheral illness affects key functions of the brain

We have examined the pattern of cytokines gene expression in the central nervous system (CNS), and pituitary in response to inflammation. We studied male Sprague-Dawley rats 0, 2, 6, and 24 h after the intraperitoneal injection of 5 mg of LPS or saline (n=6/group). Injections were timed so that all tissue collection occurred at 10:00-11:00 h. Brains and pituitaries were rapid-

ly removed in one block, stored at -70 deg C, and sectioned coronally every 1 mm. Species-specific ribonucleotide probes were generated from interleukin 1ß (IL-1ß) cDNA, IL-1ra cDNA, IL-10 cDNA and IL-13 cDNA. We sequenced and characterized all probes. Sectioning, fixing, *in situ* hybridization, autoradiography with 2 weeks of exposure, and anatomical localization of the probes were performed as described by Licinio *et al*.[29] To test the specificity of antisense probes and hybridization method, we generated controls using labeled sense and excess cold probes. mRNA levels were quantified by densitometry.[30] Total RNA obtained from pituitaries of rats treated with LPS 6h after intraperitoneal injection was isolated and reverse transcription was performed. Polymerase chain reactions (PCR) were set up to amplify the secretory isoform of IL-1ra, sIL-1ra, and the intracellular isoform, icIL-1ra.[31, 32] PCR products were cloned and sequenced. We show that the CNS responds to systemic inflammation with pronounced IL-1ß gene expression and limited expression of genes encoding the counter regulatory cytokines IL-1ra, IL-10, and IL-13. This pattern occurs throughout the CNS, including areas such as the subfornical organ, pineal gland, neurohypophysis, and hypothalamus.[33] In contrast in the anterior pituitary, we found limited IL-1ß gene expression but marked induction of IL-1ra mRNA.[33] Using cloning and sequencing we verified that during inflammation the splice variant of the IL-1ra gene expressed in the pituitary and detected by in situ hybridization is the secreted isoform, sIL1-ra.[33] In conclusion we found that IL-1ß is counter regulated differentially in the CNS and in peripheral tissues. We propose that the central manifestations of peripheral inflammation are mediated by endogenous brain IL-1ß synthesized during systemic inflammation in the context of limited central cytokine counter regulation of IL-1 bioactivity. These data show that peripheral illness alters the levels of expression of specific genes in the brain. Interestingly, it has been proposed that IL-1ß may have a role in the biology of depression.[34] The CNS transcription of the HIV-1

replication factor IL-1ß[35] in the context of limited transcription of the IL-1 replication inhibitors IL-1ra, IL-10, IL-13[35, 36, 37, 38, 39] might help explain the negative impact of systemic inflammation on the clinical course of AIDS. Additionally, we have suggested that IL-1ra may be secreted by the anterior pituitary as a systemic anti-inflammatory hormone that is released in response to IL-1ß originated from hypothalamic, pituitary, and systemic sources.

High levels of IL-1ß gene expression in the brain can explain our finding of high levels of expression of the gene encoding inducible nitric oxide synthase in vascular, glial, and neuronal structures of the brain, accompanied by the spillover of nitric oxide metabolites such as nitrite into cebrospinal fluid (CSF); CSF nitrite levels might represent a potential clinical marker for sepsis.[40] Animals with a null mutation for the neuronal isoform of nitric oxide synthase have behavioral alterations; it has therefore been proposed that nitric oxide can modulate behavior.[41]

Conclusions

Studies documenting decreased bone mineral density[13] and hippocampal atrophy[17] in women with depression show that a disorder that has been classified as a mental disease affects the functioning and the structure of the brain and of peripheral tissues. Moreover, recent molecular data might clarify novel mechanisms by which CRH hyper secretion in depression can contribute to physical illness.[28] A separate line of investigation in our laboratory has shown that peripheral illness affects patterns of cytokine gene expression in the brain; therefore, we now have evidence at the molecular level that peripheral disease modulates the functioning of the brain.[33, 40] In conclusion, molecular psychiatry research is currently addressing specific mechanisms by which diseases of the mind affect the body and diseases of the body affect the brain. It is our hope that, as our research strategies become increasingly more mechanistic, we can unravel the connections between brain function and body function. The tools of molecular

medicine and imaging open new horizons for research in depression. We can now transcend reductionism and use the latest advances in technology to integrate body and mind at the most fundamental level. At some point in the future we will no longer need to discuss the biology *and* the psychology of depression. As research advances, psychology will be understood in biological terms, and the psychological implications of biological events will be elucidated. This work is of moral, ethical, and religious relevance. We hope that, by using the latest tools in biomedical research to integrate biology and psychology, we will facilitate a more balanced understanding of the human condition.

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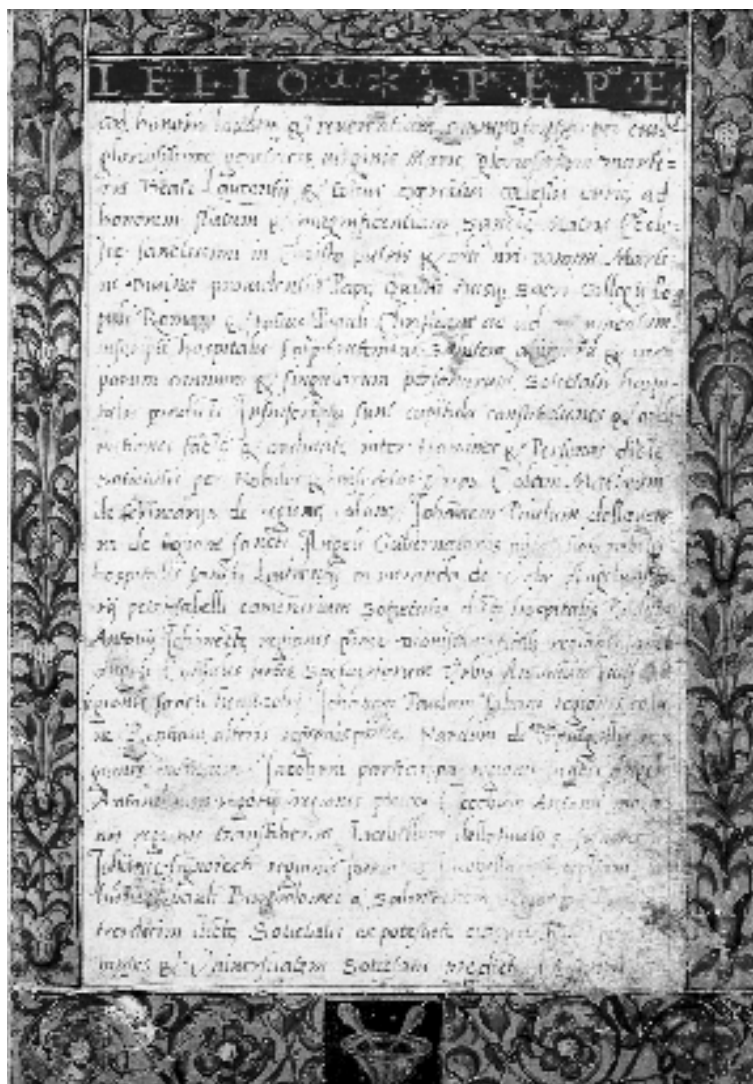
MALCOM LADER

Abnormalities of the Mind in Schizophrenia

Introduction

There are more misconceptions about schizophrenia than about any other mental illness. These misunderstandings and downright ignorance are entertained by most laymen and many doctors, and greatly colour our attitudes towards these unfortunate people. Mixed with the ignorance is fear, revulsion and a pervading lack of compassion which condemns many schizophrenic patients to a twilight existence. Too often, schizophrenia is translated literally as "split-mind" or "Jekyll-and-Hyde" as in the novella by the 19th Century Scottish writer, Robert Louis Stephenson. Schizophrenic patients are dumped into the community without adequate support and resources, they relapse, commit an antisocial act, and the headlines in our tabloid newspapers scream for better controls to protect the public from these itinerant madmen and women. Have we returned to the Dark Ages, or at best the Middle Ages? And should we, as then, involve religious organisations more intensively in the care of the severely mentally ill?

A vignette

But what is schizophrenia; what is a sufferer like? It is a most varied condition and a debate has been raging for all of this century as to the boundaries of this disorder or possibly groups of disorders. The following vignette is fairly typical.

I first encountered Duncan when he was 21. He had grown up in a close-knit family. One maternal great-aunt had died in an asylum many years ago but otherwise the family was devoid of history of mental illness. He had had a difficult birth with prolonged labour but appeared to be a normal child. By about the age of 8 he was regarded as socially inept but otherwise appeared quite intelligent. He actually did well at school although remaining aloof, and he went to a prestigious university to read Classics. Such a developmental history is typical (Weinberger, 1995). The first year passed uneventfully but half way through the second, he became increasingly isolated and began to fail to attend his tutorials. The walls of his room at College were found to be criss-crossed with a metallic-finish tape. He explained that this was to stop the evil spirits on Mars from beaming messages to him telling him to kill himself. His speech was incoherent and he appeared to be hearing voices. He was neglectful of his personal hygiene and would giggle uncontrollably at times. He was taken to the local mental hospital.

He never returned to College, never held down a regular job, never had a regular girlfriend, never had any friends, would refuse to see his family for years on end, and lived in a barricaded room in cheap lodgings. He took medication only sporadically and refused depot injections of antipsychotic drugs. He harmed no one but people shunned him. I still see him occasionally in the local Post Office where he draws his Social Security payment.

Is this a waste of life? So far 33 years of unimaginable disintegration of thought processes, of bizarre ideas, of self-neglect, of isolation from the rest of mankind. But also an example to us of a different mode of like, of persistence in the face of appalling adversity, to remind us perhaps of our limited understandings of the most complex biological entity on this planet—the human brain.

Characteristic symptoms

Schizophrenic patients can harbour a vast variety of abnormalities of the mind. The common feature is a *disintegration of coordination of mind processes.* For example, feelings do not enmesh with intellect so that a patient may laugh incongruously while describing the death of a parent. The following are the symptoms of the first order of Kurt Schneider: thought insertion, thought broadcast, and thought withdrawal, auditory hallucinations of a particular type, and delusions of control. These symptoms are highly discriminatory for a diagnosis of schizophrenia—in other words, a high concordance (over 90 per cent) will be found among professionals, such as psychiatrists and clinical psychologists, in attaching that label to a mentally-disordered individual.

Abnormal thoughts

The symptom of *thought insertion* comprises a belief that alien thoughts are being forced into the patient's stream of thought, into

his or her consciousness. These thoughts appear foreign and are often disturbing, threatening or obscene. It is not that the patient believes he is caused to have unusual thoughts but that the thoughts themselves are not his— he is thinking other people's thoughts, or the Devil's or animals or even those of inanimate objects such as a computer, a waterfall or a weathered rock. The mode of insertion is believed to be by some external means such as telepathy or microwaves. The patient is quite adamant that the thoughts are not his own.

Thought withdrawal is when a patient believes that thoughts are being taken out of his or her mind. This usually accompanies *thought blocking* when the patient experiences a break in the continuity of thought-flow through his mind and believes that his own legitimate thoughts have been filched by an outside agency, often his supposed persecutors. These thoughts may become common knowledge, so-called *thought broadcasting,* in which the patient believes that his unspoken, innermost thoughts are known to other people by radio, telepathy or supernatural agency.

As well as abnormalities of control of thought, the *pace of thought* may change becoming slowed down with poverty of thought, or quickened up with pressure of thought. Associations between thoughts become loosened or incomprehensible. This may manifest itself in illogical thinking—so-called "knight's move" or talking past the point (in German "vorbeireden"). In its severest form, thought and speech become disjointed and incoherent—"word salad" or verbigeration. Idiosyncratic words or phrases are coined (neologisms) or ordinary words are used in unusual ways (paraphrasias or metonyms). One of my patients referred constantly to his "submarragism" meaning his hidden longings to have a normal marital relationship.

Hallucinations

These are *percepts* experienced

in the absence of any external stimulus to the sense organs, and with a similar quality of verisimilitude to a true percept. An hallucination is experienced as originating in the real outside world or the assumed internal world. Normal people experience hallucinations especially when fatigued or when falling asleep or waking up. Hallucinations can occur in any modality—auditory, visual, olfactory, tactile, gustatory or proprioceptive. In schizophrenic patients auditory hallucinations are among the most frequent symptoms. They may take the form of noises, times, single words, phrases or entire conversations. Some voices are commands to the patients, other provide a running commentary and refer to the patient in the third person—"She is washing herself—she needs to—she is disgustingly dirty." Some patients hear their thoughts spoken out aloud as they think them ("gedankenlautwerden"), or immediately afterwards ("echo de la pensées"). Other modalities of hallucinations may also occur, for example, a feeling of inner putrefaction. One of my patients claimed to receive messages which he could read tattooed on the inside of the back of his skull. Usually, however, visual hallucinations are uncommon.

Delusions

A delusions is a belief that is firmly held despite evidence to the contrary and is not a conventional belief in keeping with the educational and cultural background of the individual. A delusion is usually a false belief but not always—it is the relationship between content of delusion, information available to the individual and his expected beliefs that is important. For example, a person suffering from morbid jealousy may have the delusion that his wife is constantly unfaithful to him even if it is true providing he has no grounds for that assumption. Delusions are held with rock-life intensity and no amount of argument and reasoning will shift it an iota. Some delusions

spring fully formed into the individual's mind, other develop remorselessly. Delusions may crystallise against a background of primary delusional mood (Wahnstimming). The delusion may not alter the patient's orientation—he may believe he is a millionaire but live contentedly in penury and squalor. Many of the other features of schizophrenia stem from or are explained by delusions. For example, a patient experiencing abnormalities of thought may notice a microwave transmitter on top of a building whereupon the delusion develops that this is the headquarters of the invaders from Saturn.

Paranoid delusions, that is, fixed beliefs of persecution, are particularly common in schizophrenic patients. Delusions relating to the appearance or function of parts of the body, or of special religious, pseudophilosophical or pseudoscientific import may occur. Grandiose delusions are less common but may imbue the patient with an unassailable sense of special mission in life and of being endowed with supernatural powers to carry it out. But there is typically a bizarre dimension to the belief which distinguishes it from evangelicism. Delusions of reference may be noted in which the individual believes that events, objects or other people's behaviour refer to himself. Delusions of control are beliefs that external forces govern ones actions usually via some weird mechanism. Delusional systems may accrue but become increasingly encapsulated as the patient learns to stop bringing them to general notice.

Abnormalities of Affect

Abnormalities of mood are common in schizophrenia and are of three main types. Sustained abnormalities may occur with anxiety, irritability, euphoria or depression. The last may be severe and all too often a schizophrenic illness ends up in suicide (Allebeck, 1989). Secondly, affect may be blunted or flattened with a sustained reduction in intensity and range of emotional expression.

Thirdly, affect may be grossly incongruous where the emotional response is incompatible with current speech or events.

A major feature of schizophrenia is *anhedonia*—a reduced ability to enjoy life (Norman and Malla, 1991). This may be made worse by the depressant side effects of medication and eventually lead to compliance problems. At the outset of acute phases of the illness intense emotions of terror or exhilaration may supervene in tune with the content of delusions and hallucinations. Passivity feelings may interact so that the patient believes he or she is being made to feel ecstatic or angry.

Schizophrenic patients are usually *aware* of the time, place and their own identity (more or less). Some may persist in the belief that their age is that at the outset of the illness. Thus, consciousness in not clouded as in a delirium nor is memory formally impaired as in a dementia. However, attention and concentration may be poor, and patients may be easily distracted or preoccupied with their abnormal inner thought processes. Memory is usually normal but poor motivation to recall information and events may suggest impaired memory (Tomkins et al., 1995). Recently, sophisticated neuropsychological testing coupled with advanced brain imaging techniques have shown that there are fairly widespread but rather subtle deficits in cognitive functioning which may well long antedate the onset of the illness and be present in otherwise normal close relatives.

Insight is usually impaired. Many patients refuse to acknowledge that they are mentally ill but instead develop elaborate and bizarre explanations for their predicament. Poor insight is associated with frequent relapse, severe symptoms and poor compliance with medication, thereby perpetuating a vicious circle.

Patients also show *lack of volition* and drive and may become increasingly inert. A wide range of movement disorders may be seen although less frequently in Western countries than hitherto. These include posturing, waxy flexibility, stereotypy and catatonic excitement and stupor.

Other clinical features

The above account is essentially a cross-sectional examination of the abnormalities of the schizophrenic mind. Many other features of schizophrenia are important such as the clustering of symptoms into two or three syndromes and the different natural histories of the main types of the disorder (Andreasen, 1995). New drugs have been introduced with some improvement in *prognosis* (Kerwin and Taylor, 1996). Roughly speaking, a quarter of patients do quite well, making an almost complete recovery, a half have a recurrent or chronic illness but maintain some useful level of functioning and a quarter pursue a severe relapsing or inexorably downhill course. Their prognosis is abysmal, especially now that "asylum" beds are so scarce. It is a sobering thought despite all our "advances" in treatment and management, the overall outlook for schizophrenic patients has hardly changed over the past century (Hegarty et al., 1994).

The boundaries of schizophrenia

I have described the characteristic symptoms of schizophrenia, at the core of which lie symptoms of thought and emotional disturbance. Lesser forms of the disorder abound and merge into abnormal ("schizoid") personality and eccentricity. The boundaries of the disorder are thus ill-defined and depend on the type and severity of the symptoms and the psychosocial nexus in which they arise. Mental health professionals have different views on the relationship of schizophrenia to normality. This can lead to a total inversion of epistemology as in Szasz and Laing's views that individuals labelled schizophrenic are reacting to the mad society in which they live and are not themselves inherently flawed. At the other extreme, people who criticise the society in which they live and become dissident may be labelled "schizophrenic" and incarcerated as mental patients, most notoriously in the Soviet Russian scandals 20-30 years ago (Lader, 1977).

However, there is good evidence that schizophrenia can be regarded as a disease, illness or disorder (Wing, 1978). Evidence from genetic (McGuffin et al., 1995), epidemiological, biochemical and brain imaging (Hall et al., 1994) studies all show a major and common biological component (Sedvall and Farde 1995). Thus, very recently, it was found that one of the brain receptors governing the action of the neurotransmitter, serotonin, was abnormal in many schizophrenic patients (Williams et al., 1996). Nevertheless, many features of the illness are best understood as complex interactions between biological and psychosocial factors.

Madness and possession

I have emphasised the "first-rank" symptoms of schizophrenia, prominently among which are the feeling of thought control, of dissolution of thought processes and hence a terrifying disintegration of personal integrity. This bears a superficial resemblance to the concepts of possession and witchcraft so prevalent in Europe in the Middle Ages, and still to be found in unsophisticated societies today (Lipsedge, 1996). However, there is a fundamental distinction between the two conditions. In schizophrenia, the control is exercised at a distance and the thought context is illogical or incoherent. In people possessed, the control is exercised by an external agency such as the Devil taking over the body and mind of the possessed individual whose thought content remains comprehensible, albeit distorted to the purposes of the usurping agency. In most instances possessed people are suffering from a psychological reaction to stress or social circumstances. In others, particularly with visions or states of ecstasy, an abnormality of brain function such as temporal lobe epilepsy may underlie the condition.

Of course, the content of delusions and hallucination will reflect the upbringing, education, beliefs and psychosocial position of the sufferer from schizophrenia. For example, a religious individual will have a religious content to his delusions believing that he has messianic functions or that he receives special mentions from God. The irreligious person will tend not to have such ideas or his delusions may be blasphemous in nature. But the form of thought disorder, delusions, hallucinations etc. are similar across individual patients despite widely varying differences in content.

Attitudes to mental illness such as schizophrenia

Both possession and madness caused the destruction of personal and social order, the devil wreaking havoc, the person becoming chaotic in thought and deed, and the soul being endangered or eroded. Those attitudes from the Middle Ages have persisted in many societies often covertly. Insanity is regarded as a corruption of reason, and of order, stability and equanimity of mind. It is surprising that insanity, as with most illness, was regarded as a punishment for sinning. Symptoms were a warning to search one's conscience and to repent. God warned that he would strike with madness those who failed to obey his Commandments (Deut. 28:15-28). Conversely, one of the causes of sinning could be madness. Both are deviations from the perceptions of God's pattern and order for man in his existence on Earth. Insanity could carry a stigma both in this world and the next, with damnation as a further punishment for sin.

More enlightened attitudes have generally prevailed with most illnesses, physical and mental. However, the extreme and bizarre nature of schizophrenic symptoms has led to a reluctance to view this condition as a mental illness rather than a punishment or a sign of weakness. This undercurrent of suspicion and incomprehensibility has led to our current ambivalent attitudes to the severely mentally ill, as exemplified by our discharge of schizophrenic patients into an inadequately prepared community.

The madness of schizophrenia

Schizophrenia is a complex mental illness. We assume that a subtle perturbation of brain function, most likely biochemical in nature, leads to the strange symptoms and behaviours. The changes can be gross, with disintegration of the personality, or more subtle. In the latter case, some brain functions such as creativity may be enhanced, although others, such as self-criticism, may be attenuated. Most bodily function remains normal, as does most of the routine brain functions such as perception and speech. The abnormality in the schizophrenic brain is subtle but widespread. Study of schizophrenia underlines for us the complexity of the human brain. Evaluation of the abnormalities in schizophrenia raises issues concerning interactions between parts of the brain, particularly the highest functions, unique to man, such as organised speech. Other functions such as emotions are also better understood when the nature of abnormalities is studied.

The most fundamental questions involve the nature of thought and of consciousness. The integration and control of these noumena is taken for granted by almost all of us. We expect to be separate, integrated individuals with control over our thoughts, if not all of our mind functions. We take it for granted that our thoughts are our own—it is an essential part of our being, of our knowledge of ourselves as integral human beings. We take it for granted that our thoughts are private experiences which can be communicated to others by speech, facial expression, gesture or action, not only if we wish to do so. This fragmentation of personal wholeness, of the fraying of personality and of the vulnerability of the citadel of the mind lies at the core of schizophrenia. This disorder reminds us how finely-balanced our mental processes are and how catastrophic the results of disturbance of these processes.

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IGNACIO CARRASCO DE PAULA

The Dignity of Madness

The title of this Eleventh International Conference—"In the Image and Likeness of God: Always?"—would suggest that the choice of its principal subject arose from the posing of the following question: Is the most important anthropological statement of the Bible in relation to the greatness and value of man not perhaps contradicted by the widespread experience of illness, especially where it involves an attack on the most precious faculty of man, his intelligence and his freedom, that is, his mind?

And if, as the cultural traditions of a Christian character tend to assert with unanimity, the dignity of man has a meaning in itself and of itself which is not conditioned by contingent circumstances, then what are the consequences of this state of affairs in health care, social and pastoral terms, and especially in relation to those who in various ways are involved in the safeguarding of health?

It is in this sense that I have chosen the title "The Dignity of Madness" for my paper. I do not wish to explore the idea—which is obvious, at least within a personalistic framework of analysis—that each man because he is man is worthy of, and deserves, the greatest respect, not least when he is afflicted by illness of the mind of the body. I wish, rather, to dwell upon the proposition that illness itself, even though it is a source of suffering and of limitation, confers a special and specific form of dignity upon man.

If this perception and judgement is correct,it places us before an important and involving paradox: in the man who is wounded, and wounded in that gift which enables him to feel proud of being a man; in the man who is no longer able to read what is written within himself; in that man deprived of the light of the mind—in such a man human reason contemplates the mystery of a new and unexpected dignity.

Obviously enough, before engaging in my reflections upon this subject, it has to be recognized that this proposition cannot but come up against a common experience shared by everyone—madness is an evil, a tribulation; it attacks the very source itself of that dignity which is specific to intelligent beings who because they are intelligent are free and because they are free are capable of good and evil.

Morality as a discipline which is both philosophical and theological excludes the behavior of the individual who is mentally ill from its field of competence. His actions are those of a man but they are not actions which are really human.[1] On the one hand, moral science recognizes that one is always dealing with a man who is the operator of actions, but on the other it concludes that such actions, quite apart from their objective ethical character, can be attributed—ascribed—to the individual who carries them out only when that person is fully in possession of his mental faculties. I would say that for moralists, and here I include myself, the mentally ill person should not be seen as a protagonist of history but should be considered only as a witness. I will bear all of this closely in mind during the discussion of the subject of this paper which now follows.

However, another preliminary observation is also necessary. Almost five centuries ago Erasmus of Rotterdam gave his great friend Thomas More a copy of a small work he had written—*Moirae Encomium,* or "In Praise of Folly." In the pages of this work words are a lethal weapon wielded in the hands of irony. Honesty takes on the form of dementia in order to satirize the ill-conduct of his contemporaries and more particularly of certain men and women of the Church. But in this small masterpiece madness remains a phantom, a mirage which fails to find space amongst the elegant grammatical constructions of the great humanist. This paper has much more modest aspirations. Its aim, in contrary fashion, is to deal with the subject of real madness, without, however, becoming involved in literary constructions and elegant wordplay.

1. The Concept of Dignity

The dignity of madness! All right and good. But what do we really mean when we state that a being, any kind of reality, is worthy?

A man is worthy if he by nature has worth, nobility, or excellence. To be worthy means to be deserving of regard and respect. Not because of a benevolent or positive judgement on the part of others, but because that person really possesses the qualities which command such respect and because other people could not fail to recognize them without becoming distant from truth and subsequently from justice.

Dignity is foreign to the world of compassion, clemency, or pity.

Indeed, dignity is a fitting object of that human faculty which reaches and touches the existent—both in the form of things and of people—in its specific ontological value—that is, in its quality of good. As a result, dignity is not so much a revelation of intelligence as a discovery of will. It is a quality which is understood not through the force of logical reasoning, but as a term to describe that unlimited wish for good which we call love.

One cannot recognize the dignity of something or somebody without loving that something or that somebody. And it is for this reason that at the root of cultural tendencies which do not pay sufficient regard to the dignity of man we always find an alienation, the exiling of love, and at an even deeper level the growing danger of an irrational hatred for man himself. Hobbes is very effective when he repeats the phrase "homo hominis lupus"—it is not possible to love a beast because it lacks the essential pre-condition for the bestowal of love—dignity.

This is a lesson which humanity is gradually learning at its own expense and against a background of a series of apparently interminable threats and actions against human life. These are actions which fill the pages of newspapers all over the world every single day. We are dealing here with threats which in deliberate fashion menace the most defenseless of our brethren, especially when they are at the beginning or the end of their earthly lives.

To return to the subject of this paper in more specific fashion, I would like to place great emphasis upon a simple tenet: a good which is not loved is not recognized as being worthy. The will and the freedom of existent man is not to be found in a state of neutral indifference when faced with *bonum*—as if, that is, he had need of who knows what kind of push from the outside to take a position. Freedom is necessarily attracted and seduced by the attraction of the good of the being. This is one of the central theses in the anthropology of St. Thomas. Aristotle himself, in seeking to define what good is, did not go beyond saying that *bonum* is that which all things search for,

that which nobody can help desiring.[2]

If such is the case, we have to conclude that the question of the dignity of madness is not of an exclusively epistemological character. Indeed, in order to understand the full meaning of the question before us we must take into account the faculty which enables us to love. By this assertion I wish to establish a strictly methodological criterion.

2. Human Dignity

When we preach the term dignity in relation to man what do we mean? Is the expression an alternative way of saying that man is man, and thus a mere tautological declaration, or are we adding a new element to its meaning?

It seems to me that in terms of its cultural genesis the use of the concept of dignity solely and exclusively in relation to *homo sapiens* is to be explained with reference to an acquired knowledge of the insuperable boundaries of language. We have neither words nor symbols by which to give an adequate expression to our concepts concerning the value of man. Here we encounter all the limits of symbolism as an instrument by which to gain access to knowledge. Perhaps what I am asserting here can be illuminated by placing oneself in the shoes of the author of Psalm 8. The psalmist writes: "When I look at thy heavens, the work of thy fingers, the moon and the stars which thou hast established, [I ask myself] what is man...." (Psalm 8:3-4). Even the splendid and glorious vision of a starry night is not sufficient to speak of your created being. What can I say? Only this: "Thou hast made him little less than God" (Psalm 8:5). In more modern language, and if the biblical scholars will allow me, perhaps the sentence could be translated in the following way: "You have made man worthy of you." Man is that work of yours which is especially valuable to you. Or to put it another way: I recognize in man the dignity that you have bestowed upon him.

At a rational level, there can be no affirmation of the specific no-

bility of man without reference to the concept of dignity. Indeed, the human person is such a valuable good that he cannot be compared to any other created or known good. At an axiological level, the human person in our universe is unrivalled. He is priceless. He greatly exceeds the values that are available to us. He cannot be measured in economic terms, with reference to levels of prosperity, in terms of progress, through the employment of parameters of social rank, or in similar ways. On the contrary, the status of man provides a yardstick by which to value all those things which are available to him.

One thus comes to understand how erroneous it is to place the mentally ill person within the framework of the following sophism, which, however, is not without a certain logic: man is a rational animal; as a result, when he is deprived of his rationality we can only perceive in him a humanity which has been tampered with, a humanity almost of the second class, perhaps even inferior. Such a line of argument necessarily implies that the person who suffers from mental illness is less a man than the person who is mentally healthy. It is at this point that mankind must turn to its conscience and reflect upon certain sad episodes belonging to a by no means remote past and upon certain present-day fears which are shared by many and which do not bode a happy future.

Perhaps we have exaggerated in the identification of dignity with the being who is intelligent and equipped with free will. However, both the use of reason and the control of an individual's behavior are a sign, but not a source of humanity. Notwithstanding the arguments of the animalists—with whom I share many points of view—even in the hypothetical case (which is, however, very improbable) that an animal might learn to reason, this would not mean that that animal had acquired the definitive title of dignity. In the same way, this would not mean that we would be any less bound to treat him with extreme care and consideration—precisely because all living beings, in a certain sense, form part of the

dignity of man, the lord and servant of the creation.

The concept of dignity thus translates, at an axiological level, the Christian vision which places the human person at the center and at the summit of the universe, the only creature which God wanted in itself. It also expresses a fundamental ethical principle which requires that the human person should always be treated as an end and never as a means, and which forbids him to be treated as a instrument, as a tool. And God himself was the first—and I hope you will here allow me the employment of rather approximate language—to adhere strictly to this rule in his approach to men.

3. The Dignity of Madness

The discussion which has hitherto been conducted on the character of dignity leads us to the Genesis statement which is the emblem of this eleventh international conference: "in the image and likeness of God".

Indeed, when I ask myself about the nature of the dignity of man I certainly pose a question of an axiological nature. But at the same time I raise an ontological problem—the question of causes, the question of the ultimate reason for why the human person is so valuable.

If we refer again to the example of Psalm 8 which has been cited in this paper as an expression of the amazement which is felt when man considers man, we can ask ourselves the following question: in the eyes of God how is the human person seen? What does the Creator perceive when his gaze falls upon his creature made of flesh and spirit? The Bible provides the following answer: God sees himself, God contemplates his own countenance, his own image. It is for this reason that God loves man in a way which we would never be able to express or evoke adequately were it not for the fact that He himself revealed the nature of this love through his Son, the Word made man—Christ, the perfect image of the Father.

When we deliberate upon the *dignity of madness* in essential terms we are asking what God thinks about this very question. What value does the mentally ill person have in the eyes of God? We ask ourselves whether the Lord—and we with him—also perceives his image in those who are not able to grasp that they are the mirror of the divine gaze.

The Bible refers to the tenderness of God towards the poor, the disinherited, the sick—all those who can be seen as being innocent victims without a guide and without protection. Those who suffer from mental illness without doubt form a part to the full of this category. Furthermore, history teaches us that the mentally ill person has all too often been exposed to the insensitivity and the discrimination practiced by the so-called healthy.

The Bible even speaks about the madness of God. Madness was the Cross. "Mad!" declared the lawyer Festus to Paul when the latter was explaining his faith to him (Acts 26:24). The Apostle describes himself as a fool when writing to the Corinthians (2 Cor 12:11). Furthermore, the Book of Wisdom (5:4) warns us about how wrongdoers declare the just to be mad in far too easy a fashion. Indeed, it is no easy task to distinguish great men before they have obtained a specific place in history: is this man a madman or a saint or a genius?

It is certainly true that in this context madness is not referred to in a pathological sense but as a form of behavior which does not belong to the usual or as a phenomenon which goes beyond the parameters of daily experience. Thus it is that living in coherent fashion with one's own human dignity can seem to be an example of authentic madness to some. However, the evident linguistic difficulties which we encounter in distinguishing between the normal—in the sense of what is healthy and thus not pathological—and the normal in the sense of mediocre, of the condition opposite to that of the hero (the genius or saint)—are not without their significance.

This difficulty is at the root of the marked embarrassment which medicine experiences in finding a definition of illness which satisfies all opinions. The same problem arises in relation to mental illness.[3] Certainly all kinds of formulas can be drawn up and listed, beginning with that of the World Health Organization. One of the greatest contemporary experts in the field of medical anthropology, V. von Weisacker, tired of the endless polemic on the subject, was moved to declare: "I define as being sick that person who calls me as a doctor and whose need I as a doctor recognize."[4] Obviously enough, this declaration is too simplistic and bears the marks of a polemical challenge. However, it brings out the tension which exists within the sick person: a lack of satisfaction about what he is and the hope—supported by the state of need—that he will recover or achieve improved health.

In the mentally ill person the image and likeness of God emerge in a specific light: that of a state of incompleteness, that of the need for help. Is this not perhaps the condition and the fundamental destiny of the man who searches for salvation? In this sense the individual who suffers from mental illness is for all of us a witness both of our origins and of our destiny. In him is to be found a dignity which is both a gift of God and a task for man.

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Notes

[1] S.THOMAS, I-IIae, q.1 a.1.
[2] Cf, *Etica a Nicomaco*, 1,1 (1094 a 3).
[3] See *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), 4th ed., published by the American Psychiatric Association, Washington, 1994, pp. xxi-xxii.
[4] V. VON WEISACKER, *Filosofia della Medicina*, edited by T. Henkelmann, (Milan, 1990), p. 84.

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Creativity and Mental Disturbance

Introduction

It is not very easy to give an accurate definition of *creativity* as this is a broad concept with a certain complexity which, because of this, can be understood in several different senses.

In what concerns us, we have always understood creativity as the expression of a totality of manifestations which characterize the *originality* of an individual or of a group of individuals.

That was, in truth, the concept we tried to state in our book *Psychology of Creativity,* seen through the biography of four "talented people," published in 1990.[1]

Those manifestations concern the various capacities (feelings, motivations, reflections and behaviour) that an individual or a group of individuals may show as a consequence of the different *incidents* experienced during their evolution and maturation. Sometimes such incidents are related to the psychophysiological and sensual experiences that follow evolution and maturation; on other occasions, they are related to the projects and ambitions each individual or group of individuals gradually builds up.

We usually say that in this sense creativity seems to be, for the human being, the route of hope by means of which he anxiously aims at finding the paths of his return to Eden. In other words, we could say that creativity is the skill which the human being can get of dialoguing, abstracting, understanding his role in the family and in society and of elaborating, by means of his intuition, a quite accurate idea about his destiny.

We consider that the main abilities and psychological motivations that integrate the process of creation are thought, memory, intuitive perception, an extraordinary memorization, and a strong connective fluency, together with a persistent will and an intense awareness of the environmental events and circumstances which encircle the individual.

So, let us take the opportunity to wonder whether every human being and every individual, with no discrimination at all, has a creative ability.

For a long time many famous intellectuals have tried to give an answer to that question. Many authors, from Kant to Butler, from Piéron to Trousseau and Valéry, have dealt with this problem, in relation to which Carl Rogers, an American psychologist with an anthropological-humanistic orientation, developed a psychopedagogic therapy that was given the designation of *non-directive creative attitude.*

According to that author's criterion and experience, every individual has enough forces for this creative development, for the acquisition of culture and adaptation to the environment.

However, these forces can only fully develop if the individual's relations with the environment are *authentic* and *empathetic.*

By "authenticity" Carl Rogers means that the relations of an individual with other people need to be supported by equilibrium and harmony, and by "empathy" he means the way through which those relations should mainly be directed to an "understanding" type of communication.

The first controversial point of Rogers' interpretation is to accept or not to accept that only in a "harmonious" and "authentic" environment an individual will be able to create and reach high levels of personal and social meaning. There have been many cases of skilled people who have created valuable works, although they have lived in a "not harmonious" and "not authentic" environment.

Rogers' interpretation and "comprehension" is, naturally, a way of regarding creativity from a general and anthropologic-humanistic point of view, i.e., a psychotherapeutic perspective which is the result of the experience of a man who devoted all his life to the practice of psychopedagogic therapy.

But there are other interpretations of the context and meaning of the creative impulses.

To a certain extent, Rogers' interpretation is an anticipated and optimistic answer to the desire we all have of knowing whether every individual has a creative skill.

It is clear that the answers to such a doubt are far from being unanimous.

As there are optimistic authors, like Carl Rogers and the Spanish philosopher Ortega y Gasset, who thinks that "every man carries with himself, in a lower or higher degree, the possibility of increasing the metaphysical weight of the earth," the truth is that many other authors agree that the power of creating is a gift of some privileged human beings.

Obviously, all of us are able to create something, in a certain mo-

ment. Sometimes it is the creation of a work which will become famous; other times it is a mere attitude or initiative, which can contain a certain originality.

Many other times, our creativity shows itself through our interest in imitating, admiring or consuming other people's creativity.

In this sense, we can say that every man has a certain instinct of creativity or imaginative adventure intrinsically in the desire of going beyond himself.

But it is obvious there are some human beings who are more capable of creating than others, and it is in that first group that we can include the talented and genial personalities. The word "creativity" derives from the verb "create," the ability of causing something to exist, taking something from nothingness ("the non existent"), or else, establishing relations that had not been conceived up to then, i.e., the ability of inventing, showing something new, "innovating."

Man has always attributed this ability to the "Supreme Creator," the divinity who is supposed to have created the world from the "nothing." It is for this reason that the current French philosopher Jean-François Lyotard, states that the work of creation leads to theology. Generalising, we could therefore draw the conclusion that man, when he creates something new, comes closer to God and, overcoming all his frustrations, becomes immortal by his return to Eden.

Goethe said that "art" in its different forms, poetry included, was the way of going beyond life.

Let us try to go to the very soul of some of those personalities we can call the "builders of the world" and the "creators of culture" (musicians, writers, poets, philosophers and scientists) and who, thanks to their exceptional gifts, start aiming at perfection, at the high moments of their creation.

Interpretative theories of creativity

The great psychological perspectives that more systematical-ly and in a global sense have tried to interpret the creative genesis are "the structuralist way," the "anthropologico-existencialist way" and the "psychoanalytical way."

The structuralist's perspective, in which different theories are integrated, like the "psychological development" of Jean Piaget (1896-1980), the "linguistic" theory of Noam Chomsky (1977),[2] and the "structuralist theory," of Claude Lévi-Strauss (1958),[3] is supported by the concept that creativity corresponds to a complex psychological process of "forms," "images," "structures" and original "configurations" that show specific symbolic characteristics, not superposed on elementary parts that constitute them.

Therefore, the creative mind would have a gift for orientating, correcting or transforming structures or configurations of a constitutional, physiological, imaginative or ideative nature and taking them as a starting point, organizing new systems or even universes with a completely new system, which would become explicit and comprehensible by means of the symbols of communication and of language.

In this sense, language appears as a pre-eminent verbal system, like a pattern for all forms of thought and, through creativity, able to become colours, shape, volume, or vice versa.

According to this structuralist perspective, with cognitive foundations and supported by the basic categories of human thought (Roman Jackobson, Malinovsky, Radcliffe-Brown), the creator would be able to use certain systems of ideative-imaginative-linguistic interaction, in one of which the organization and the formulation of thought would be centered.

It is mainly to the work of Jean Piaget that we owe quite complete information about the way the process of knowledge acquisition is developed during adolescence.

The author's studies on the psychology of development proved that it is only during adolescence that an individual begins to be able performing symbolic mental operations, formulating assertions and solving problems.

In truth, it is only from this age on that the human being begins to be capable of creating, penetrating his inner world, and of defining his own identity. There have been many artists who, in autobiographic descriptions or in "memoirs" have reported that it had been at that age that they had felt their inspiration gain force or their creativity emerge.

This aspect of self-identity can have a very expressive influence in the genesis of creativity, as seems to be the case with Fernando Pessoa, the Portuguese poet of this century who said that "the intelectualized sensation was the basis of every form of art, and that it was the consciousness of that sensation that acquired an aesthetic character and value."

Nevertheless, the structuralist interpretation by itself doesn't seem likely to explain clearly the foundations of many literary, plastic and musical creations in which, besides the logic of number space, time and cause, the experienced configurations and the emotional structures that enrich their contents must be valued, sometimes even emphasized.

On the other hand, there are many cases of gifted people whose creative productions are multidimensional; those individuals certainly have cognitive systems with a multivalent interaction, as must have been the case with Leonardo Da Vinci, to cite an example.

In this respect, we must remember that for the explanation of the creative phenomenon the existence of certain volitive structural components of persistence and decision is very important, that is to say, the structure of the will mentioned by Nietzsche that enables the gifted person to "select" the configurations he thinks the most productive, and "eliminate" those he considers secondary and not useful.

Michelangelo was one of the most typical examples of that power of decision.

Therefore, we think that it is acceptable that the structuralist perspective might help us to understand the way the structures of

logical thought, which are the foundations of a certain scientific creativity, can organize themselves in the way Descartes defended. It is also on the basis of this structuralist perspective that some authors have recenty been establishing a certain relation between genius and mathematics, and also between this latter and some mental disturbances.

The anthropologico-existentialist perspective is based on the concepts of the existential analysis of Soren Kierkegaard (1813-1855) and of the intentional movement of conscience of Edmund Hüsserl (1859-1938) for the explanation and understanding of the different states of existence and consciousness of the human being in relation to the world he lives in.

This perspective was improved by the "ratiovitalist" concept of Ortega y Gasset that a man does not truly exist unless integrated into his circumstances.

For Kierkegaard there can be many fundamental ontological structures, corresponding to the individual way of "being in the world" including moral and spiritual values and relational experiences.

According to Hüsserl's point of view, human consciousness appears as an experience of that existencial essence, that is to say, as an intentional movement towards the comprehension of the object.

Among the different states of existence experienced by the individual, the *aesthetic state* (of impetuous desire) would be the one that could best define the personality of a creator. But the *regligious state* (of anguish and of a feeling of abandonment) would be the one in which, through suffering, the individual's subjectivity enables him to find the meaning of his existence.

Therefore, for the existentialist philosophers, authenticity in the human being expresses itself in anguish, in the way of living in preoccupation.

Man "lives in an irrational dispair and consequently becomes an alienated, empty being, with no hope and no faith."

Blaise Pascal (1623-1662) had already said that "anguish is a ver-tigo that takes possession of us and it is by means of it that we become conscious of our condition."

For Kierkegaard, anguish puts us face to face with the choice of our existence, because anguish, as Heidegger says, is a cosmic feeling that becomes characteristic of the human condition, compromised with the world.

Choice will thus be the privileged movement of the existence of each individual, and the elaboration of an original project which will permit him to escape from alienation (the loss of the human essence). The author of a creative work would be the one who, through a kind of eidetic intuition, might have a great ability or a special form of perceiving the world.

For the anthropologico-existentialist perspective, neither the logical systems nor reason (in the rational sense) will therefore be the fundamental structure of creativity.

For Ortega y Gasset, "reason" is nothing but an integrative function of life.

Existentialists prefer a theory of consciousness, in its perceptive and imaginative aspects. And Ortega y Gasset thinks that the real energy nucleous incrusted in human consciousness is the function of life he calls *vital reason*, whose stimulating action of sociocultural structures decisively contribute.

Essence would only exist from a personal perspective of existence. And that perspective, which is primordially acquired in an intuitive way, will be the more significant, the more intuition and individual consciousness are endowed with an artistic or creative feeling.

For the *psychoanalitical perspective,* namely for Sigmund Freud (1856-1939), its creator, artistic production would correspond to an effort of sublimation and to a way of trying to overcome certain unconscious pulses, often reinforced by certain infantile impulses of an erotic nature.

Such impulses would be the main energy source of human activity, organized into a conscious structure which, apart from any scale of values, would be respon-sible for the whole psychic functioning of the individual, both in his normal and psychopathological expressions, including artistic and outstanding ones.

In this respect, the role of the subconcious in the genesis of the work of art has been explored by a great number of psychoanalists, since psychoanalisis was created. For many of them the creative impulse, which would be no more than a brilliant facet of a possession feeling or an oneiric symbol that has its expression in shapes and colours, would essentially be supported by conflicts, like the Aedipus complex and other infantile fantasies, deeply incrusted in the subsconscious.

Shakespeare's Hamlet, would be a significant example of that psychoanalytical theme, according to which the scandinavian prince strongly wishes to get rid of the man who occupied his father's place, as his stepfather.

In the "Mona Lisa" by Leonardo da Vinci, in Edgar Allan Poe's tales, in *Pygamalion* by Bernard Shaw, as well as in almost every artistic expression, orthodox psychoanalysts have no doubt in finding the impulses of an infantile conflict with incestuous characteristics.

The psychonalytical conception admits that affective fantasies of children do not always reflect love. In certain cases, they may involve anguish and even "hatred."

Jean Paul Sartre and Charlie Chaplin seem to be good examples of people who suffered from deep anxiety in childhood.

And as an example of references to experiences of hatred during childhood, there has been frequent mention of the French writer Marquis de Sade (1740-1814), who is supposed to have deeply hated his mother, a feeling that led him to charge his work with "blasphemies," as is the case with the "Dialogue Between a Priest and a Dying Man."

In literature, architecture, painting, in every work of art, Freudian psychoanalysis has tried to find an expression of conflict in which the artist's *unconscious fantasies* are symbolically projected onto his love object.

But the libidinous conception of human nature had to face strong opposition from some social and scientific groups, including psychoanalysis itself, as happened with Alfred Adler (1870-1937) and Gustav Yung (1875-1961).

Creativity and mental disturbance

Besides these three theoretical conceptions of genius, many authors have supported the possibility of a close relation between creativity and mental disturbance, or even, in a more radical way, between *genius and madness.*

In the first case, those authors admit that certain individuals, victims of an "inferiority complex," may, under certain circumstances, overcome their difficulties and frustrations and change that "complex" into creative motivations.

There are two examples of genius frequently referred to in this situation—Toulous Lautrec and Lord Byron.

Toulous Lautrec, who had an enormous sports ambition at the age of 14, became the victim of a serious deficiency involving congenital anthrosis, aggravated by two falls with two legs broken.

From then onwards, Toulouse Lautrec suffered from a complex, because of his awkward and grotesque figure, no taller than 1,50 m.

That deficiency and the ensuing crisis of alcoholism (he was admitted to a hospital for "delirium tremens") did not prevent him from expressing himself in remarkable paintings.

The same must have happened with Lord Byron, who suffered from paralysis of the right leg, with a deformity of the foot, besides his psychopathological heritage.

In spite of these negative aspects, though, Byron showed great talent, so great that it influenced, in an evident way, English and German romanticism.

Summarizing our considerations, we could say that much has been written about some phenomena of talent, like Goethe, Goya, Kant, Copernicus, Stendhal, Tasso, Newton, Holderlin, Nietzsche, Maupassant, Poe, Baudelaire, Verlaine, Van Gogh and Dostoievski.

In fact, it was the study of some of these intellectual phenomena that permitted some notable authors of the 19th century to regard the work of certain of those talented personalities as a kind of "biopsychopathological degeneracy."

For example, for Moreau de Tours (1804-1884), Francis Galton (1822-1911), Lange Eichbaum (1928) and Cesar Lombroso (1836-1909), there would always be something common to an artist and to a mental patient.

According to those authors' ideas, it would be common to find the presence of an excerbation of excitability in most talented personalities.

Ernest Kretschmer (1888-1964), who particularly devoted himself to this problem, also stated that an artistic work may also contain a somewhat strange element of abnormal predisposition which may become indispensable for outstanding creations.

And a typical example would be the case of Vincent Van Gogh (1853-1890).

Manuel d'Assunçao (1926-1969), a very gifted Portuguese painter, used to say that it was at the climax of his depressive accesses that he reached his greatest capacity of abstraction. It was as if rejected reality emerged into consciousness in a magnetic way and as if sorrow and pain changed into creation.

We could refer to other cases in which certain components of genius are interwoven with some psychopathological manifestations.

In fact, there have been many situations with psychopathic precedents in the families of creators, as happened with Byron, mentioned before. And there have also been many personalities of genius who have collapsed into unruly behaviour, into alcoholism, for instance.

After the advent of psychoanalytical conceptions, the coexistence of artistic creativity and homosexuality has often been referred to.

The contents of imaginative activity are frequently ambivalent and ambiguous, and in every creation, especially in the one which expresses itself with the most refined sensibility, we can notice that there is a mixture of masculinity and femininity.

Probably it is because of this that many critics have suggested the existence of a homosexual tendency in people of talent and many artists.

In our view, these two kinds of behavioural expression are not necessarily interdependent.

As Kretschmer mantained "the intrinsic value of genius is not a number of arbitrary rules, or the simple determinant of a moral and aesthetic ideal."

A genius is rather an individual who possesses a "specific psychic system capable of creating, in a higher degree than others, perfectly defined positive aesthetic or vital values that soon receive the label of an exceptional and peculiar individuality."

We willingly agree that certain expressions of anxiety, certain feelings of deep "nostalgia," and a certain emotional instability may be a source of inspiration for some artistic productions, even exceptional and outstanding ones. Nevertheless, to be a genius is neither a privilege of every person nor can it be at the mercy of this or that frustration or complex.

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Notes

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DINA NEROZZI FRAJESE

A Measureless Mind: Manic-Depressive Illness

There is a particular kind of pain, elation, loneliness, and terror involved in this kind of madness. When you are high, it's tremendous. The ideas and feelings are fast and frequent like shooting stars, and you follow them until you find better and brighter ones. Shyness goes, the right words and gestures are suddenly there, the power to seduce and captivate others is a felt certainty. There are interests found in uninteresting people. Sensuality is pervasive, and the desire to seduce and to be seduced, irresistible. Feelings of ease, intensity, power, well-being, financial omnipotence, and euphoria now pervade one's marrow. But, somehow, this changes. The fast ideas are too fast, and there are far too many; overwhelming confusion replaces clarity. Memory goes. Humor and absorption on friends' faces are replaced by fear and concern. Everything previously moving with the grain is now against—you are irritable, angry, frightened, uncontrollable, and enmeshed totally in the blackest caves of the mind. You never knew those caves were there. It will never end. Madness carves its own reality. It goes on and on. and finally there are only others' recollections of your behavior—your bizarre, frenetic, aimless forms of conduct—for mania has at least some grace in partially obliterating memories. What then—after the medications, psychiatrist, despair, depression, and overdose? All those incredible feelings to sort through. Who is being too polite to say what? Who knows what? What did I do? Why? And, most hauntingly, when will it happen again? Then, too, there are the an- noyances—medicine to take, resent, forget, take, resent, and forget, but always to take. Credit cards revoked, bounced checks to cover, explanations due at work, apologies to make, intermittent memories of vague men (what did I do?), friendships gone or drained, a ruined marriage. And, always, when will it happen again? *Which of my feelings are real? Which of the me's is me?* The wild, impulsive, chaotic, energetic, and crazy one? Or the shy, withdrawn, desperate, suicidal, doomed, and tired one? Probably a bit of both, hopefully much that is neither."

This description done by a manic-depressive patient, is able to draw, with few words, a complete picture of the illness (F.K. Goodwin and K.R. Jamison, 1990). The description also clarifies why these patients bear "a measureless mind—that is, a mind where feelings can expand from elation to despair, a much wider excursion than the usual mood fluctuations that are part of human behavior. Besides *mood swings*, *cognitive and behavioral alterations* are also an essential part of the syndrome.

Manic-depressive Illness is a disease which affects mood: it is a medical condition which has to be diagnosed, studied, and treated in a medical context. The illness ex- presses itself mainly through *psychological manifestations*, yet it is *biological in origin*, although some *precipitating environmental factors* are needed to start the process, at least in the early phases of the disease. Manic-depressive Illness is one of the most easily identifiable disorders; it has been known for many centuries. Descriptions of the disease are found even in the Old Testament. *Areteus* of Cappadocia, in the second century A.D., was the first to suggest that *mania and melancholia were part of the same process*: "Melancholia is without any doubt the beginning and even part of the disease called mania." Over the centuries the clear concepts set forth by the ancient scientists were obscured by multiple philosophical and pseudoreligious beliefs. At the end of the 19th century, *Kraepelin* reaffirmed the concept that mania and depression are part of the same process, and, for the first time, he used the term *manic-depressive psychosis*—a disease which, he stated, was totally different from what he still called *dementia praecox* (schizophrenia). Schizophrenia in fact tends to be chronic and to follow a deteriorating course, while manic-depressive illness is episodic and exacts a less devastating toll from the affected individuals.

DIFFERENT FEATURES OF SCHIZOPHRENIA AND MANIC-DEPRESSIVE ILLNESS	
Schizophrenia	Manic-depressive illness
• Sporadic disorder • Cronic disorders • Progressively invalidating process	• It runs in families • Episodic • Less invalidating

In spite of all the evidence scientifically gathered, even today it easy to find that the illness is frequently misdiagnosed: either as schizophrenia or as unimportant. Luckily manic-depressive illness has a more favorable prognosis than schizophrenia; it is less invalidating and, if properly treated, can allow those affected to have a "normal life." If left untreated, patients will suffer from devastating mood swings and uncontrolled impulsiveness with painful consequences which will affect their entire life. It is fundamental to point out that a significant proportion of these patients—at least 15%—if untreated, will commit *suicide* (Guze and Robins, 1970). Needless to say, negative consequences will also affect family members and, occasionally, society as a whole, whenever the patient becomes violently aggressive. On the other hand, the high levels of energy and creativity typical of the manic or hypomanic condition, can lead, in some individuals, to important achievements in many artistic and productive fields (Redfield Jamison, 1993).

Symptomatology

Manic-depressive Illness occurs in *multiple forms and degrees of severity*. Behavioral manifestations—during either the manic or depressive phase, are distributed along a spectrum—the so-called "*manic-depressive spectrum*," where the most severe forms of pathology gradually decline to a sort of personal predisposition, without any sharp boundary.

The manic episode

The manic episode is the one that characterizes the illness. It may start gradually, but, most often, the onset is rather abrupt. The essential feature of a manic episode is *mood alterations*—which may be elevated, expansive, or irritable—for at least a week. The disturbance is severe enough to cause a marked impairment in occupational functioning or in social and personal relationships, or to require hospitalization to prevent harmful consequences to self

or others. Besides mood alterations, *cognitive and behavioral symptoms* are also present which include: inflated self-esteem or grandiosity, decreased need for sleep, pressure in speech, a flight of ideas, distractibility, psychomotor agitation, and increased involvement in goal-oriented and sexual activities. Sometimes i*rritability* and *hostility* may be the main features; therefore, the patient may become extremely destructive for himself and others. The unifying character of the whole symptomatology is represented by an overwhelming degree of energy in every activity, together with an impulsiveness which is totally out of control.

The depressive episode

The essential feature of a depressive episode is *depressed* or irritable *mood* or loss of interest in all, or almost all, activities. The full symptomatology must last at least two weeks. The associated symptoms include loss of energy and fatigue, feelings of worthlessness or inappropriate guilt, diminished ability to think or concentrate, indecisiveness, psychomotor agitation or retardation, significant weight loss or gain, insomnia or hypersomnia, and recurrent thoughts of death or suicidal ideation. The disturbance must not be caused by any other medical condition and must be *sufficiently severe to cause* a *marked impairment* in everyday activity. Depressive symptomatology varies according to the age of onset. In infancy and in senescence physical symptoms are more prominent, while psychological features are mainly found in adolescent and adult patients.

The Switch Process

The switch process represents all biological and behavioral events associated with the often dramatic change from mania to depression. The change from depression to mania is rather abrupt, occurring sometimes over the course of a few hours or a few days, while depression is a more slow and gradual process. Depressive and

manic episodes do not recur cyclically in all patients, since the illness involves periods of full remission of symptomatology and periods of well-being, which make the recognition of the disorder difficult on some occasions. The variability of behavioral manifestations and the onset and duration of manic and depressive episodes are difficult to forecast and represent a totally individual characteristic. The switch process *is the most difficult and dangerous period of the illness*. This is the time when manic and depressive symptoms coexist, the so-called "mixed states," which cause unbearable suffering to patients. During the switch process aggressive and impulsive behavior may take place which may be dangerous to patients and to the people around them.

Epidemiology

What is the size of the problem? The risk of suffering from a manic-depressive illness, in the general population, varies, according to different studies, from 0.5% to 7.5%. In a recent study, performed in the USA, the estimated risk of suffering from the disease has been calculated to be around 1.6% (Kessler *et al.*, 1994) of the population. If we consider a less severe symptomatology, then the percentage of the population likely to be affected noticeably increases.

Manic-depressive illness affects men and women at the same rate, while in major clinical depression women represent at least two-thirds of the affected individuals.

The higher incidence of the disorder found in the upper social classes apparently reflects only better access to treatment and a better education; the disease thus appears to be equally distributed among all social classes. In general, there are not higher rates for the illness in the urban population as compared to rural areas, although, according to some researchers, the intensity of *stressful life-events* could act *as a precipitating factor* in the population living in big cities, therefore contributing to an earlier onset of manic or depressive symptomatology in people living in large urban areas.

EPIDEMIOLOGY: THE RISK OF SUFFERING FROM THE DISEASE

Equally distributed between men and women

Equally distributed among social classes
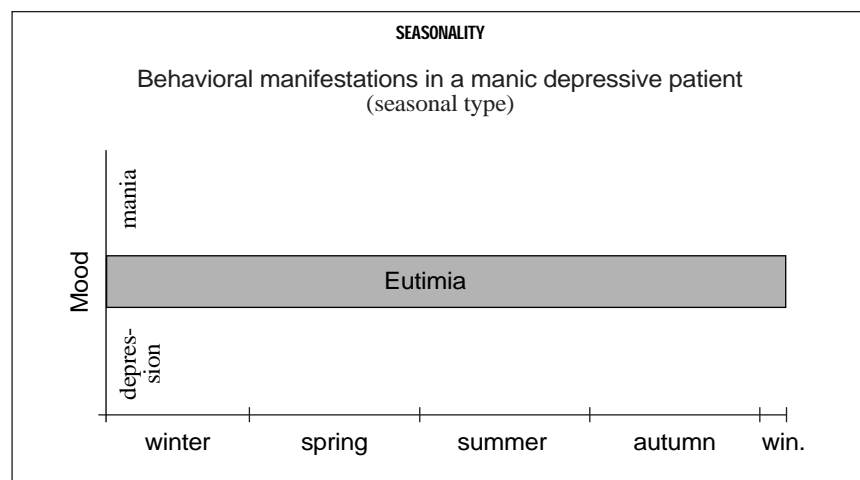
Equally distributed between urban areas and rural areas

We need to focus our attention on the *homeless population*. This is a growing phenomenon, in many western countries, partly as a result of immigration, and partly as a result of the closing of psychiatric institutions. We can say that a proportion of 30% of the homeless are to be considered as people suffering from a manic-depressive illness, considering that alcohol and drug abuse frequently may mask this mental disorder (Arce and Vergare, 1984).

Looking at the marital status, manic-depressive patients show a higher incidence of divorce, or broken relationships, which would seem to be the result of the disorder rather than the cause.

and modern researchers suggest that the phenomenon could be related to the *abnormal response to light stimulation* found in manic-depressive patients (Mayers and Davies, 1978; Carney *et al.*, 1988). The increased sensitivity to light is also present in subjects defined as "at risk" because they have a marked family history of manic-depressive illness, and this peculiar response to light stimulation exists even before the onset of any clinical symptomatology. According to some researchers, this feature seems to represent a biological trait which is genetically determined, not only an epiphenomenon linked to the disease's state (Nurnberger *et al.*, 1988).

very sharply on the topic: "...My enemies referred the insanity to the drink, rather then the drink to the insanity" (Poe, 1980).

MANIC-DEPRESSIVE ILLNESS, ALCOHOL AND DRUG ABUSE

cocaine 15%

alcohol 45%   other or none 40%
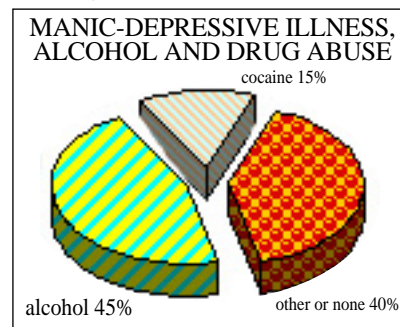
Alcohol and drug abuse, especially involving *cocaine*, is particularly elevated among manic-depressive patients. Patients with either manic or depressive symptomatology also constitute a significant proportion of the total alcohol and drug-abusing population (Regier *et al.*, 1990). Increased alcohol and drug abuse in these patients has been interpreted as an attempt to relieve the painful feelings linked to mood swings: the so-called *"self-medication" hypothesis* (Khantzian, 1985).

Seasonality

Almost two thousand years ago, Areteus realized that the disease had a special seasonal pattern: mania exploding during the spring and summer months and depression occurring mainly during winter time.

Drugs, Alcoholism, and Manic-Depressive Illness

The coexistence of substance abuse and mental disorders has been frequently reported in the literature (for a review, see Regier *et al.*, 1990). In some instances, mental disorders may be the result of

Legal Aspects

The altered behavior arising mainly from the manic upheaval may cause significant legal problems. There are two ways of looking at the issue: one standpoint relates to the precautions needed to protect the patient from the negative consequences that might arise from his behavior; the other deals with all the protective measures that necessarily have to be applied to avoid heavy burdens on the community.

It is important to understand that violence within domestic walls, frequently brought to court, might arise not from a mean person but from a misdiagnosed pathological condition, particularly when alcohol and drugs are part of the picture. In this case, the right answer to the problem may not be found in jail, as sometimes requested, but in proper medical evaluation and treatment.

Homicidal outbursts may also find an explanation in manic-depressive illness. Of course, socially dangerous individuals may not

SEASONALITY

Behavioral manifestations in a manic depressive patient
(seasonal type)

Mood | mania | Eutimia | depression

winter   spring   summer   autumn   win.

This cannot be considered an absolute rule; nevertheless, a seasonal pattern in symptomatology has been observed for centuries,

substance abuse; most of the time mental illness itself appears to be the cause of drug abuse. The American writer E. A. Poe focused

be set free, and society has to be protected from them; nevertheless, in a civilized country, a jail sentence should go together with appropriate medical and psychological treatment.

In some instances, the reason for referring these kinds of patients to the judge is "excessive involvement in pleasurable activities which have a high potential for painful consequences—e.g., buying sprees, sexual indiscretions, or foolish investments" (according to DSM IV diagnostic criteria). Most of the time the intervention of the judge is requested to prevent the destruction of family property.

Manic-depressive illness has to be taken into consideration even in a work setting, to preserve the job of the affected person, whenever possible.
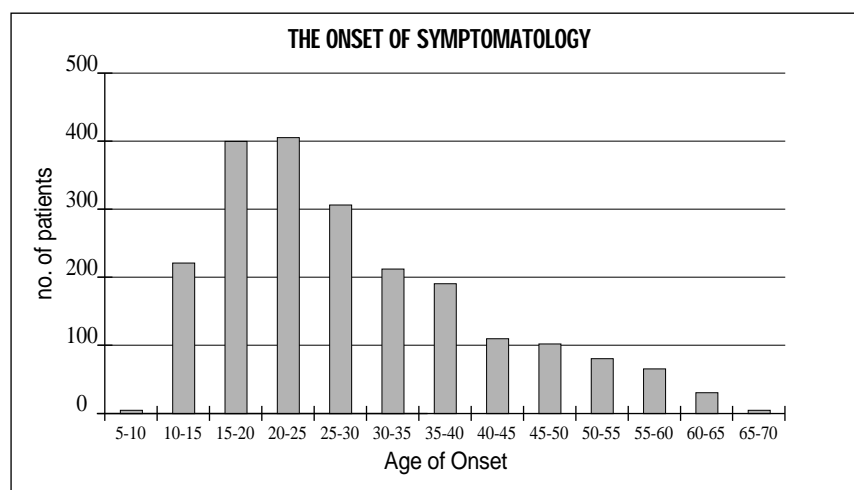
The Origin of the Illness

In ancient times melancholia and mania were regarded, respectively, as the result of an excess of black or yellow bile and, therefore, as *a medical condition*. It is surprising to see how, after more then two thousand years, the concept has remained practically intact—the bile having been replaced by noradrenaline.

Substantially, the illness may be considered, in an ultrasimplified way, as the result of an excess or a deficiency of noradrenaline, respectively, in mania and depression, at the level of the Limbic System. Noradrenaline is considered to be the most important excitatory neurotransmitter acting at the cerebral level; the Limbic System is that part of the brain where emotions are elaborated and lies under cortical regions—therefore, beyond the control of higher centers. This ultrasimplified conceptual framework has been set forth and confirmed at highly qualified research centers throughout the world in the last 50 years. The core of the illness is, therefore, a *biochemical imbalance* which induces, together with an extensive variation in noradrenaline cerebral content, an extensive variaition in mood.

The onset of symptomatology peaks between the ages of 15 and 25, with the vast majority of cases starting before the age of 30; sporadically, the illness may appear during infancy or after age 50.

THE ONSET OF SYMPTOMATOLOGY

Precipitating events play an important role in the onset of the first episodes of either mania or depression. According to some researchers, early precipitating events may actually activate the preexisting *biological vulnerability*, thereby making the individual more vulnerable to the next episodes (R.M. Post, 1986a). This is a crucial point, inasmuch as it lends support to the fundamental role of *early therapeutic intervention* to reduce the severity of behavioral manifestations.

Genetic Aspects

Over the years genetic evidence has become too massive to be ignored, and the inescapable fact that manic-depressive illness runs in families has to be taken into account. If the illness is the consequence of altered cerebral neurotransmitters, as it appears to be, it is no wonder that, as people inherit the eye color or the shape of the face, they can also inherit some abnormalities linked to the neurotransmitter systems. It is a fact that 2\3 of the patients have a positive family history for the illness. Moreover, the risk of suffering from the illness in the offspring is 30%, if one parent is affected, a percentage which increases to 70% if both parents are affected (Gershon *et al.*, 1982a).

The genetic aspects of some mental disorders have been ignored because problems linked to mental illness were not tackled in a positivistic and rational way. The fear that the discovery of a genetic diathesis might cast a stigma on patients led clinical observers of the past to ignore something that in the end turned out to be inescapable. Ignoring the existence of problems does not mean that they are magically annulled; it only means that their solution is made more difficult. The consciousness that manic-depressive illness can be genetically transmitted may foster a correct evaluation of initial symptoms whenever they appear, thus permitting the initiation of proper treatment leaving less room for devastating mood swings.

Preventive and Therapeutic Aspects

The only preventive intervention is linked to *early recognition* of the disease and early treatment to minimize lifelong psychological, social, and possibly biological consequences. This is possible only if there is consciousness of the existence of the illness within the family. In fact, if some other member of the family has already been diagnosed as suffering from the disorder, it is easier to recognize the early symptoms of the disease and get oriented. Otherwise the whole family will keep on wondering and asking about the reasons for incomprehensible behavior which is attributed to bad will,

if not to a mean personality.

Therapeutic intervention is based upon neuroleptic drugs, benzodiazepines, lithium salts, antiepileptic drugs, antidepressant drugs, and psychotherapy.

Fully developed mania usually requires hospitalization. The possible stigma that may result should be weighed against the sometimes rapid progression of mania into a condition that could be dangerous for the patient and the rest of the community.

Neuroleptic drugs are extremely useful whenever severe symptoms, such as delusions and hallucinations, are present. Neuroleptic drugs are used briefly to avoid side effects which also include a possible switch to depression. Because sleep deprivation can contribute to the progression of the manic episodes into more severe stages, *benzodiazepines* are used as sedative and hypnoinducing agents. *Lithium salts* were considered to be the most effective mood stabilizing agents, and this is probably still the case, although some other *anticonvulsant drugs*, such as Depakin and Tegretol, may represent the preferred treatment for patients not responding to lithium therapy.

In the depressive phase of the illness *antidepressants* are, of course, the standard treatment, with some caution regarding tricyclic compounds, which might precipitate manic episodes. The new compounds, known as serotonin re-uptake inhibitors, appear to be safer in this regard.

Cognitive and *behavioral psychotherapy* is an essential part of the therapeutic process and focuses on the negative or distorted thinking pattern of the patient. The therapist and the patient use current happenings in the person's life as material for their discussion. Trying to rationalize emotional aspects is not an easy task in these patients and cannot be tackled without the support of pharmacotherapy.

The Essential Role of Family Members

Whenever the manic episode is full-blown, it is impossible for the patient to look for help; therefore, the role of the family is crucial in this phase. It is up to the family to convince the patient to seek help and to see a physician—a tough assignment. Moreover, it is always the family's role to perform the hard task of making sure the patient is taking the prescribed drugs, at least to the point when he will be able to regain his full autonomy.

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WANDA POLTAWSKA

Nonhuman Man

Introduction

Although the concept of "humanity" at first sight appears unequivocal and unambiguous, the real truth is that during the epoch we live in there is a clear and evident need for its definition—as, indeed, is the case with very many other concepts which at one time were clear-cut in their meaning—because this term is repeatedly misunderstood.

At the present time, it may be observed, various distorted criteria lead to the individual not being included within the *genus humanum* of homo sapiens. What has happened is this: what man is and what he is not, or who he is not, has been subject during our times to fluctuations and variations determined by a variety of factors which are not only social and political in nature but also of an ethical character, to such an extent that at the end of the twentieth century man seems unable to discover his true identity.

What is man?

It appears that it is to this fundamental question that the modern world is unable to give an unequivocal answer; and the history of the century which is now drawing to a close involves numerous episodes and examples of men denying to each other their true identity as "men." Man feels threatened and in losing his feeling of security he seeks to defend himself and thus becomes aggressive. The declarations of the rights of man, of the rights of the child, and of the family which every now and then are proclaimed by various institutions lack executive power and remain mere words—such terms are unable to defend those who are threatened.

1. The Personalist Concept of Man

Christian anthropology lays down in unambiguous fashion what man actually is—a being created by God the Creator in his image and likeness as man or woman. This being not only is brought into being by the creative idea of God, but is considered as being his child, indeed his favorite child. This is reflected in the fact that being the object of his special love, He sent his own Son into the world for the good of this creature, a Son who through his own passion and death redeemed this beloved creature. But this striking origin of man requires an act of faith to be accepted, an act of which twentieth-century man seems incapable. Contemporary man is not able to accept or does not want to accept such origins and ends up by narrowing and limiting the dimension willed by God, satisfying himself with truths which are much easier to accept, given the state of his limited rational powers.

John Paul II has often sought in his speeches and addresses to emphasize the great dignity of the human person who has—as has been observed above—a divine descent, while at the same time contemporary man, indifferent to his Creator, strives to invent new conceptual systems designed to define himself. In this way numerous social and philosophical ideas have come into being, a phenomenon which can be explained or at least understood by observing individuals—in their way of living one can only with infinite difficulty detect an element of likeness to God. In the personalist conception of man, however, every human being *in fieri est* and he always advances towards greater completeness, and thus the whole of his life must be dedicated solely to a development seen in these terms.

Christian anthropology attributes human rights to every man regardless of his state of development because it is based upon the fundamental criterion that man is the created being of God and is his child. In the same way it cannot accept that any reality whatsoever—dictated by man or by other factors which can impinge on his destiny—conditions and thereby limits his personal dignity.

For this reason our neighbor is a person who not only must be totally accepted but must also be loved. It is with this knowledge that Christianity approaches all men, without exception, and it is for human rights understood in these terms that the Church has fought for centuries and still continues to fight, even though in our times her efforts come up against, and have to deal with, obstacles which are very great and imposing.

2. Disturbances in the Development of the Person

Research carried out on the development of children has enabled us to establish an average statistical norm by which to monitor such development. These criteria produce a means by which to classify the person who has developed normally, even though it often happens that theory does not always coincide with what actually happens in practice. It is clear that development depends on, and is condi-

tioned by, various kinds of factors which can check or accelerate the rhythm of development and growth. However although it is possible to establish the rules which govern the growth of the body and intellectual capacities in a form which is relatively objective, it is far more difficult to establish the rules which govern social and mental development. Employing an index which seems suitably reliable, certain people are seen as having developed normally whilst others are deemed to be "underdeveloped" or effective in a limited sense. This last takes place when the development has been disturbed and these people are thereby prevented from carrying out normal social functions and procedures.

*A) The Fate of People Who Are
   Not Completely Effective*

For a Christian, the evaluation of the human person involves no doubt at all. Jesus Christ affirms that He himself is to be found within each of these "poor people," both in those who are not yet born and are thus completely defenseless and in those who are afflicted by any kind of handicap or impediment. For centuries the Church has sought to offer her help to those people marked by such a fate and destiny, and she has done this in all the difficult situations which have been met with.

The history of the saints of the Church presents an account of hundreds of holy men who have consecrated their lives to such an undertaking. Outside Christian ethics, on the other hand, in differing epochs and countries, people afflicted by this kind of handicap have been treated in a very different way, beginning with Sparta and finishing with present-day legal systems which throughout nearly the whole of the world deny the right to life to sick people, and not only to people who are sick but also to those who suffer from forms of handicap. Furthermore, to justify this pre-ordained attitude of rejection of the unborn child there is an attempt to substitute the appellation "man" by inventing definitions which are ever more perfidiously subtle, such as embryo, pre-embryo or even fertilized "oocyte."

But every believer is more than well aware that man, independently of his stage of development, is always a man, and is so from his conception. And conception, more than being an object of scientific debate, often becomes the object of political manipulation and chicanery. The moment of conception of human life is the moment of the union of the cells of the mother and the father. This belief is mandatory and allows of no uncertainty for all men of reason.

*B) Disturbances of Personality
   and Other Psychic Alterations*

It would seem obvious that the presence of illness does not have a bearing on a proper conception of what man is, and yet the history of mankind shows that people affected by psychic disturbances are often forced to undergo the rejection of the whole world. They are frequently treated worse than animals, and all this despite the fact that mental illness should not be a reason for the abandonment of the rights of man. In opposite fashion, one of the first actions of Hitler in Poland was the mass extermination of the mentally ill (and the staff of their clinics).

It is a well known fact that certain forms of mental disturbance deny the individual the possibility of communicating, and that others are not able to communicate with the person subject to such illness. But this has no effect whatsoever on the fact that the man is always a man, a being who bears rights.

3. Regressions

Among those whom we often refuse to deem "human persons" are to be included the elderly, where the processes of cerebral decline have created a deterioration which is so serious that the individual not only loses the capacities which previously constituted his intellectual and even his moral powers, but also his own awareness of who he is. For this reason, senile illness, rather than provoking a sense of human pity, often engenders a selfish attitude which leads those who are near to the elderly person towards a rejection of that old and sick person. He often

becomes removed not only from his own home, but even from the world itself. The modern tendency of approving euthanasia—an attitude which is gaining ever great support—is a more than an evident testimony to this reality.

4. The Criterion of Utility

There has thus been an increased tendency to attribute the dignity of man only to those people who are able to produce goods which work to the benefit of the development of material values. In reality, behind this attitude we can detect the presence of the right of the strongest. A society constructed along these lines does not defend the weakest of its members but, on the contrary, marginalizes them or eliminates them in pitiless fashion. We can here observe systems of classification employed to discriminate against different groups within mankind. They operate at different levels, each of which corresponds to a differing stage of humanity: there are the weak and there are the strong. There are different reasons for weakness and its expression also takes varying forms, but on the world stage there is an unceasing struggle for the dominance of the world—both of the world of objects and of people. In this struggle the weak perish.

5. Humanism

In the history of this struggle of might against weakness, we can find every now and then those coordinates which make up the quintessential human factor of man. In such an instance there is a definition of what really distinguishes man from the animal kingdom—that is, the capacity for judgment and for love. Man finds something within himself which leads him to a "metamaterial" and "metacommercial" attitude, and only this approach can be assigned the definition of being fully human—humanitarian. But such behavior towards others can be seen as right and normal only if it includes all men, without the operation of distinctions of any kind.

This is because the appeal—

which is in appearance fully justified—to behave in human fashion towards others—that is, to treat them with comprehension and compassion—can also degenerate. It does this when it becomes an instrument for the satisfaction of the interests of a social group or of selfishness in any form and thereby becomes totally negative, even leading to the justification of acts which are not human. Is this way the slogan "mercy killing" in actual practical terms becomes the slaying of the elderly and of children. The slogan "the good of the mother" means the killing of a newly-conceived child and in similar fashion the good of a nation becomes the elimination of an opposing nation.

Indeed, the twentieth century has witnessed a series of manipulations, at times through the employment of various slogans, which falsify reality and create merely the appearance of what is good. For example, faced with the example of the satisfied smile of a woman on television who has conceived a child through artificial insemination, nobody thinks any longer that this smiling woman has been treated not as a human person but as just another farm animal subject to experimentation. In this way, we can see how the appearance of good conceals the real essence of the question.

6. The "Anus" of Humanity

The extermination camp of Auschwitz has been called by this name, and, unfortunately, it is not the only place of its kind in the world. The twentieth century has known thousands of such places of torture—places where some men have decreed and effected for others a form of destiny which is so cruel that its very existence beggars belief. Paradoxically enough, we may ask, what really defines the human being in such cases? The answer is simple—the ability to be inhuman in relation to others. No animal would be capable of such brutal and sinister acts as those perpetrated by man upon his own kind. Thousands of men are forced to endure conditions which are usually considered "inhuman,"

and yet these conditions are created by other men. Mass experiments on people, hunger, cold, forcing people to undergo pseudo-medical tests, the torture and killing of totally innocent men and women carried out in the name of a slogan bearing an ambiguous meaning which is often interpreted in a distorted fashion—is this humanity?

In reality, what criteria really define a man? A thousand times over the mite of an innocent child as large as a pinhead is worthy of the name "human" when compared to an SS man in a concentration camp or a gynecologist who destroys thousands of innocent creatures every day without batting an eyelid. Today there is a great deal of talk about inhuman medicine and inhuman governments, but in truth the whole of mankind is threatened in relation to its identity. There is now an urgent and pressing necessity for man to return to his roots. What, therefore, we may ask, is man?

6. The Samaritan

We need to return to the model presented by Christ, a model which is clear and unambiguous and which not only gives rise to no doubt but also suggests the only criterion for acceptable methods of evaluation: a "human" is that man who not only knows how to welcome the needs of others but also brings them relief and does everything to bestow practical and effective help. These are not mere fine sounding rhetorical declarations—they are acts, acts tailored to man.

It is in basing ourselves on such acts, indeed, that we can discern who a man is. This is because they condition and define those who carry them out. Thanks to his acts, a man can become a man of a superior moral level; he can grow in his humanity to the point of the full achievement of this faculty—and this is something which lays bare the holiness of man. In contrary fashion, through his acts a man can lose his humanity, the human factor—he can deny himself. In this way human acts become witnesses to man. And his acts will accompany him to eternity—they will

becomes his witnesses.

During my seminars on pastoral medicine for the students of my medical faculty I often take advantage of the following example. In the Jagellonica Library of Krakow two important documents are to be found, both of which go back to 1947. One of these is a sentence from the Nuremberg trials which condemned the Hitlerite doctors to the death sentence; the other is a monograph on the illnesses caused by hunger, the scientific production of a number of Jewish doctors. While dying from hunger in the Warsaw Ghetto they engaged in scientific observation and study, each applying and contributing his own particular specialization. After monitoring the consequences of starvation on the human body, they proceeded to outline seven stages in the acquisition of illness because of hunger. When the Ghetto was destroyed, the doctors were able to consign the results of their research to a Warsaw clinic, where some years later they were published under the title *Non Omnis Moriar*.

What I do is to suggest to my medical students that those doctors, whether Jewish or German, might actually have been colleagues, given that they were more or less of the same age; they might have studied medicine together at Heidelberg, but, in fact, they met with very different fates. They began from the same point, but the first died as heroes (the doctors went to their deaths together with the patients entrusted to their care), whereas the second met with an infamous end. The acts of man depend upon his free will because humanity, being, and life itself have not only been given to man by God but also entrusted to him as a moral undertaking.

And thus we see that the divine economy is distinct from the human economy. In the eyes of God the oppressed becomes the victor, and the tyrant is defeated!

For man, who is man?

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Psychiatry and Criminality

Introduction:
The Social Panorama

To properly appreciate the relationship between psychiatry and criminality, it is important to first look at the present situation in our society and the events that have taken place over the past several decades.

The Biblical reported stories of Cain killing Abel, and other reports of violence found throughout history and literature support the fact that violence and victimization have been part of the collective life and daily relationships since time immemorial. Today, social violence is rampant in many of our streets and homes, and at times in places of employment. however, it should be recognized that social violence is related to social historical periods and that its highs and lows seem to follow the cyclical returns of the past hypothesized by Giovan Battista Vico.

Violence, we know, is often the expression of frustration and hostility, at times generated by profound dissatisfaction with the business of life. Today, a good percentage of our citizens, especially in the Western world, direct themselves inappropriately and unsuccessfully towards ever changing goals that culture and society incessantly manufacture for them. Social systems seem to create an undercurrent of manipulation of the members of society. Bureaucracy, extreme rationalism and utilitarianism have also changed man to an organism whose behaviors can often be predicted, manipulated, and controlled.

Moral-ethical taboos that have withstood the passage of time and that are unquestionably part of the human archetypes have been shattered. Social criticism and incessant social activism have undermined authority at all levels of social behavior.

We have reached the point that moral values are seen as part of a theory of relativism, together with the breakdown of other valuable forms of institutional life. The present-day family, even though accepting a dynamic existential adaptation to new technological discoveries and cultural changes, often does not pass on to its members those traditional values of honesty and responsibility so important for good citizenship and self-esteem. I do not underestimate that vast socio-economic events such as lack of jobs, poor educational opportunities, the search for a quick solution of problems in the fleeting, unnatural nirvana of illicit drugs have contributed greatly to the above in further shaking at its roots the western hemisphere families that have been stable and united for many years, fully supporting of and supported by the Judeo-Cristian tradition.

In the past several decades, to be more precise, pseudo psychologizing—half-explanatory and at times filled with confusing interpretations—has often undermined the relationship among individuals in our society and especially among family members. Progressively, we have witnessed the loss of authority of the father, the increasing loss of the basic role of the mother as a dispenser of love, and even the children in our society have lost their joy as budding members of a part of a community and of the world. People have assumed an attitude of indifference, apathy, and extreme dependency. From this state, unbridled, immature, and often antisocial—or for that matter, anti-anything—attitudes have taken hold.

Destructive rebellion at an individual/personal level, is reaching high peaks among the world's citizens. Children kill parents, parents kill children, men abuse women and children psychologically and physically, rape is rampant. Children kill police officers, people kill or attempt to kill authority figures. People assault, maim, and brutally murder one another at random. A singer writes a book full of demeaning pornography with no literary value and full of distorted sexual messages which is acclaimed a best-seller the first week of publication.

Religion and faith, and the belief in God have also come under scrutiny and attack. Their positive and beneficial influence on society at large and on individuals and families has been undermined. At times, religious representatives have been led to address not primarily the matters of the soul but also social and human policies that have led to misinterpretation of what Christian community life is, or should be.

This is the negative side of the social panorama that must be dealt with. This is the confused situation of a large stratum of humankind in contemporary society. It is supported by extreme individualism that reaches the point of substituting oneself for the Creator, aided by the power given by technological discoveries in all fields of knowledge. On the other hand, it reveals itself in its failings and weaknesses

and in that aggression that good moral, ethical values and a supporting family minimized in the past through understanding and aid in the achievement of self-control.

In this panoramic view, one must not forget the flooding of the streets with drugs and alcohol, and the effect of the deinstitutionalization of the mentally ill which took place in the sixties and seventies, basically humane and well-intentioned, but with often unexpected and harmful consequences to the chronically mentally ill. We have all had the opportunity to witness severely disabled and disenfranchised mentally ill people parked on city sidewalks, living under bridges, sleeping in the waiting rooms of city bus or train stations, deprived of care and malnourished, at times angry and disorderly, unholding their right to be sick and to refuse treatment, disrupting the normal *modus vivendi* and frequently arrested because of social disturbance. Presently, indeed, the jail is often the repository of the mentally ill.

Should psychiatry share in a "*mea culpa, mea maxima culpa?*"

Since the task I was given is to try to enlighten you about the relationship between psychiatry and criminality in contemporary society, I will have to take you back a while to question whether psychiatry has in any way contributed to this present state of affairs. As we all know, during the past decades, with the advent of psychoanalysis, the Western world, particularly the so-called New World, acclaimed a schematic approach to man, making it a part of the understanding of human nature. Unfortunately, it moved it into a therapeutic approach to human ills that supported pragmatism in interpersonal relationships, at times leading to hedonism, rebellion against norms, extreme individualism, and disregard for traditionally important values and relationships. Accepting the Freudian scheme, many psychiatrists lost that part of humanism essential to the understanding of humankind and to their professional healing armamentarium. They be-

came technicians, and their attitude, reflecting the attitude of society, was often too permissive towards the expression of angry, hostile, disruptive feelings, believing that it benefited their patients. In so doing, however, they often disregarded a more objective approach to interpersonal relationships, homeostasis of the individual himself, life in a family, and security for the progeny when present.

New psychiatric and sociological themes in the sixties and the seventies led to unbridled eruptions of civic hostilities in an attempt to redress at times justifiable claims through disruptive behavior.

However, when humankind forgets that *natura non facit saltum,* turmoil often ensues. One cannot and should not redress disturbing situations with disruptive types of behavior. That only brings about confusion. The chaotic situation that we have witnessed during the past decades certainly testifies to that.

During the past decades, psychiatry, with its cathartic permissiveness, has inadvertently quasi justified disorderly behavior by embracing an attitude of *laissez-fairism* and relativism, and viewing society as the primary cause of people's ills, indeed criminogenic. Who is not aware of the progressive undermining of authority—beginning with that of the father—who has been portrayed as *padre padrone*. These various means of indicting society and authority have brought about unbridled impulsivity, resentment, hostility, and hatred, and not only social protest, but protest within families, disrupting the harmonious living of many of them.

A psychiatric approach to human problems, in order to be successful, must be holistic. Man should be seen as a composite of physical, spiritual, psychological, and environmental factors. It is my belief that psychiatry should base its technical expertise on well-rounded humanistic knowledge, which should include not only psychology but philosophy, sociology, religion, and—why not?—common sense. That background would minimize the prejudicial solutions of any sectarian psychiatric theory and cause them to see peo-

ple as human beings in a world that slowly opens up to them but of which they are not the creator. A psychiatrist should be able to help any individual, if necessary, to walk through this life, to accompany him or her through it, even for a brief period of time, without breaking or taking away from him or her those beliefs and hopes that are certainly necessary. Unfortunately, this type of assistance often has not been delivered. Psychiatrists, however, are social beings and their thinking often reflects the way in which society is going about life.

The Crime Scene

Let us look at criminality in contemporary society before discussing a possible remedy for the situation in which we find ourselves, I speak in particular of the United States, which is often the forerunner of things both good and bad. It is perhaps one of life's great truths that crime makes its greatest impact upon those people who feel the constraints and the indignities of having to live with poverty on a daily basis.

Crime, however, is not alien to the middle-class and the wealthy. Nevertheless, in the United States, murder rates escalate primarily in inner cities with their large minority populations and heavy drug use. Most of the crime victims are young and black, as are the victimizers. Many of the victims of crime happen to be in the wrong place at the wrong time.

Violent crime, without doubt, is a major problem throughout the world, even though the highest rate is the prerogative of the United States. People are not only harmed by strangers but are often victimized by those they love in their own homes. Forty-five percent of homicides result from domestic violence, and within those domestic walls children are being raised and usually learn and incorporate into their behavior the violence of their parents or the adults around them. They live in a climate of ambivalence, fear, and sado-masochistic aggressive-defensive behavior. And they usually adapt to it. This learned behavior keeps them, together with the adults around them,

in a state of insecurity, producing a lack of proficient achievement in school, an inability to relate to one another properly, an inability to eventually hold gainful employment, form a family and care for themselves and their children. This usually leads to their marginalization into that large cauldron of dependent persons who daily become increasingly demotivated to be a productive member of society.

Their dehumanization, their depersonalization, their inner aggressivity and their manipulative passivity at times explodes in the worst types of crimes. One witnesses not only the most unconscionable crimes committed by the most recent serial killers, but also the dreadful mass killing committed by borderline minds which unleash their hostility against society onto groups of people. One witnesses numerous cases of explosive violence which make one question whether people are unable to accept this dehumanized society of ours—the continuous struggle for survival in a rapidly changing socioeconomic world where fluctuations of markets do their share of killing without using weapons.

Frequently, one witnesses random violence and killing of people by users and abusers of drugs and alcohol. Many harbor deep hostility against authority possibly due to long resentment over the absence of a father figure and their subconscious perception of violence done unto them by the social system.

These are young people who are virtually conditioned to kill by the crimes they see in the streets or in the mass media. The raping or beating or killing of unsuspecting women is frequently reported, but the number of cases may be even higher than that reported because many persons, shameful or fearful, do not report rape, especially if it happens within domestic walls.[1]

We often witness lust-pedophilic type of behavior in which children are not only sexually abused but often used as pornographic material. Often, these children disappear. In the United States there are about 5-6,000 people who disappear during any given year. Many of them are probably preyed upon by criminal offenders. Cases of battered children and battered women are frequently reported. I have seen autopsies of children as young as one year of age who, crying for attention, have been viciously killed by persons under the effect of cocaine abuse.

Crimes of violence are ubiquitous, no doubt. There is no social stratum that has the prerogative for them, and obviously no culture is immune. However, it is the high rate of crime that is appalling today, and one wonders what is happening in our society. A survey of 100 inmates in one house of correction in the United States revealed that the inmates attributed their fall into criminal behavior to a breakup of their families and a lack of male leadership in their lives. It seems that our society is growing into a fatherless society. However, not only the father is lacking, but also the mother, who because of social and economic factors, is often absent from the home, and the children are left to themselves or to the supervision of strangers. Often, criminal offenders themselves are aware that the lack of love and nurturing from families prevented them from developing any sense of value in their life and the inability to establish a loving relationship.

The most recent statistics regarding correctional institution population in the United States report that as of June 30, 1994, local jails held an estimated 484,000 adults, or about one in every 398 adult United States residents.[2] The jails held an estimated 992,000 people in state and federal prisons at the end of 1994. The number of criminal offenses accounted for in the United States in any given year is in the range of many millions and every year throughout the country 2,000,000 people enter the correctional system, even though temporarily. The total number of adults under some form of correctional supervision in 1994 amounted to 5.1 million.[3] Although the number of homicides in the United States is reported as declining during the past several years, the number reaches approximately 30,000 annually.

It is interesting to note that the number of suicides is actually higher by several thousand more than the homicides.

Most probably, both homicides and suicides reflect the outer- and inner-directed aggressivity which follows despair and the inability to cope with a way of life which for many people is becoming more and more difficult. Marginalization, alienation, dissolution of bonds, lack of jobs, use of illicit drugs, and the devasting cocaine and alcohol addictions are all factors that enhance the existential or psychological disturbances of many of the American people. However, one should be cognizant that even other countries throughout the world are devasted by the same criminal victimization.[4]

Juvenile crime has become a drama for society and creates a moral dilemma for the judicial system. The crimes are frequently senseless, utterly destructive and motiveless and the sentences of these young people are an indictment of society. Many of these young offenders live in underprivileged conditions, but that does not justify their antisocial dyscontrolled actions. It may, however, support the implication that there is something wrong with the way society deals with them. There is no justification for killing when not in self-defense. It is morally wrong, and we must not psychologize any longer in saying that the acts of violence in our streets are an identification with the aggressor and a destructive way to halt the further victimization of the victimizer. Strangely enough, these are people who at times, when under the influence of drugs or alcohol, hallucinate both the voice of God and that of the devil in their confused mental states, almost putting into a nutshell the eternal problem of all societies: the struggle between good and evil. Only rarely, however, in my contacts with them do they voice an interest in God. Certainly, religious dictates are missing in their lives and most of them have no inner spirituality and no religious connection. There is social confusion in their lives and no goal or purpose. But many of these persons can be rehabilitated, especially the very young, before their criminal behavior becomes recidivistic.

In observing this type of society, the words of the Divine Poet, Dante Alighieri, are certainly helpful. The

poet, indeed, stated: "When I had journeyed halfway through my life, I found myself within a shadowed forest, for I had lost the path that does not stray."[5] How can the analogy between the mid-life crisis of Dante and the present-day social crisis be supported? How can the problem of an individual compare with an entire society? Both society and individual development pass through cycles. In society, there are periods of prosperity and enlightenment, alternating with periods of depression and obscurantism just as there may be alternating mood states and behaviors in the life of an individual. The despair of the mature Dante may well remind us of the regressive despair of one part of contemporary society, so mature in other ways. As Dante found himself in the dark forest of depression and lost "the path that does not stray," many in our society have lost the right path. Many people seem to be in a forest of social, cultural and ethical darkness, where the instinctual, impulsive, disruptive drives at the basis of antisocial behavior are increasingly invading interpersonal relationships. Dante believed that one should look up and be directed by wisdom and experience when searching for the Ultimate Truth and be motivated by love.

Psychiatry's Task

How can psychiatry help reverse this upsurge of criminal behavior? Psychiatrists have at times given up their primary role to ancillary professionals, many of whom do not possess their diagnostic and therapeutic skills, and they should attempt to regain that role. They should abandon the therapeutic approach of *laissez-fairism*, the accepted theory of absolute relativism, which tended to nullify values and contributed to the birth of a secularized religion. Their approach to a culture of human omnipotence which has thus far only augmented feelings of inadequacy and despair should be relinquished.

Psychiatrists can help people through their technical knowledge, their empathic listening, their understanding, and their reflections with their patients who need support and treatment, without consciously or unconsciously undermining the importance of values—ethical, moral and religious. Above all, they must uphold the personal responsibility of the individual. It is an arduous job, but, if motivated by *caritas* and a sense of humane and communal duty, can certainly be successful. Psychiatry should deal with people in their totality, giving a greater importance to their spirituality. That is why psychiatry has partially failed in its promotion of the welfare of the world. It, too, often forgot the spiritual side of humankind.

What about psychiatry and the criminal offender? Violence is one of the most important societal issues today because of its effect on victims, because of the fear created in the community at large, because of its enormous cost to society. Much can and should be done to prevent it. But there is now a wide consensus that law enforcement alone cannot provide an answer to the problem.[6] Preventing violence demands not only a long-term commitment but also a comprehensive approach that is not focused solely on aggressive responses and that calls upon various professionals. Psychiatry must be a part of that approach. It should actively participate in detecting those people who may be prone to possible violent behavior. The purpose should be not only preventive but therapeutic. While it is difficult to anticipate violence, especially in individuals such as serial killers, who offer the greatest difficulty in detection and rarely come to the attention of mental health professionals prior to their apprehension, for the majority of criminal offenders who are disturbed adolescents, frustrated young people, and homicidal/suicidal borderline or depressed individuals, much can be done to alleviate their despair and control their aggressivity. This is especially important at a scholastic level and in the workplace, and implies the cooperation of competent professionals. Appropriate treatment of these individuals will help guarantee the safety of society.

Psychological problems begin early in life—it has even been theorized that they begin *in utero*—but most often in childhood. For a growing individual, *gli esami non finiscono mai*. There are, indeed, crucial stages in which hostility, aggression, and violence may take over and explode. Since antisocial behavior is most frequent during that period of life that goes from 16/17 years of age to about 34 years of age, and is often preceded by escalating rebellion during childhood and adolescence, psychiatrists should pay close attention to the defiant child, the antagonistic adolescent, the antisocial young person, but also to the person who is apathetic, withdrawn and isolated. They must speak out against the conditioning of film violence in children and adolescents. At times, the famous ounce of prevention is worth a pound of cure.

In the legal field, psychiatrists must maintain their objectivity and not become partisan in judicial assessments of competency or legal responsibility of persons brought to trial for criminal offenses. In fact, at times psychiatrists are manipulated by the legal system, often with dire consequences for society.

Psychiatrists should willingly reach out to the inmates in correctional institutions, hold group therapy sessions for anger control, educational courses on the manifestations of anxiety, depression, and other manifestations of emotional illness, and teach people about life problem-solving choices useful in avoiding aggressivity. In their contacts with these offenders, particularly in the United States, they must take the opportunity to discuss the unfortunate consequences that gun ownership often brings about.

Indeed, "firearms...rank second as the cause of accidental death in children 10 to 14 years of age, accounting for 72 percent of homicides in this age range."[7] By participating in the re-education of offenders, the psychiatrist will become aware of a new and different world—a parasocial world of crime and punishment where convicted people, in spite of everything, may help to redress the ills of society through their forced reflection. Obviously, the correctional institutions must reach out for psychiatrists in the hope of creating a more humane environment for the inmates and better rehabilitative programs.

Most importantly, psychiatrists should be persons dedicated to caring for the deviant, even though not overtly mentally disordered.

Greater help, however, will have to come from a moral rebirth, a renewed spirituality, a re-evangelization of people. In this, the clergy will have a unique opportunity to become involved, not only from the pulpit, but with direct spiritual counseling of aggressive criminals. People need direction.

They need support to find their spiritual self and to be told they are wrong when they are wrong, rather than having their feelings of being a victim but not a victimizer unquestionably supported. This lenient, permissive attitude so far demonstrated toward criminals has created almost a justification for their conduct and has robbed them, through a demotivating understanding, of their capacity to bounce back, become remorseful and accept responsibility for their actions. To say, "They work with the hand life dealt them" should not be the basis on which to build a therapeutic relationship with people who commit crimes.

Conclusion

To summarize, while psychiatrists can do much to help in the early detection of possible offenders, there are many factors which are facilitators of violence. A basic cause of the violence is to be found in the progressive disintegration of the family. A disproportionate number of young offenders come from broken homes and their poor upbringing does not lead to the formation of that good character so important in any society. They lack pride and do not feel shame. Pride and shame usually facilitate the character formation of children and adolescents: pride in scholastic work and civic achievements, dedication to one's community or a humanitarian cause, or to one's family welfare. Shame is the feeling that people experience when they recognize that their actions not only do not conform to their personal values and expectations but not even to the expectations of others. These feelings are universal and do not know racial or religious barriers.

Proverbs (22:6) states: "Train up a child in the way he should go; and when he is old he will not depart from it," and it certainly reflects the wisdom of humankind through centuries past. Heeding it would be wise in view of the chaotic situation in many of our families at present, and in so doing perhaps reduce the criminality in society.

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Notes

[1] Together with collaborators, I conducted a statistical study in the city of Milwaukee on homicide, rape, robbery and assault which covered a period of 25 years. The four categories of violent crime that we considered statistically demonstrated that in a city like Milwaukee, stable in its population, showed that murder increased 511% between 1965-1990, rape jumped 1,712%, the frequency of robbery rose 1,990% and the number of assaults rose by 217 percent.

[2] About 94% of all prisoners were men; 47% were white; 51% were black. Probation, there were nearly 3,000,000 adults on probation as of December 1994. Probationers made up 58% of all adults under correctional supervision in 1994. Approximately, 20% of the probationers were women, a larger proportion for any other correctional population. About 66% of the adults on probation were white and 32% black. Six out of ten persons released from probation had successfully completed their sentences.

From 1980 to 1994, the probation population grew by more than 1.8 million, an average of 7.2% annually. The number of prisoners rose by 9% during 1994, the equivalent of 82,200 inmates. An estimated 690,000 adults were on parole at the end of 1994, an increase of 2.1 from 1993. Nine of every ten parolees were men, estimated of 53% of persons on parole were white, 46% black, and 1% of other races. The number of adults on parole tripled during the 14 year period (from 220,438).

On December 31, 1994, the United States Army, Navy and Marine Corp held a total of 2,782 prisoners in 33 facilities. Approximately 98% of military detainees were men and 2% were women. Half were non-Hispanic whites; 39% non Hispanic blacks; 7% Hispanics; 4% other races. Of the offenders, 17% percent were convicted for rape and 15% for sexual assault. Prisoners convicted of murder or non-negligent manslaughter accounted for 11%, as did those convicted of larceny and theft.

During 1994, 306 immates were received under sentence of death by state and federal prisons, and 112 had their death sentences removed by means other than execution. State and Federal prisons held a total of 2,890 prisoners under sentence of death of December 31, 1994. An estimate 57% of those under sentence of death at year end were white and 41% were black. Half of the inmates, and here we are talking about non-military inmates, had been under sentence of death for at least six years. Thirteen states executed 31 male prisoners during 1994. Men made up 90% of adult

jail inmates. While, non-Hispanic inmates accounted for 39% of the jail population; black non-Hispanics for 44%; and Hispanics for 15 percent. The annual average increase was 7.2 percent between 1980 and 1994. (Bureau of Justice Statistics, Executive Summary, July 1996, NCJ-161559, U.S. Dept. of Justice, Correctional Populations, 1994, Washington DC, pp. 1-4.)

[3] Ibid.

[4] Deaths from homicide in some countries per 100,000 population in selected years: USA (1991) 26,254; Northerm Ireland (1992) 1,627; Italy (199) 1,627; Finland (1993) 166; Portugal (1993) 149; Greece (1993) 133; Switzerland (1993) 111; Sweden (1992) 117; Norway (1992) 47; Denmark (1993) 63; Germany (1993) 966; France (1992) 581; Spain (1991) 346; England and Wales (1992) 288. (World Health Statistics Annual, 1994, Geneva, Switzerland: WHO.)

[5] *The Inferno,* Canto I

[6] See GOLDING in Bibliography No. 10

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ADOLFO PETIZIOL

The Sickness and Death of Listening: The Drama of Loneliness

In Italian the term *solitudine* means both a condition without emotional significance which involves an absence of interaction with other people, on the one hand, and a condition which is emotionally involving and imposing characterized by the lack of a relationship, isolation, and abandonment, on the other. In English, however, we have both 'aloneness' and 'loneliness'.

In the first case the absence of an interaction with other people nonetheless presupposes the existence of a resonance of self-consciousness, an internal perception which is ready to direct itself towards the perception of others and the environment, an opportunity to participate in one's own life and to live it out in integrated fashion in the environment. I am referring here to what German phenomenology defines as an "appresentation," a psychic act which works in the constitution of the alter ego by analogy with the ego. From this mechanism there is born that perceptive experience of the externality of the other person, of the objectivity of time, of one's own world, of the shared world and of one's neighbor.

The relationship with the world of the other is born in solitude from a special propensity involving a "direction of the act" where the vital flow of the person manages to move in harmony with the vital flow of the other person. From the two solitudes is born a sharing of emotional and affective forms of space.

The opposite path—that is, the one which moves in the direction of the act towards a divergence of the two vital flows—leads to a new solitude which is different from that which existed at the outset. This is the solitude of the loss of a relationship, of detachment, of melancholy and nostalgia. This is the solitude of mourning, of the loss of the maternal breast; the solitude of someone who loses an object of love, an object towards which there was rightfully a vital flow. This is a form of solitude which is experienced and expressed as a feeling which leads to the resolution and the integration of relationships with the lost object and to an adaptation to the fact of that person's disappearance.

We can detect the presence of three stages in the process of the experience and expression of the feelings provoked by the loss of such an object.

In the first stage denial and protest are the sentiments which prevail. The individual seeks to

Eymma Gula.
Eymmopus Gutti.

reject the fact that the loss has taken place. He feels incredulous at the fact and full of anger. Certain attitudes which are aggressive and destructive can arise which involve paranoid distrust and feelings of persecution—all because of the loss of an ability to enjoy the experience of a relationship infused with love and affection.

The second stage involves resignation and surrender. The reality of the loss becomes accepted and pain becomes established. The feeling of solitude blends with melancholy and a sense of nostalgia, both of which are provoked by the loss which has taken place.

According to Klein, the feeling of solitude in the individual experience of the process of integration marks the move to the state of depression. The process of integration represents the positive moment of adaptation to the fact of the disappearance of the lost object, of adaptation to a reality deprived of illusory perfections. The integration contains elements of suffering which are expressed by the feeling of solitude—that suffering which is necessary for a reduction of the idealization of the lost object and to an accompanying achievement of personal independence.

The third stage—that is, detachment—is characterized by the abandonment of the object, by adaptation to a life without that object. If the individual manages to overcome the loss, he becomes able to attach himself to a new object and to tolerate the solitude he has to endure by a process of projecting the positive aspects of the previous relationship onto another object.

From this examination of these three stages we can perceive the differences that exist in the way the feeling of solitude caused by the loss of a person cared for is experienced and expressed.

The solitude of a person who is unable to experience and express the loss of the presence of a dear one leads to the living out of a sense of persecution. The loss of the object in this case leads to a state of isolation and self-marginalization. The proper and healthy unfolding and evolution of the individual's feelings is disrupted; he feels deprived of something, and he wants to remedy this loss. As a result, the individual ends up by depending on an illusory and unrealistic ideal object which acts as a substitute. In the best of cases there is an interruption of the process of self-identity and independence and an accompanying inability on the part of the individual to be alone.

But in the worst of cases this solitude becomes an experience of unhappy isolation which is crowded with ideal and illusory symbols which disrupt and fragment the individual's normal relationship with reality. Such, indeed, is the condition of autism, where the persecutory anxiety of the loss of the object multiplies the fragments of an identity which is no longer comprehensible. This very fact of incomprehensibility goes on in consequential fashion to determine a feeling of extreme solitude which becomes a form of existential isolation. This form of solitude is marked by the symptomatic phenomenology of different kinds of psychoses.

This is the most obscure, surprising, and at times bizarre form of solitude, which is characterized by a disturbance of the flow of oral communication. The adjective and term "autistic" refers to the precursors of communicative forms of behavior, to that stage of development where a word does not yet have any kind of meaning.

When, on the other hand, the negative connotations of the loss of the object completely immerse the feeling of solitude, the anxiety connected to the perception of this absence becomes translated into a feeling of death and depressive

guilt. In such situations we find that the anxiety provoked by separation—the tragic fear of being alone and abandoned, of being drained of the vital lifeblood of authentic affection—comes to dominate the individual.

If we now move from a consideration of the problem of solitude from the point of view of personal experience to the rather different realm of interpersonal dynamics, we immediately perceive the fundamental importance of the crisis of the process of listening.

We live in a society characterized by the imposing presence of systems of mass communication and the world of the mass media. Such a society is strongly marked by the sending of messages which are directed at groups of people. The epoch of giant means of worldwide communication gives man the opportunity to greatly expand the quantity of information which he receives, but this also involves a diminution of the very quality of such information. The content of the messages also bears witness in a direct way to the crisis in values which now afflicts our society.

The mass message is impersonal and seeks to impose a collective identity on the person who receives that message. It ignores any form of emotional involvement and runs along lines which are detached and dissociated from an affective point of view.

The emotional repertoire of a person is usually made up of emotional experiences which arise through relationships with other people. In the world of mass communication, however, there is a more or less illusory activation of experiences involving human relationships which often lack significance. Until the illusion is seen and understood as an error, its value is exactly the same as that of actual reality. But once the illusion is recognized, it is no longer an illusion. Indeed, the very concept of illusion, and that concept alone, becomes an illusion.

Mass communication often represents an illusory substitute for interpersonal communication. Relationships between people seem to be negatively influenced and

conditioned by the crisis in family values, in major ideologies, and in the various groups of social support. The interpersonal relationship itself is often replaced by a superficial listening to messages which are completely drained of their emotional coloring. And the reality which is thus experienced becomes crowded with elements of vicarious reality in a sort of paradoxical process of "acting out" where collective hyper-reality becomes banality and meaninglessness.

The presentation of an integral reality causes the suppression of the illusion, and with this the death of individual and subjective reality. All the qualities of reality—such as emotions, perceptions, representations, and will—become virtual in character.

Virtual emotion thereby comes to create a content for personal consciousness which is not real. The subjective emotional experience—which is the intrapsychic by-product of a complex process of activation directed in physiological terms at achieving the survival of the individual—does not refer to messages which come from the real environment of human relationships, but which instead derive from the world of the already prepared.

Just as the virtual suffering of the ghost limb follows from the amputation of the real limb, so each virtual element follows from the amputation of reality, and the predominance of virtual communication follows from the amputation of the reality of listening.

The individual will becomes an artificially weakened artificial limb which is itself virtual. The will to possess the object of desire in real terms becomes the virtual realization of a desire which is itself a virtual representation, a projection into the internal mental space of needs which are not always necessary. The loss of the virtual desired object is followed by the loss of will and a blocking of the real experience of affection.

This survey of the influence of the virtual on the world of human relationships brings out the importance of the aspect of the solitude which springs from the death of listening. Listening gives way to

judgment, and understanding gives way to the need to know.

Individual differences come to be emphasized in human relationships and the relationship between the medical doctor and his patient is a part of this process. In the discipline of psychiatry in particular, the therapeutic relationship has in historical terms been based upon the moral judgment of the sick person. Deviant forms of behavior and madness were identified, stigmatized, and responded to with a process of marginalization. Psychological and psychodynamic advances and understanding should then have modified the clinical approach to the mentally disturbed through the introduction of the concept of *transfer* and with the opening up of fruitful paths of research in relation to the meaning of symptoms and syndromes of madness. The anti-psychiatric revolution then promoted a great change in the way the mentally ill were treated and sought to place them outside lunatic asylums, those places of marginalization. This step should have augmented and developed the culture of listening and of the acceptance of psychic deviation and difference. Biological psychiatry itself should have bestowed a new clinical dignity on the mentally ill person, a dignity which the psychosocial approach had severely undermined.

From all these new steps and innovations, which all too often proved unrewarding, there arose that state of contradiction which present-day psychiatry is now having to deal with and experience.

The objectifying knowledge of illness takes the place of diagnostic evaluation and assessment; the theory of psychotherapeutic methods and techniques prevails over the therapeutic relationship; the opening of the lunatic asylums becomes a process where the phenomena of marginalization and isolation increase.

Callieri argues that objectifying knowledge precludes an openness towards authentic difference in others. Given, therefore, that a relationship with another person is necessary in the clinical act, it becomes clear that the establishment of a nosological diagnosis employing only objectifying criteria comes to be a strictly anti-clinical act.

From what has been said hitherto, it becomes clear that the clinical dimension of psychiatry should be based upon understanding and that there should be an overcoming of the limits of classification and labelling. It needs to employ an authentically existential approach and as such should be based in part upon the value of subjectivity. Such subjectivity should be understood not as that which is arbitrary, but as an existential movement of a subject directed towards understanding another subject. Only in the dynamics of the encounter between two subjectivities can there emerge the global understanding of the pathological psychic element which is a point of departure for any kind of treatment, whether biological or psychological in nature.

The act of understanding must be directed towards the creation and establishment of a therapeutic alliance where the suffering subject remains in a state of implicit waiting for the beneficial action achieved through the psychiatrist's listening to his experiences.

In relation to the illness of not listening to which my analysis pays such great attention, I am necessarily drawn towards laying stress upon the therapeutic purpose of the clinical encounter within the discipline of psychiatry. This is because at times not the slightest attention is paid to the benefits that the patient can gain from such a process. This is a form of listening which in actual fact is emptied of its fundamental curative purpose and often enters into a realm of intellectualistic or pseudoscientific voyeurism. In the therapeutic relationship there must be an atmosphere which encourages the hopes of the patient that he will overcome his difficulties rather than relapse into or remain in a state of defensive isolation.

It is too often the case that the need to study the technical possibilities of establishing an interhuman relationship in a psychologically correct way has led to the creation of rigid and formal attitudes and stances. On the contrary, the psychiatrist must maintain his own vitality, the integrity of his own personality, his own humanity, and his own style. His neutrality must not be coldness and his sensitivity must lead him constantly to that therapeutic point which exists between distance and closeness to the patient.

The nosographic dimension, although kept at a level appropriate to scientific communication, must be placed at the margins of the relationship with the suffering individual, who does not want labels but real answers to his questions. The diagnostic element appears rudimentary when placed beside the problem of listening to the requests of the patient, which are often couched and expressed in codes which are bizarre, but which are always related to the great and abiding needs of human existence. Yet modern psychiatry over recent years has preferred to concentrate upon objectifying methods and approaches involving ever more detailed syndrome models which become ever more drained of real meaning. Diagnostic action involving interpretation at a psychological level which is all-embracing and full of communicative functions in relation to the sick person seems now to be in crisis.

I believe that we need an effective integration of the experiences offered by psychoanalysis, traditional psychiatry, the neurosciences, social psychiatry, and crosscultural psychiatry, if we want to overcome the very deep cultural crisis which has afflicted psychiatry. In a world afflicted by the neurosis of nonlistening, the discipline of psychiatry must regain the credibility of a science at the service of suffering man, of a science which is able to decodify the most cryptic calls for help, of a science which is able to provide valid and effective answers without the construction of alibis by which to become isolated in a world of mere speculation.

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DIEGO DE LEO, PAOLA MARIETTA

Suicide: Determinism or Freedom?

Cultural and Historical Changes

The freedom of an act of suicide—the fact of "performing" that act rather than "committing" it—and the whole question of rational suicide are matters which have become the subject of marked attention over recent years. This is true not only in relation to experts of the scientific community but as regards public opinion as well.

It has been observed that public opinion has changed its overall approach to this whole area and that at a general level it has begun to perceive suicide as a choice carried out in certain life contexts. In a study by Cutler and Danigelis which was published in 1993 it was demonstrated that in 1991 70% of individuals belonging to their sample were in favor of a law which authorized medical doctors to end the life of patients suffering from incurable illnesses. In 1950 the respective figure was only 31%. 66% of the population interviewed in 1994 in Michigan seemed to be in favor of assisted suicide (Bachman *et al*., 1996). However, different results emerged from a study conducted by Seidlitz *et al*. in 1995 which was carried out on a representative cohort of elderly people—only 42% of those interviewed expressed themselves in favor of the legalization of assisted suicide.

In the world of health care the concept of health has changed markedly because the tendency has been to move away from giving importance to the illness itself towards laying stress on individual well-being (De Leo, 1993). Attention has thus become focused upon the concept of quality of life and upon the notion of a good death.

Interest in the whole question has given rise to the creation of a number of associations which defend the right of man to die "with dignity"—the Hemlock Society, which was founded in Los Angeles in 1980, and the Deutsche Gesellschaft fur Humanes Sterben which was established in the same year in Berlin (Battin, 1994). Furthermore, since 1993 forty-seven states of the United States of America have passed legislation which defends the right of people who find themselves in situations of incurable illness to die through the employment of a document which is termed a "living will" (Battin, 1994) or through the agency of a representative upon whom the individual confers the power to decide whether he should go on living if he should no longer be in the condition to exercise this choice himself (Humphry, 1991).

The theoretical justification employed to support the idea that the act of suicide in certain circumstances can be the outcome of free choice is based on the belief that in situations of suffering a week of living only involves useless anguish and a prolonging of pain. In his book *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*, Derek Humphry (a journalist who founded the Hemlock Society) has outlined the principles of that association. However, this work may also be considered as being a kind of manual by which to take your own life. The work has been roundly criticized, not least by Kass (1991) who declared that: "Thanks to Derek Humphry's book, our youth (in attempting suicide) need no longer fail." The case of Dr. Jack Kevorkian and his death machine

(Humphry, 1991) has given rise to similar such criticism and attacks from 1990 onwards. We know about many Kevorkian "cases" in addition to the first and by now famous and infamous instance of Janet Adkins—the cases, that is, of Quinlan, Saikewiczs, Spring, Eichner, Bouvia, Cruzan (West, 1993; Bettin, 1994) and many others. At the present time of writing we know of at least forty cases of individuals who have been helped to commit suicide by this "Dr. Death."

We should not, however, fall into the trap of believing that the whole subject of the right to death is of recent date although it is certainly true that the subject is nowadays discussed in different terms. Indeed, a papyrus of 2,280/2,000 BC demonstrates the antiquity of the debate. This document deals with the question of suicide because a man tired of living expresses his intention to kill himself and asks his soul to accompany him (Evans and Farberow, 1988). Many of the questions raised by this papyrus echo those of contemporary debate: does a man have the right to end his life, not least when he finds himself in very difficult and trying circumstances? How can the conflict between individual freedom and social responsibility be resolved?

In the ancient Israelite world the act of suicide was rather uncommon and in general it was not accepted. This was because of the strong attachment to life and the optimism which so characterized this people. Although there are examples of suicide (from Saul, Razis and Zimri to Judas Iscariot), neither the Old Testament nor the New Testament openly condemn or prohibit suicide.

The conception of suicide to be

found in the ancient Roman or Greek worlds was not always the same. Aristotle condemned suicide as a cowardly action and as an injury to the state but Plato held that in general it was acceptable only in certain specific situations. On the whole, because honor was a dominant value of these peoples suicide was generally seen as a suitable solution to a status of dishonor.

Between the seventh and the fifth centuries BC Greek culture was marked by a certain pessimism and a disenchantment towards life. Sophocles, Euripides, Heroditus and Democritus, for example, believed that suicide was the best way (if not the quickest) by which to leave this life. The poison by which Socrates killed himself—hemlock—was introduced specifically during that period.

In his work *De Ira* Seneca defended suicide and observed that eternal law provided only one way of entering this life but many ways of leaving it. The historian Zenon argued in favor of suicide in circumstances which involved unbearable pain, mutilation, or incurable illness.

At the outset in the Christian world there was a strong attraction towards suicide because it could involve martyrdom. But with St. Augustine, the Father of the Latin Church, the attitude towards suicide changed radically. In *De Civitate Dei* St. Augustine argued against suicide on the grounds that it went against the Fifth Commandment of "thou shalt not kill." The first authentic and explicit prohibition of suicide within the Christian church is, however, to be found in the Council of Arles of 452 and the Council of Orleans of 533—on these occasions suicide was defined as being the worst of all crimes. Subsequently people who had committed suicide were denied burial in holy ground (967).

In the thirteenth century St. Thomas Aquinas elaborated a more precise position for the Church as regards this whole area. In his *Summa Theologica* this theologian presented three fundamental arguments against suicide: self-destruction is not in harmony with man's natural inclinations; man does not have the right to deprive society of his presence and his activity; and

man is the property of God and therefore only God can decide upon the moment of a person's death.

This position was later criticized by Hume (1882). Over the centuries suicide has been seen as a blasphemous act (that is, a religious sin) but also as something which is shameful. Indeed,until the nineteenth century the person who attempted or committed suicide was considered the author of a crime worse than murder. Thereafter there was an important change—a move from seeing suicide as something shameful to considering the man who managed to commit suicide as not responsible for his death because he was not *compos mentis*. The famous English legal expert William Blackstone (1962) described this shift in opinion in the following terms:

"But this excuse (of lunacy) ought not to be strained to the length to which our coroner's juries are apt to carry it, viz., that every act of suicide is an evidence of insanity; as every man who acts contrary to reason had no reasons at all; for the same argument would prove every other criminal non compos, as well as the self-murder."

In this way suicide ceased to be seen as merely an existential problem and begun to be seen in medical terms as well. This in turn gave rise to investigation into the causes of suicide and into the risk factors which might induce a person to take his own life.

Determinism and Suicide

When suicide is approached in deterministic terms it means that the phenomenon becomes subject to the principle of causality. The term causality suggests the "connection which establishes a relationship between two entities according to which the second is to be predicted with certainty from the first" (Galimberti, 1992). From such a line of reasoning suicide becomes the necessary consequence of previous physiological or psychological factors, an awareness of which permits the identification of certain risk factors.

Although biological research is an area of inquiry which is relatively recent,it has managed to achieve much through biochemical studies

of people who have attempted suicide and through post-mortem investigations into suicide victims. It has undoubtedly increased our ability to understand this most complex and intricate subject. The most relevant information provided by biochemical research relates to the abnormal working of the serotonin system of the human body. Serotonin has been discovered to be an extremely influential neuromodulator which acts on the central nervous system. Low levels of its metabolite (5-hydroxy-indoleacetic acid) have been discovered in suicide victims or in people who have attempted suicide—especially where violent methods have been employed—and this quite independently of whether these people belonged to a specific diagnostic category or not (De Leo, 1994).

Most post-mortem studies using tritiated imipramine have revealed a decrease in the number of connected presynaptic sites and other studies have shown an increased number of postsynaptic receptors in the pre-frontal cortex. Research into levels of prolactin reactions of phlenfluramin—an overall indicator of serotonin processes—have revealed abnormal reactions in people who have attempted suicide and are at the same time victims both of greater depression and personality disorders. A large amount of evidence has shown, therefore, that a decrease in the serotonin processes constitutes a biological indicator of "predisposition" although it is still not yet clear if this is the direct outcome of a specific "suicide factor" or rather the indirect product of such psychiatric illnesses as depression, schizophrenia or alcoholism (De Leo, 1994).

Other works of research have shown that genetic factors may bring about a disposition to suicide. Harberlandt (1965, 1967) and Roy (1991), for example, have discovered high levels of correspondence in relation to suicide attempts in identical twins. But such levels are even higher in relation to such psychiatric illnesses and disturbances as schizophrenia and depression. The presence of a psychiatric illness is thus thought to be a marked shared element. The research carried out by Schulsinger *et al.* (1979), on the other hand, has pro-

vided good evidence to suggest that there exists a hereditary vulnerability to suicide which is independent from—or at most superimposed upon—the genetic transmission of an affective disturbance (De Leo, 1994).

Psychic disturbance has for some time been identified as a contributory factor to suicide and has thus joined hypotheses of a genetic or biochemical nature. The World Health Organization (1993) argues that a form of psychiatric disturbance is the strongest risk factor working for suicide and that there is sufficient evidence to maintain that individuals who suffer from psychiatric pathologies are more likely to attempt an act of suicide or to actually kill themselves than normal people. Mood disturbances, alcoholism and schizophrenia are thus seen as the pathologies which bear the greatest risk of suicide and within these categories the most likely to cause suicide are the sub-groups of recurrent major depression and type II bipolar disturbance (Scoco and De Leo, 1995).

Various approaches to the subject have enabled us to analyze suicide from different angles of interpretation but the cause of a suicidal act is not to be identified in one variable because suicide must be seen as a phenomenon which is brought about by many elements. Whatever one's point of view, a greater awareness of the biological variables which are involved, in conjunction with their use within wider psychosocial studies, can but increase our knowledge about suicidal forms of behavior (De Leo, 1994).

Free Choice and Rational Suicide

In opposition to, and in disagreement with, determinism there is an alternative approach which sees the suicidal act as an action motivated by a deliberate choice to which the individual attributes a particular meaning. From this point of view, in seeking to interpret an act of suicide it should be seen that not all people are ready to accept the idea that life is the supreme good of man. For example, Amery (1990) has employed the phrase "the situation which precedes the jump" to refer to that moment when the logic of life becomes substituted by the anti-logic of death.

The logic of life is present in every situation, at a daily level, at the moment—that is—when we remind ourselves that "we nonetheless have to live." The person who chooses death places himself outside this way of thinking—for him life has lost the value of being a supreme good. It can happen that life imposes limitations and limits upon us—that is, insuperable barriers which make life unbearable. Forms of incurable illness are exactly such barriers and constitute elements which deprive an individual of his independence and freedom. It is precisely at this point that the alternative of death rears it head, an alternative which is deemed to be "free" because it is chosen by the individual as the only possible means by which to detach himself from something which constitutes an unbearable burden—his own body.

It is thus argued that it is through death that all limits and limitations imposed by life are overcome and that it is always through this policy that a project is implemented which involves the achievement of true and final freedom. Jean Amery has laid especial and overriding stress upon the right which every man has in relation to his own death—such a right, it is argued, should never be called into question. Man can obey anybody and also himself and it is by this route, it is said, that he can choose in favor of death and thereby reject the logic of life. The person who strives to save a person bent on suicide from his fate, it is observed, could well turn that individual into a different person but that person would not necessarily be better.

In this approach the concept of natural death has to be redefined in radical fashion. Death can be defined as being "natural" only in relation to the person who wants it. Even in the case of an elderly person who is aware that his time on earth is coming to an end there could be a strong desire for life. The person who commits suicide is thus seen as an individual who has chosen a free death as his natural death. He has, as it were, brought forward the moment which would anyway have come and in this way he has become the architect of his own death (Amery, 1990). To put it in essential terms, the message which the person who commits suicide communicates to the world is that of being able to belong to himself. In so doing he demonstrates that he has an equal right both to life and to death.

It is more than obvious that the employment of this approach as a way of understanding suicide involves a denial of the need to establish whether a determining cause of the act of suicide exists or not. We can thus more easily understand why such figures as Stig Dagerman (1991)—a Swedish writer who died at the height of his success and fame—chose an early death while engaged in a struggle between the desire to be happy and the impossibility of being so, and between the need to be free and the limits and limitations of life. The same may be said of Sylvia Plath (1992), an American writer who killed herself at the age of thirty-one. In letters to her mother she frequently made clear that she was unable to bear the idea of being mediocre and these letters also indicate that perhaps she took her own life at a moment when she no longer felt able to rise to the occasion of the experiences of her life.

For Margaret Pabst-Battin, the idea that the suicidal act is an expression of free choice amounts to a correct definition of suicide or rather of that act of suicide carried out by a person who does not display elements of psychic disturbance of any kind and who at the same time is able to perceive—through a sound evaluation of reality—that death is preferable to life (Battin, 1991).

In 70-80% of cases people die of degenerative illnesses after a long period of suffering (Battin, 1993; 1994). Modern medicine enables man to survive in states where every form of independence has been lost even though cerebral functions remain unimpaired or in a condition where the individual is in a vegetative state of cerebral death. The terminally ill could therefore easily constitute a category at risk when we come to consider the policy of rational suicide; but the same could also be said of the elderly. Indeed, old-age can involve major changes at a cognitive level and can lead to

psychological changes and the creation of a new self within the elderly person (Pajusco and De Leo, 1994). As a result, the decision to take one's own life would not really be a choice between life and death but rather a decision as to whether the new self should live or die (Prado, 1990).

Battin (1991) has drawn up a list of elements which the health care worker, the doctor or more simply the person who looks after a person who wants to end his own life, should consider, appraise and evaluate. This list, it is argued, should help people to understand if a rational or irrational choice is involved but first and foremost it should lead people to reflect on the fact that the person who contemplates suicide is not always a depressed person or somebody who is some way is affected by a form of pathology. In this approach suicide could in certain cases be the outcome of an independent and balanced choice which is in harmony with that person's cultural background or personal history.

In the opinion of Conwell and Ciane (1991), one should avoid both therapeutic overkill and paternalistic kinds of care. One should not impose forms of treatment which prolong the life of the patient and in so doing ignore the independence of choice which every person has as a right. At the same time it is argued by these authors that it is equally necessary to engage in a careful evaluation of the other courses of action which are open to the individual concerned in addition to that of taking his own life.

Appelbaum (1988) sees rationality as a feature of the free choice of an individual and dwells at length upon how this can be judged and assessed. In his opinion it is necessary not only to inquire into whether the individual is able to choose in an effective way but also to reflect upon the consequences of that choice for the person involved and for the social network more generally.

From this point of view the presence of rational suicide may therefore be detected through a consideration of:

1. the realistic appraisal or otherwise of the life situation of the individual concerned; 2. the integrity of his mental processes;

3. the logic of the motives behind the choice and the unanimity of judgement on the part of external observers (Mackenie and Popkin, 1990).

Seen in such terms, only a small percentage of suicides—between 5% and 10%—could be defined as being the outcome of a "rational" act in the light of present-day scientific knowledge or could be considered as the only possible alternative to an unchangeable state of suffering (Diekstra, 1992).

The Role of the Health Care Workers—Prevention Always and in Every Case?

It is very unlikely that a psychiatrist will not have the experience of having to treat patients afflicted by suicidal ideas or individuals who have already tried to take their own lives (Heyd and Bloch, 1995). The possibility that a patient will kill himself can involve very serious legal consequences for the medical practitioner but it can also provoke a strong psychological conflict within the doctor himself. As Battin points out (1991), if an elderly person or a terminally ill patient asks a medical doctor to end his suffering and his life, that doctor may not be prepared to consider suicide as a possible course of action and thus may not know how to react. In such a situation, and whatever the request which is made, the response of the health care operator should always aim at ensuring that suicide does not take place. The health care operator may thus come to react to these requests by adopting safety measures which are unsuitable or which are not sufficiently therapeutic in their aims or impact.

The belief that suicide is the expression of mental disturbance or the outcome of an irrational choice or a means by which to ask for help implies the adoption of different forms of intervention on the part of the health care worker (Heyd and Bloch, 1995).

Hillmann (1972) believes that the death of a patient vulnerable to suicide is the most obvious error which a doctor whose guiding principle is "primum nihil nocere" could fall into. In particular, he argues that the psychiatrist is not only the promoter

of life and health but also of the organic well-being and life of the body. The position of the analyst, on the other hand, because it is not prejudiced by professional training but made up of a unique relationship with the patient, is said to be directed towards the principle of "primum animae nihil nocere." The analyst is said not to act with prevention in view but in an attempt to understand the meanings which that particular individual attributes to his own experiences, including that of death. For the psychiatrist failure would involve the suicide of his patient but for the analyst failure would consist in the betrayal of the intimate alliance formed together with the patient (Hillmann, 1972).

Szasz (1986) argues that a medical doctor generally feels fully responsible for the suicide of an individual in his care because he had accepted the duty of preventing that patient's suicide in all situations quite apart from whether that individual was actually capable of taking his own life. In the view of this author, health care workers in the field of mental health should feel responsible for a suicide and the responsibility which the health care worker assumes means that he should be very far from holding the opinion that death falls within human rights. On the contrary, he should always see death as something which should be kept off for as long as possible. The approach which Szasz (1986) adopts is that of treating the individual who is vulnerable to suicide in the same way as the doctor treats other patients, or rather that he should help him (and without coercion) only when the action of the doctor is requested and accepted by the patient. Szasz goes on to argue that suicide should be seen in the same light as abortion or divorce—that is, its acceptability depends upon the circumstances.

In general, it is clear that the ethical position of the health care worker in relation to life influences his stance in the debate about the right to death. Indeed, it should be observed here that the point of view which holds as an absolute principle that human life is sacred and upheld by laws which are independent of human will ("ethics of the sanctity of life") attributes to no man the right to die. An approach, instead, which

is based upon the importance of the quality of life ("ethics of the quality of life")—something which follows rules established by man—would appear to offer people a way of seeing the right to die as the conclusion of a life which would otherwise not be worthy of being lived.

A fundamental point of the first approach is the absolute principle according to which human life must be respected because it is sacred. Its sacredness does not derive so much from the concept of life as from the fact that it is human, or rather a life of the person as such. The Instruction Donum Vitae from the Congregation for the Doctrine of the Faith (1987) observes that "the inviolability of the right to life of the innocent human being from the moment of conception to death is a sign and a requirement of the inviolability itself of the person, to whom the Creator had made the gift of life."

In contrary fashion the second position stresses the importance of the quality of life and lays emphasis on respect for the free choices which each individual can make.

Natoli (1992) has, however, laid stress on how difficult it is in the modern world to define the concept of "quality of life." Indeed, whilst in the ancient world many values were recognized as such by the majority of people, in the modern age it is more difficult to identify what a value is or what is meant by the dignity of life or of death.

Euthanasia and Assisted Suicide

Active euthanasia involves causing the death of an individual who has explicitly requested such a path of action (Eareckson Tada, 1992). Passive euthanasia refers to a death obtained by a person who has not been able to give his consent because of a serious illness or deformity but which has been imposed with the approval of the members of his family or by those who have been responsible for the patient (Eareckson Tada, 1992). Assisted suicide takes place when the health care worker provides the person who wishes to die with the actual instruments by which to kill himself (Eareckson Tada, 1992).

Diekstra (1992) has proposed certain clinical criteria upon which assisted suicide should be based and these have also been advanced by Quill and those who work with him (1992). They are as follows:

1) The request should be voluntary and made directly by the person who has chosen to die.

2) At the moment of making this request the individual should be *compos mentis*.

3) The wish for death should be constant and stable and should have existed for a marked period of time within the individual (at least six months).

4) An intolerable form of suffering (a subjective fact) should be present.

5) There should be no prospect of any possibility of improvement at all in the condition of the individual (an objective fact).

6) Help in committing suicide should be entrusted to someone who is a specialist in the field.

7) The specialist should have consulted other colleagues (from one to five in number).

8) Injury and damage to other people caused by an act of assisted suicide have to be avoided.

9) Every decision and moment in the process which has brought about assisted suicide should be recorded and written down for the purposes of subsequent legal and professional evaluation of what has taken place.

Quill *et al.* (1992) strive to emphasize certain aspects of the method by which assisted suicide should be implemented: the patient should not be alone at the moment of death but should be supported by those who have been nearest to him, and the method chosen to achieve death should not make the patient suffer further.

In Holland euthanasia has been prohibited by law but is tolerated where certain practical criteria are present (Battin, 1993; 1994). In cases of euthanasia it must be established that the patient was not pushed by somebody in the direction of this course of action; the choice must have been constant over time and not a transitory wish; the patient must have been in a state of acute pain which was defined by the individual himself—and not by a medical doctor—as being unbearable; the patient must have made attempts to overcome the alienation caused by the illness or there must have been an evaluation by the patient of how he could have addressed and managed his disability; he must have reflected on the information he received about the diagnosis of his condition; and he must have thought about his own future and considered the question of euthanasia. Finally, another specialist must have been consulted and this in order to prevent the decision being swayed by the emotions of the patient's doctor or by his cultural background—this latter being the more probable.

A recent study has shown that in Holland in 1990 1.8% of all deaths in the country were associated with active euthanasia and 0.3% with assisted suicide. Although the majority of doctors (54%) had implemented euthanasia or assisted suicide at least once, two in every three requests for such a practice had met with a negative response (Diekstra, 1992). The diagnosis of the majority of cases involved cancer and the average age of patients was about sixty (Battin, 1994). 88% of medical doctors who worked in nursing homes from 1986 to the middle of 1990 had never helped a patient to die. The remaining 18% had practiced euthanasia fifty-one times (out of 164 requests) and assisted suicide twenty-three times (out of fifty-three requests) (Van der Wal *et al.* 1994).

Many criticisms are levelled against the Dutch approach to this whole question. The first involves the fear that the practice of suicide may spread beyond all control with the result that the medical doctor becomes a figure associated with the bringing of death. Attention has also been called to how the Hippocratic oath is being violated. The original Greek version of this oath forbids doctors to administer lethal drugs or medicines to anybody at all even when they are requested by the patient himself. It should not, however, be forgotten that in the Greek version of the Hippocratic oath doctors are also prohibited from carrying out surgery or teaching medical techniques for money. Neither of these two rules are presently obeyed in the world of modern medicine (Battin, 1993).

In the United States of America the problem of terminally ill pa-

tients in a state of coma is very common. In recent years medical doctors have had to deal increasingly with cases of passive euthanasia. In many states the law governs what the doctor must do when requests are made to turn off the machines and instruments which keep the patient alive. The question of the right to die is dealt with in such situations more indirectly and the role of the doctor appears to be more hidden or even invisible. Obviously enough, the "American approach" is not without its critics.

First of all, the interruption of certain forms of medical treatment which are being applied to a patient can have different results and in this way it is not easy to decide how the patient should be allowed to die. It can also happen that the patient who is deprived of this treatment does not die immediately. This can involve the illness coming out into the open in all its manifestations and thus result in an extremely painful death for the patient.

Furthermore, the difference between believing that no means of life support can save the patient and the belief that it is not worthwhile to invest large amounts of resources in supporting that patient in that particular situation can at times be very subtle indeed. There is no national health service in the United States of America, and therefore a patient, even though covered by private medical insurance, may feel that he is never really protected. In certain cases a medical choice could become in reality a financial choice (Battin, 1993). Moreover, emphasis on the economic aspects of the case could transform the relationship between the medical doctor and his patient from "managed care" into "managed death" (Grassi, 1995).

From a questionnaire carried out in the state of Washington on a sample of doctors chosen at random, it emerged that 48% of those questioned agreed with the proposal that in no circumstances was euthanasia justifiable; 39% had the same view about assisted suicide; 54% believed that euthanasia should be made legal in certain cases and 53% held the same opinion about assisted suicide. Among these medical practitioners, oncologists and hematologists were generally opposed to the ending of life whereas psychiatrists were more in favor (Cohen et al., 1994).

Another survey revealed that in the state of New York 61% of medical doctors believed that an act of suicide could be rational but 51% argued that the doctor should never be obliged to help his patient to take his own life, whatever the circumstances of the case. 31% of those interviewed, however, were in favor of the legalization of assisted suicide in certain situations (Duberstien et al., 1995).

In the state of Michigan 56% of medical doctors declared that if they had to choose between the legalization and the prohibition of assisted suicide they would support the first course of action. In response to a broader range of proposals relating to the question, 40% were in favor of legalization, 37% proposed "no law" at all, 17% supported the prohibition of any kind of ending of life, and 6% were uncertain in their approach to the subject (Bachman et al., 1996).

The term "euthanasia" is certainly linked to the Nazi period and to the treatment meted out at that time to the Jewish population. For German National Socialism the term had a meaning which was completely divorced from its Greek origins. The corruption of the meaning of the term "euthanasia" began with the so-called "T4 program," which was launched by Hitler in 1939 and involved the mentally ill, the handicapped, and the chronically ill of "Aryan" stock being selected for death without any request for euthanasia having being made by the murdered individuals themselves. The T4 program was then continued in the concentration camps, where people deemed unsuitable were selected for death for the most varied of reasons.

In Germany, therefore, euthanasia has remained associated with that terrible period, and German doctors have never been given powers to decide and act directly in relation to death. However, assisted suicide in the case of rational and responsible individuals is not seen as a violation of the law and in part is institutionalized (Battin, 1993; 1994). In this context the doctor does not intervene directly but the danger in this situation is that the diagnosis of the patient's condition will not be sub-jected to further control; that the means chosen to achieve death will not be suitable or adequate; and that subsequently these means (in this instance, drugs of some kind) will be used by somebody else without any kind of control being exercised.

In this area article 579 of the Italian penal code punishes as a criminal act of murder that person who consents or rather "encourages the death of a man with his consent" (Canepa, 1988)—as long, that is, as the person who has encouraged the act is an adult and someone who is not mentally ill. This could also be the case in euthanasia, but there is no explicit legislative norm on this point.

In article 580 of the Italian penal code instigation to, or help in, committing suicide is deemed a crime. This article concerns those "who cause others to commit suicide or reinforce in others a will to suicide or who in any way aid its practice" (Canepa, 1988). The punishability is dependent upon the death of the individual and increases when a minor or a mentally infirm person is involved. This article could cover assisted suicide where the individual is supplied by the means by which to take his own life.

Conclusion

As is evident from this paper, the question of the determinism or the freedom of an act of suicide leads us to reflect upon how we should act, whatever the position we actually come to adopt.

When the position is embraced which asserts that precise determining causes are at work in an act or attempted act of suicide, then the health care worker must intervene preventively both in relation to potential acts of suicide and as regards safety measures to be applied to those people who have already sought to take their own lives.

When the principle of causality is adopted, we may be led to forget the importance of the final effect of an action and fail to understand the meaning attributed to that act by the individual himself. If the act of suicide, for example, were a phenomenon which is always attributable to mental disturbance or disorder, then the motivations of the suicidal per-

son would become of marginal importance because his illness constitutes the final answer to all inquiry as to causes.

Perhaps the health care worker should undertake an operation of introspection in order to understand what his professional and personal opinions are, in order to adopt a stance which does not interfere with an acceptance of the individual's decision to take his own life. Indeed, it often happens that the "professional self" is in conflict with the "individual self" and is more moved by personal feelings of compassion and pity than by considerations of professional responsibility and training. The conflict between the rational and irrational parts of the health care worker and the patient could make assisted suicide a "phenomenon of a most dangerous kind which most certainly cannot be reduced to a model of behavior governed by merely legalized criteria (Pellegrino, 1993).

Reflection on such questions and issues does not necessarily mean that the health care worker should take action. It implies, rather, that he should in the first place work with his own patient towards establishing the rationality of what is being projected (Werth, 1996). Secondly, he should not adopt absolute opinions in relation to actual or potential acts of suicide (Pritchard, 1995), but he should analyze each individual case and condition as if it were unique.

It should be stressed that although, on the one hand, the deterministic approach, which takes cause and effect into account, may in effect diminish the freedom of man, on the other, support for the principle of free choice should involve an awareness of the fact that although only a life rich in meaning is worthy of being lived, in reality life itself is the only instrument by which the richness of this meaning can be achieved (Heyd and Bloch, 1995).

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MARIO FRANCESCO POMPEDDA

Psychic Incapacity and the Sacrament of Marriage

1.

The essential reason and central point of connection between the sacred and supernatural entity represented by the sacrament of marriage and the psychic (in)capacity of those betrothed to marry is to be found in the fact that the only—but at the same time indispensable—element in the constitution of marriage is *consent*, and thus that *human act* by which the spouses give themselves to each other, and accept each other, in mutual fashion.

This can only be understood if beforehand attention is paid to the relationship between what we can call a *natural institution*—that is, marriage seen within the framework of the order and the law of nature—and the marriage itself celebrated and existent between baptized people, which is therefore a *sacrament*. Without entering here into profound theological questions and more specifically into the doctrinal principles relating to Catholic dogma and faith, we can at this stage simply observe that the institution of natural marriage and of sacrament-marriage is unique, even though this last constitutes, and has a very special, physiognomy which is attributable to the baptism of the spouses—something which bestows a sacramental character and thereby has specific supernatural gifts.

Present-day canon law reminds us in succinct fashion that the matrimonial pact by which a man and a woman establish a community between each other for life, and which by its nature is directed towards the well-being of the marriage partners and the procreation and upbringing of children, has been raised by the Lord Christ—where it involves baptized people—to the dignity of a sacrament.

However, the source is the same, the act from which the marriage springs existentially and individually is the same, the obligations and the rights which flow from the pact are the same, and the juridical relationship which emerges is also the same. We can safely affirm that only *in* the consent and *from* the consent equally and only is there born and contained both natural marriage and sacramental marriage—that is, the conjugal bond.

However, consent is in its essence and exclusively a *human act*: it is specific, that is, to man. But not simply because it is he who carries it out, but because it is specifically to be ascribed to him because of what he is by nature—a rational being in whom intellect and will interact and operate in unified fashion and in syntony.

One can therefore say that there is the sacrament of marriage where between baptized people there is consent, that is, a human act.

2.

Two anthropological facts, however, should be borne in mind so as to avoid the construction and presence of a theory which goes against the historical, and in a certain sense existential, reality of *man*.

The first fact is that marriage is not only an institution which belongs to the natural order and natural law which is inherent in human nature. It is also a state towards which man by innate impulse is attracted, a condition towards which his own psycho-physical development directs him. One could say that nature assumes the task of preparing and maturing the male and female individual for marriage and of bringing it into existence. If therefore by nature each man is led towards marriage not only can this right not be denied to him without transgressing the natural order itself, but in the same way one could not hypothesize—if not as an exception which has to be rigorously justified—a subjective condition which precludes the exercise of such a right in practical and individual form. One must, in contrary fashion, begin with the assumption that precisely because of this natural impulse which involves man because of what he is, each individual person is by nature rendered suitable and capable of marriage.

There is another anthropological fact which must be reiterated at the outset in relation to the subjective elements which are specific to the human psyche. As a consequence of what has just been observed about the first anthropological fact, but also in full correspondence to the sufficiently elaborated juridical, or, rather, cultural requirements, there must be a reference (and not in abstract fashion) to the psychological capacities of the betrothed persons. It must be effected in practical terms in relation to unintellectual-volitional development of such a kind as to correspond to the act which is to be carried out—that is, specifically conjugal consent. If such were not the case one would necessarily be led to affirm (with reference to the minimum limit of the act itself) that marriage could bring within itself individuals who were not suitable and indeed incapable of a truly human act. This would be contrary to the definition

itself of marriage as a choice of life.

But at the same time, and where the maximum term of the act which is to be carried out is borne in mind, one would undeniably end up by requiring extraordinary intellectual and volitional qualities which are not to be found amongst most people. In this way marriage would cease to be that right which is universal and present in all men and at base that institution which is fundamentally natural. It is therefore a human act, but in its rational component elements correlated and thereby proportionate to the reality—we should say here to the importance which is undoubtedly of essential moment because it involves the whole existence of individuals and by indirect routes of the whole of society—which is present within marriage.

3.

What has been said hitherto about the inescapable and fundamental anthropological aspects of the question in order to delineate the contours of the analysis of this paper necessarily leads us to direct our attention both towards the active subject of marriage—which is *man*—and towards the specific and essential object of the choice which he makes within it, that is, the *marriage pact or contract*.

Indeed, reference to psychic *capacity* (or, conversely, *incapacity*) would make no sense if in talking about the sacrament of marriage we did not make absolutely clear what we meant by the reality of *man* and at the same time of the *institution of marriage*.

All this involves beginning from a starting point of philosophical thought which is therefore also cultural. This is not the place to dwell upon the means of demonstrating the truth or acceptability of this starting point. But it can be said that from this point we recognize and affirm the presence within the world which surrounds us of rational entities or beings. We do so not only theoretically and by doctrinal definition but also at an existential level and thus through a reality which has demonstrated itself historically in the universality of individuals who take part in human nature. These rational entities or be-

ings are endowed with a volitional and intellectual faculty which enables them to be arbiters of their own choices in an aware and responsible fashion and in particular of personal undertakings which involve them entirely and which are directed towards the creation of the good of the other partner in mutual communion, and at the same time of the good of other beings which may be brought into life through full cooperation.

4.

At the base of this set of anthropological dogmas there is the postulate of an essential but radical *freedom* which constitutes a power of man. This is not so much a question of nonsubjection to external agents—because from this point of view one would have to speak about the freedom of constriction imposed by other people—but more that capacity for autonomous decision and aware self-determination, and thus for conscious planning choice which belongs to the whole existence of the individual himself.

But the question of freedom itself is inseparably connected, indeed logically preceded, by that of the question of the nature and effective operative capacity of the human intellect, that is, of the real faculty of *objective awareness of the true*. It is from this point indeed that there begins the whole series of questions relating to the relationship between psychic capacity and marriage.

5.

Indeed, what intellectual awareness in this context are we actually referring to?

It is in fact self-evident that where the light of reason has been completely extinguished both for persistent causes such as cases of psychosis and more in general all those conditions where there is detachment and alienation from external realty, and where there are transitory causes such as complete drunkenness, serious subjection to drugs or suchlike, because of the very fact that an authentic *human act* can not exist or take place it follows that in the same way there is

no actual possibility of reflecting and consenting and that there is thus no capacity to engage in the conjugal pact.

However, the canonical concept of psychic capacity in relation to marriage goes beyond this stage because it implies the achievement, and therefore a situation created by, *maturity*—something otherwise known as *discretion of judgement*. In this state of maturity there is joined to abstract and in a certain sense theoretical awareness, and in a way which completes it, an effective possibility of *evaluation* at least in an essential overall sense of the act which is carried out and of its implications. In a specific sense, that is, in relation to the marriage bond, of what it means for the person of the contracting partner, and thus with an intellectual projection towards future life, in relation to what must be shared in dual union with the spouse—and this where there is no exclusion of the transmission of life and the upbringing which must be given to possible children.

We should not consider even this sufficient in the context of integrated theological-canonical doctrine rooted in a modern knowledge of man if this doctrine is above all compared with and placed beside the certain conclusions of recent psychology expressed by various schools. This is because maturity also implies the ability to choose after a conscious evaluation of the motives which are involved in that choice. *Conscious evaluation* does not exclude that within man there also exist and operate unconscious motives bound up with impelling and almost known impulses which are present on the threshold of his consciousness. Here we are really touching upon man at his deepest part, and at the same time meeting him in his most authentic real and historical existentiality. However, that unconscious can be dominated by man and he can place his most essential and vital choices in relation to it, that is if we do not want to think—even hypothetically—that he does not enjoy that level of intellectual reason and elective freedom which enables him to be seen as the governor of his own choices and at an even deeper level of his own existence.

If such was not the case in individual and particular instances we would be dealing with people who would have to be seen as being mentally incapable.

6.

The action of man, however, is essentially and definitively produced by his *will*. And this would not be the expression of the human person nor would it allow the attribution of responsibility to the acting subject if he did not bear within himself the qualification of *freedom*. We refer here exclusively to *psychological freedom*.

This means that man, despite all the influencing factors which bear upon him from the upbringing and education he has received, from the culture and the social environment in which he is immersed, from the irrational tendencies of his being, from his own special emotional system, and finally from his own subconscious, is able to arrive at decisions with conscious deliberation and by an act for which he feels himself really responsible.

This concept which I have just enunciated does not mean the denial within man of the existence or even the directive activeness of inner impulses, of drives which at times are strongly impelling, of anxieties in relation to the satisfaction of needs which are connatural and almost fundamental, or even of possible psychic deviations which bring about decisions which are not supported by acceptable motivations and in harmony with his dignity. On the contrary, by the employment of this concept there is the affirmation that notwithstanding everything man at the apex of his rational and specifically spiritual being, in his domination of what is placed in his way and what obstructs him, knows how to rediscover himself in his most intimate and authentic reality. He is thereby able to take rationally motivated decisions of which he considers himself the author, even though this is achieved with extreme difficulty.

This does not mean that we are forgetting about individuals who because of a special psychological personal condition find themselves in an anomalous state when compared to that of most other men, or are influenced by psychic disturbance which can not always be defined as "mental illness" (if, that is, it is possible to give an exact scientific sense to such a term) but because of which they do not have complete mastery over their own decisions and are thus unable to determine and govern them. In such a case there arises the question— which is also to be applied to marriage and more specifically to the consent from which the conjugal pact derives—of their psychic capacity. That is if one does not want in peremptory and immediate fashion to argue that in such a case there is a real and authentic incapacity.

7.

Considering marriage as an institution which is also juridical in character and seeing it in this analysis from this point of view, it is self-evident that such an incapacity must always be looked for, established and almost circumscribed within a sphere which is strictly juridical. This must be done with the criteria which belong to this discipline, and at a more specific level—in relation, that is, to the sacrament-marriage—with parameters which belong to canon law.

But this always involves a fundamental appraisal of the condition of the *psyche of the subject*, and thus of the emotional-volitional-intellectual mechanism by which an individual moves within his inner life until he reaches the achievement of his own decision, of his own choice, of the formation—in a phrase which is strictly relevant to the subject under discussion—of the act of consent. Here we encounter a point of contact between canon law and the sciences which study the human psyche, that is, with psychiatry and psychology as well—this last being understood as experimental research and thus carried out with the method of empirical inquiry (distinct in this way from metaphysical or philosophical psychology).

It is the inquiry, with its consequent configuration of the individual in his rationality, which constitutes the basis which cannot be departed from and which is indeed absolutely necessary in every further juridical argument and judge-

ment about the psychic capacity of the betrothed person, and this always in relation to that specific consent which lies at the base of, and thus gives effective rise to, the marriage itself.

8.

This specific dimension can only be truly seen to be present when consent, and thus the capacity of the subject, is placed in relation to its object, to its own content, and therefore to marriage. This not only or exclusively in a static sense— that is, seeing that human act as it is formed and constituted (which is specifically the *act of consent*), but also, and above all else, in a *dynamic sense*. By this is meant that psychological moment which gives rise to the perfecting of a status, of a reality which is the marriage bond. Involving a relationship with another person and in fundamental terms a mutual self-giving-acceptance of the human persons of the marriage partners, this would necessarily remain a mere abstraction if there were no reference to its substantial content—that is, to a commitment to reciprocal behavior—at the base of specific obligations to which specific rights correspond both relatively and *specularly*.

If therefore in psychological terms one or other or both of the betrothed persons were not able to meet the requirements of what constitutes the marriage pact, there would necessarily follow an incapacity to establish that pact, to realize that bond which by its total nature is both temporal and vertical in its dimensional character.

9.

The historical reality in which we are immersed and in which we act makes us aware, and at times with lacerating tragedy, of the enormous difficulty which man meets with in being adequately capable of such an undertaking, of living the conjugal life, that is, in all its implications. And at the very deepest level of being capable of a giving of oneself to the other in a voluntary and totalizing pact of genuinely human love—that which is the very concept itself of marriage understood in its natural sense but even

more in its sacramental dignity.

Here we come up against the influences and conditioning impact of the external world, above all else that sense of the relativity of everything which seems to pervade contemporary man. That fear, at times that terrible panic, of launching oneself into a project which involves and drags with it one's own existence into the future. That habit of living for the fleeting moment and directing one's gaze almost with repugnance away from that undertaking which embraces tomorrow and the day after tomorrow and "always." That insecurity—wrapped at times in external self-confidence—which makes man cowardly, makes him almost adopt an attitude of desperation in relation to his own destiny but primarily towards his own moral abilities and possibilities. That widespread and almost generalized state of neurosis which creates a truly weak and insecure man. All this, when we consider the sublime commitment of a loving giving of the totality of one's own self to another person, could raise serious doubts about the widespread if not generalized capacity to take on, and thus to fulfill, the obligations of marriage.

10.

In this stressed context and picture of contemporary mankind, the Church once again is called to remember and indeed to present an image of man where he is certainly weakened in his deepest being, but is always capable of a life which in dignified fashion corresponds to one created and formed in the image and likeness of God. The living and illuminating presence of God which is present in the deepest part of his being contains such force as to lead man to his highest destinies.

This is a message directed to all men but it is even more valid and full of meaning for those who celebrate the sacrament of marriage in faith in Christ.

To these people Christ once again speaks a word of hope through the Church so that there may be installed or re-installed—for the good of humanity and for each individual—that natural institution which the thought of the civilization and philosophy of ancient Rome did not hesitate to define as being "*principium urbis et quasi seminarium rei publicae*" (M.T. Cicero, *De Officiis*, I. 54): "the first nucleus of the city and almost the seedbed of the state."

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Intelligence, Freedom, and Holiness

My first proposal, in an act of deliberate discipline, is to respect the order of the title line; therefore we shall take intelligence as an introduction and holiness will be discussed in the final section.

In fact, we are dealing with a *ladder here*, one in which you must ascend the first rung, intelligence, in order to access the second one, freedom, which in turn will lead you to the anthropological summit occupied by holiness. For there is a conditioning in this progression: one cannot be free without the intellectual resources required to understand the alternatives implied by a free choice, as one cannot be virtuous without a margin of inner freedom allowing one to practice morality and good. But the validity of this reasoning is somewhat relativized when we remember that, as we shall see later with greater accuracy, intelligence and freedom in both their functioning and their structure are *multiple* o *plural entities*, which therefore require specification of the exact variety of intelligence or of freedom we are referring to at any given time.

If there is a person worthy of the utmost idealization in the eyes of all the observers, that is precisely he who combines the three attributes contained in the title of this paper, and who so does to a degree that allows him to be proclaimed at the same time a perceptive and intelligent, self-controlled and free, virtuous and holy, being. In the combination of this trio of *anthropological axes lies*, no doubt, the most sublime paradigm for the development of a human being and human behaviour. To arrive to such a proclamation was, perhaps,

the ultimate purpose of this Eleventh International Conference when it assigned me, maybe overvaluing the scope of my experience, a paper with such a complicate and ambiguous headline.

For, as extremely obvious as the conclusion just reached is, our subject matter is in itself an exceedingly complex one under both of the conceptual approaches through which it can be addressed: first, the *analytic* approach, which leads us to each of such axes separately and tells us right from the beginning about the formal polymorphism resulting from their poly-dimensional structure.

In the other conceptual front, a *holistic* approach allows us to discover a labrynthine web of hierarchized correlations between these three axial capacities of the human being, as well as their *complementary* nature—since intelligence is ascribed to the psycho-organic plane, freedom to the psycho-spiritual plane, and goodness or holiness to the psycho-ethical plane. This complementarity can be found in the humanistic conception of Max Scheler, which Pinto Ramos[1] summarizes as follows: while intelligence is biologically conditioned and is a predictable structure from the standpoint of the evolution of life as well as a requisite of the same, freedom and holiness are fundamental characteristics of the spiritual being and, indeed, the spirit is not predictable from the standpoint of life and is not required by it. The fortunate complementarity of these three positive entities stretches, therefore, from the *organic substratum of life*, where intelligence flaps its wings as the pristine ideal instru-

ment, to the *realm of spiritual and moral values*, transcended by the sheaf of human freedoms. All of which evidences that to the complexity of our subject now its sheer vastness must be added, a vastness which comprises nothing less than the *metaphysic* duality of essence and existence and the *anthropological* duality of nature and spirit.

In spite of all these identifications and coincidences, the labyrinth of correlations linking intelligence, freedom and holiness cannot be signposted today without taking into account their common context, formed by the *development of personality* in a *postmodern* environment. In the transition from the modern to the postmodern society, a society characterized by both a postindustrial stage of development and the massive invasion of communication media, the three entities here analyzed experience severe risks and changes, which we shall review here succinctly.

Human intelligence now competes with the *artificial intelligence* of robots and computers and is exposed to the threat of being contaminated by it. The working environment in the Internet, for example, forces us to think and react as a machine on many occasions, which allows obsessive-compulsive phenomena to emerge. The postindustrial society is a *controlling society* which, by definition, imposes severe restrictions on personal freedom. As a result, the human being embarks on a search for escape and easily ends up hooked to that very escape.

And so arise the new drugless addictions, among which is num-

bered precisely the Internet-addiction. In connection with this postmodern decline of values, we should ask the theologians whether one could justifiedly speak of a postmodern holiness, be it only on a contingent basis.

2.

In my last book, *El talento creador. Rasgos y perfiles del genio*, I study the "encyclopedic face" of intelligence and represent it in different forms grouped in couples: fluid and crystallized intelligence; verbal and executive intelligence; natural and artificial intelligence; practical and theoretical intelligence.

If we perform an *anthropological appraisal* of the meaning of each of such modalities of intelligence, the most valuable varieties of human cognition emerge as the following four modules:

1st—*Crystallized* intelligence, being the operational capacity developed and maintained by a sufficient thinking and studying activity, allows to cleverly handle personal experience and to convey it to other people and is, in sum, the common heritage of both the genius and the sage; while fluid intelligence becomes most notable in the production of information, a process that reaches its highest development in the highly-gifted person.

2nd—*Verbal* intelligence, which is defined by working with images of words and is much more resistant than its opponent, executive intelligence, to the attack of age.

3rd—*Natural* intelligence, which is characterized by the always-present task of rational comprehension, an activity which is not to be found in any kind of machines. These, although recognized as possible artificial-intelligence entities, may be qualified, on the grounds of such a handicap, as stupid artifacts.

4th—*Theoretical* intelligence, that enables us to build symbols, to set out problems and to make questions; while its opponent, practical intelligence, operates as a kind of adaptive capability at a much lower mental level.

Three human types are considered as *superintelligent*, on many occasions on insufficient documentation.[2] They are the highly-gifted person, the sage and the genius. The *highly-gifted person*, propelled by a vast amount of knowledge and information gathered by means of a privileged fluid intelligence, achieves brilliant results in school examinations and psychometric tests—an intelligence quotient higher than 130 being precisely his/her conventional hallmark.

For their part, the genius and the sage, although they both have a highly-developed crystallized intelligence, are very different in other cognitive aspects. The mind of a *genius* is distinguished by its original contributions in the form of discoveries or creations obtained by exercising lateral thinking (*thinking aside*, in Koestler's[3] terms), or *penser à coté*, in which creative thinking unfolds itself as an association of logical-rational and intuitive thinking with imaginative and oneiric insights. Usually, the true value of the work of a genius is not adequately assessed before his death. It is for that reason that apparent and ignored geniuses are so abundant.

On the other hand, the sage is worthy of admiration for his brilliant ability to learn from experience, as well as for his great facility to communicate, which allows him to afford his experienced wisdom to his fellow human beings with particular dexterity.

Academic policies, choosing to place themselves at the service of those achieving the best results in school tests, many of whom belong to the highly-gifted stock, have ignored the members of the two other classes of superior cognitive structure: those who learn and reason wisely and those who take paths untrodden by the common logic in order to build unknown elements.

This preferential treatment of the highly-gifted to the detriment of the sage and the genius is both an error and an act of injustice—the former as serious as the latter. An error, because the highly-gifted person is a triumphant professional who is nevertheless unable to contribute a single new idea—

while the genius does—or to let his fellow human his beings profit from his experiences—as the sage does.

And an act of injustice, because the ways of life of the genius and the sage represent the best human examples to be selected among those possessing a privileged mentality.

A comparative assessment of the highly-gifted person, the genius and the sage by means of the parameters of freedom and holiness (or virtue) allows us to confirm the *lower* position of the highly-gifted person, who in general is basically driven by competitive, personal interests or at least encouraged by a tug for competitiveness. By contrast, the whole life of the sage is oriented towards promotion of *social values*—which would allow us to consider him, in principle, as the champion of virtue—while the genius, if he is to be recognized as such, must sustain a demanding struggle with the environment that puts the solidity of his autonomous freedom to a test.

3.

Beside the existentialist thinkers, Tocqueville[4] is one of the modern philosophers who has proclaimed freedom as the *supreme value* of human life with strongest emphasis. Zubiri, the great Spanish philosopher, attaches freedom to the ultimate essence of man. Although many other quotations on the excellence of freedom could be produced here, the highest merit corresponds to the ancient Judeo-Christian notion according to which every man is *free* since he is fully *responsible* for his life.

Let no one, however, believe that all opinions coincide on this fundamental issue. Always, although more in the past than nowadays, there have been negators of human freedom, who postulate that everything is determined.

Kant, the philosopher of reason, postulates that human action is free not because it is not determined o hetero-determined, but because it is *self-determined* in the form of a will governed by ratio-

nal motives. We had better speak of *freedoms*, in the plural, in order to harmoniously link all the varieties of freedom, each of them endowed with a highly-developed structural dimension. The two basic varieties of freedom, around which all the others revolve, are the freedom of choice, as an *individual* freedom (although Saint Agustine called it *libertas minor*) and the civil liberty, as a *social* freedom. In order to establish a hierarchical order between them both, we should listen to Unamuno: "Freedom is in mystery; freedom is underground, and it grows inwards, not outwards. Freedom is not in the foliage, but in the roots."

The freedom to *choose* among several options is a common practice in life, usually carried out without need of deliberation. Therefore, most of the people are not conscious of the role they play in the process of choosing. "A choice is only meaningful here and now, it only exists in the present." (McEvoi[5]). Freedom of choice is strongly conditioned at its source by *moral freedom*, without which it would become mere arbitrariness. In some choices also participates a careful examination of the available options by means of *hope*, which induces us to decide on feasible options or alternatives, and/or *foresight*, that allows us to weight in advance the possible and probable results of each option.

With these ultimate consequences of the freedom of choice is linked still another, rarely-discussed variety of inner freedom, which might be termed freedom of *action*. To exercise it, as Kant said, does not mean to erase the wish chosen by will, but to be able to withstand it and control it, preventing it from becoming behaviour. Hume[6] (1711-1776), the great classical empiricist English philosopher, postulates that freedom can only be understood as "the power to act or not to act in accordance to the determinations of will." The clinic study of *addiction*, especially of drugless addiction, the addiction to non-chemical objects, such as food, sex, television, buying, game and work,[7] has shed the clearest light on this freedom of action. A wish that grows ever big-

ger, until it becomes uncontrollable and irrepressible, in the pathological matrix of those modern illnesses we call drugless addictions. Apart from this *partial* or selective loss of freedom attested in the field of addiction, inner freedom is *always* impaired when a psychic disorder occurs. There are total or partial impairments (as in addiction) and gradual impairments (the loss of only degrees of freedom). Mental illnesses are freedom illnesses, and psychiatry is the *pathology of freedom*. One of the basic aims of practical psychiatry is to restore their inner freedom to the mentally ill.

Regarding *external* freedoms, our starting point might be *natural* freedom, which is only limited by the individual's capacities, and which takes shape in the basic variety of *civil* liberty when the natural human rights are limited by the general interest as result of living in society. Also in this front, psychiatry has adopted a well-definite position. "Psychiatry finds the normal conditions for its practice in a social field where the dominant ideology has taken possession of the natural freedoms" (Sztulman[8]). This quotation firmly establishes the impossibility of adequately developing the science of mental health in a freedomless waste, as well as the psychiatrist refusal to be manipulated, whether as a victim or as an accomplice, by a *freedom-killing* environment ruled by regressive laws—false laws, in Nieto Blanco's opinion.[9]

Jaspers[10] presents rational *dialogue* and *tolerance* as two immanent attitudes in the exercise of freedom. Both of them stem from the acceptance of a plurality of ways of thinking and living. "The reproach projected on the tolerant that his acceptance of the other's ideals and beliefs is due to the weakness of his own ideals and beliefs belongs to the particular logic of the fanatic conquerors of absolute truths" (Alonso-Fernández[11]).

None of the conceptual varieties of freedom here discussed (freedom of choice, freedom of action, moral freedom, civil liberty and legal liberty) is alien to the field of virtue, which we shall address now.

4.

Sanctity cannot be attested in a subject who does not possess a *conjunction* of intellective development and exercised freedom that allows him to be considered, to say it with Max Scheler, a *person* in the full sense of the word, a capable and free individual responsible for his own acts. Such a person is the owner of his behaviour. And the latter, in turn, deserves to be described as a *person's conduct.* In Schelerian terminology, he who is not a person, cannot be a saint, or, more accurately, cannot be taken as a *model of sacred values*.

Let us not forget that holiness in the result of an appraisal, a positive religious appraisal of a person with a proven exceptional conduct pervaded by some difficult virtue.

Man's *estimating* ability first appeared in the world with the emergence of *moral conscience*. A book of mine discusses this subject in depth, following the train of thought of the acute ideas contributed by the Swiss psychiatrist Manfred Bleuler. The appraising function capable of distinguishing good from evil, fair from unfair, filled the first-established conception of conscience. For a long time the only concept of consciousness was the concept of moral conscience, which is the meaning of Greek *syneidesis* and its Latin successor *cum-scientia*. Only after the Renaissance the meaning of a conscience capable of moral Knowledge extended to cover all kinds of knowledge, giving rise to the notion of *consciousness* in the psychological sense.

The German language [also] has two designations for the Spanish word *conciencia* [meaning both "conscience" and "consciousness"]: *Gewissen*, which means moral conscience, and *Bewußtsein*, which means psychological *consciousness*. While the origin of *Gewissen*, the word used to translate Greek *syneidesis*, is lost in the mists of time, *Bewußtsein* started to be current only in the beginning of the nineteenth century, and was used to reflect a new meaning of consciousness established by the Romanic languages.

With this is proven by historio-

graphical means that the estimating function of the moral conscience is immanent to the human spirit, and that its late extrapolation to all kinds of knowledge marks the emergence of consciousness in the psychological sense as a kind of secularized conscience.[12]

5.

To address now the problem of *axiology* in general. The conceptual development of axiology as the science of values represents an amazing achievement of the twentieth century. It was the Spanish philosopher Ortega y Gasset[13] who sensed with greatest clarity this feeling of amazement: "Thus, the version behind which Worth has most often preferred to disguise itself has been the idea of Good. For centuries, it was through the idea of the good that thought came closest to the idea of the worthy. However, Good is but, whether the substratum of value, or a kind of values, a species within the genus Worth."

No less amazing is that precisely our century, the setting of so many atrocities (the evil of our century has been defined by John Paul II as a crisis of values[14]), has been the womb capable to give birth to the development of the fundamental values of reason. The facts and circumstances that allowed this birth to take place at that moment were accumulated during the eighteenth and nineteenth centuries.

Foremost among the scientists and philosophers who with adequate training write about values are the thinkers Max Scheler and Ortega y Gasset, united not only by this common concern but also by a friendly relationship, although their opinions may differ in some respects.

According to the Orteguian conception, the values are *positive or negative meanings* characteristic of the real things and they conform to an objective scale, although only some people can perceive them. Thus, ortega describes the values, first, as "unreal qualities residing in real things or objects"; second, as objective elements; and, third,

as data accessible only to subjects capable of perceiving them by virtue of their estimating ability.

Max Scheler's ideas coincide in the first and third respects, but not in the second. The objectivity of values, according to Max Scheler, as in general that of ethics—which is the science that holds the key to axiology—is severely relativized by History.

Regarding the third Orteguian postulate, Max Scheler holds a fully concurring opinion, since modern resentment is in his opinion the origin of the trend to judge true only what everyone holds to be true, as though *unanimity* were a criterion of *truth*. Men, he adds, agree only about the lower values. The higher values will be negated or reduced to lower ones by many people. This is how an *inversion* of the axiologic hierarchy takes place, according to which the values ascribed the spheres of usefulness, pleasure and economy are raised to absolute values.

A similar error has extended to the field of *health* as well. Thus, the phrase "health ethics" has served as a protecting wall used to equate healthy with good, in transgression of the limits between haleness and morality. *The moral significance of health depends on how it is achieved and used.* There are evil ways of using or achieving good health. Pascal even referred to a "good use of illness." Contrary to the contentions of the Philistines of the ethics of a vitality which invades the supravital values, there are many ill people who are extremely valuable for society and who represent *moral models*.

The catalogue of *axiologic models* valid for a concrete existence (*Dasein*) varies with the authors, not only in the types they include, but also in the hierarchical organization of the same. The most frequently used supreme concept is that of moral goodness. Spranger[15] systemizes the most appreciated human models into the following four types: the *Homo theoreticus,* linked to truth; the *Homo aestheticus,* linked to beauty; the *homo socialis,* linked to altruism; and the *Homo religiosus,* linked to goodness. Max Scheler devotes his unfinished posthumous work to the

axiological models, offering three exemplary profiles: the saint, in the sphere of sacred values; the genius, in that of the spiritual values; and the hero, in the vital sphere.

6.

While *goodness* is a moral judgement that, as we have seen, has been valued by human conscience since its very beginnings, the perception of *mysticism*, which merges with goodness to give rise to holiness, is more problematic, since it presents many different faces. The longing for the absolute, the search for the transcendent, the experience of the mystery, the direct connection with Divinity, the state of special consciousness of a believer: these are some of the experiences used to define or describe mysticism.[16]

As an example of the contrasts or oppositions to be found among different mystics, let us remember that, while the genuine mystic experience is *luminous*, the supreme Spanish mystic, Saint John of the Cross (1542-1591) reaches the summit of mystic spirituality within a real and experienced environment of *darkness* and night. The encounter between God and Man takes place, in Saint John of the Cross, nightly. Our Saint consecrates night to God, and day to night.

"The dark night of the soul" is the passage to transcendence, which Saint John identifies as a dark night because in it the following two key aspects are united: first, the absence of incandescent light—"the darkness of the soul".

Saint John of the Cross adopts a conflicting stance in respect of the general mystic experience when, after conceiving this life as truly dark night, he feels the rapture of the darkness of darknesses emanated by God, not letting himself be troubles by the two *curses* of night: the dramatization of death and the concealment of the real behind the unreal.

In his *Hymns to the Night*, Novalis proclaimed the nocturnal religion as the religion of death. In his poems, some of them still undecipherable, Saint John of the Cross talks with God, Death and

Freedom. Since John of Avila, apart from being perceived as a great saint and an unusual mystic, was a sage infused with the gift of *Spanishness* and took the appearance of lonely Quixotic figure, who maybe secretly inspired Unamuno's verses: "*He aquí un español, un Don Quijote,/un pobre pasmarote...*" [Here we have a Spaniard, a Don Quixote,/a poor simpleton...].

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Notes

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ERMANNO PAVESI

The Intelligence of the Universe

To speak about "intelligence of the universe" might seem like a provocation to many currents of contemporary thought. What has characterized and continues to characterize certain tendencies of both science and the interpretation of the results of scientific research is an attempt to explain reality in unified terms as the product of a development of matter which has taken place in conformity to natural laws. The description of this development seeks to exclude completely not only a supernatural action but also the existence of a plan, a meaning or a purpose in reality at all its levels: the universe, living creatures, and mankind and its own special existence. In other words it is implied that the teleological question has no meaning. The task of the scientist, it might be asserted at the outset, is certainly to study reality through the employment of the scientific method and the making of clear distinctions between facts, demonstrable laws, theories and working hypotheses.

The way of looking at things which sees the universe as a cosmos, as the expression of order and harmony, has been placed in doubt during the past and during recent decades various thinkers have asserted that new knowledge in the field of physics has led to its confutation in definitive and incontestable fashion.

The theory of relativity, quantum mechanics, the principle of indetermination, theories about the origins of the universe, lines of argument derived from the study of the infinitely great and the infinitely small, have all sought to throw doubt upon the validity of other interpretations of reality. In extreme cases the very concept of reality itself is called into question on the grounds that it is itself unknowable and that the image which man has of it is in actual fact merely a subjective representation if not an erroneous construction.

The natural sciences such as physics and chemistry can contribute to expanding and improving our knowledge of reality because they explain certain aspects of it but they are not able to give a reason for reality in all its aspects, in its entirety, especially when it comes to consider the whole question of life forms. It is precisely the study of life forms, that realm where the organization of matter is more complex, which reveals that they cannot be explained solely with reference to the laws of physics or chemistry.

The Aggregation and Organization of Matter

Let us take as an example a substance such as calcium carbonate. This substance is to be found in nature in very different forms and is the constituent part of anorganic forms such as stalactites and stalagmites, a snail's shell, or the shells of other kinds of mollusc. When one goes into certain grottos one is often amazed at the richness in forms of the stalactites and stalagmites which at times seem to take on the appearance of humans or certain kinds of objects. The form of each stalactite, however, is purely a matter of chance and is the result of a process of sedimentation involving the calcium carbonate which is contained in those drops of water which have dripped down for centuries or even millennia. It should be stressed that only observation is able to recognize the similarity between external form and a form which really exists.

In the case, on the other hand, of the shell of a snail we encounter a precise form. The three-dimensional helicoidal form corresponds to a plan of construction which is very precise. The growth of the shell cannot take place within a process of chance or by means of automatic advance through the imposition of new layers of calcium carbonate because the angle of the curves and the diameter of the section change constantly. When we study a shell, we must recognize that at each moment of its formation the snail secretes the calcium carbonate in a way which conforms to its final form.

A section of the shell of another mollusc, the nautilus, brings out

the precision of its internal architecture. It contains chambers organized in a regular way which go to make up a logarithmic spiral.

From a physical point of view, the atoms of a stalactite cannot be different from those of the shell of a snail, and from a chemical point of view we are dealing with exactly the same kind of salt. There exists, however, a substantial and important difference between these two formations. In the case of the stalactite, the aggregation of the calcium carbonate has taken place in conformity to chemicophysical laws. Its external form is purely a question of chance, and at any given moment it is impossible to predict with precision how its shape and character will develop in the future. But in the case of the shell of a snail the growth certainly in the same way depends upon the physicochemical properties of the calcium carbonate, but it also takes place according to a very precise plan which is based upon the information contained in the genetic patrimony of the snail itself, which is codified within the DNA structure of this living creature.

DNA

DNA is a chain made up of a sequence of four special molecules—the nucleotides. This sequence amounts to an archive which contains the codified information necessary to the development and the life of every living organism. Without DNA, therefore, there can be no life.

After Stanley L. Miller had demonstrated experimentally that by passing an electric current through an atmosphere made up of water vapor, methane, and ammonia one could create numerous chemical substances synthetically—among which are to be found the basic components of organic composites—the thesis came to be advanced that reactions of this kind during the primordial period led to the formation of these substances in such quantities that there was a spontaneous synthesis of ever-more complicated chains which in the end gave rise to systems which were able to reproduce themselves.

This theory has been criticized by many scientists. The German chemist Bruno Vollmert, for example, emphasized that in the experiment conducted by Miller the component elements of DNA the nucleotides were only produced in minimal quantities and that there were, above all, substances with only one radical, such as formic acid and monamine, which are not adapted to the formation of a long chain. Vollmert used a comparison to support his criticism. Let us imagine the formation of a chain where we take a pearl at random out of bag. Some of these pearls have one hook and some have two. When a pearl with only one hook has been added the chain can go on in one direction until another pearl with only one hook is encountered. When we know the respective percentages of the two kinds of pearls that are present in the bag we can calculate the probability that a chain of a given length will be formed. In discussing the "pre-biotic brew" obtained by means of Miller's experiment, Vollmert makes the following declaration: "Every chemist who is an expert in the field of polymerization knows that in a mixture of this kind where substances with only one radical predominate, macromolecules such as DNA or proteins cannot be formed."[1]
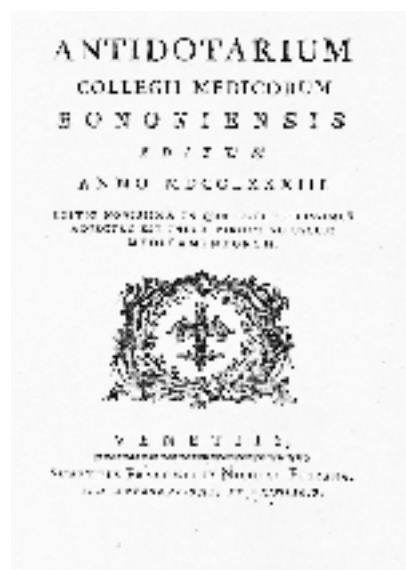
Vollmert emphasizes the role of another factor which can block the formation of long chains—the

presence of water in the "pre-biotic brew." The reactions of synthesis are reversible and the length of the chain is inversely proportional to the concentration of the water. This facilitates the fractioning of the chain to the point of even preventing its formation if the concentration is such as to render the reactions of splitting faster than those of the synthesis. Vollmert believes that the "pre-biotic brew" is not suitable for the formation of chains of the length of DNA and therefore that "one must regard the formation of a chain of twenty to fifty nucleotides as being impossible in itself."[2]

Friedrich Cramer, the director of the Max Planck Institute for Medical Experimentation at Gottinga, also believes that "the origins of life cannot be explained by a mere reference to chance without rules: life on earth has developed with much greater ease than would have been possible through simple statistical fluctuations. It might appear that from the very beginning a mechanism was at work which selected the "right" molecules and allowed them to survive."[3]

As a chemist, Vollmert tries to explain the chemical basis for certain biological transformations— namely, that the appearance of a new gene presupposes the appearance of a new segment of DNA. Estimating the average length of a gene at 1,500 nucleotides, Vollmert observes that there are $10^{1,000}$ possible combinations and that as result a chance appearance of the "right" sequence is absolutely improbable. Before the definitive appearance of the complete gene the formation of this chain cannot even be guided by the selection factor. Indeed, if one excludes every kind of finalism, it must be recognized that it is only by chance that a segment of DNA which has formed itself spontaneously is able at a certain moment to demonstrate that it contains the information by which to produce a new enzyme.

Indeed, it should not be forgotten that a chain of molecules is nothing more and nothing less than a chain of molecules. At the very moment at which we refer to a sequence of nucleotides, we necessarily introduce new cate-

gories—that is, we consider that chain as a chemical structure which has certain built-in kinds of information. Moreover, the codified information is only a useful plan of construction if a "reader" system is also present—a system which is able to read and decodify the information contained in the structure of the DNA. In addition, another system must also be present which is able to carry out the instructions.

Living Organisms

If one passes from the individual gene to the DNA chain of the most simple organisms we know about—those made up of a single cell like, for example, the escherichia coli—the probability of finding the right combination becomes even more remote. The above-mentioned director of the Max Planck Institute of Medical Research has calculated that the number of possible combinations in genetic writing is $10^{2,400,000}$. His conclusion is more than forthright: "It is therefore impossible to obtain this plan of construction of a living organism by mere chance. A hypothetical robot which could try out and assess a new combination would not be able—even to the slightest extent—to go through the whole range of possibilities even if it worked without interruption for a period equal to that from the Big Bang to the present day (= 10^{17} seconds). Indeed the time necessary for such an exercise would be equal to about $10^{2,400,000—17}$ which is $10^{2,399,983}$ times the age of the universe. The entire age of the universe therefore takes on almost negligible proportions when compared to the time needed for an "order produced by chance."[4]

An examination of the structure of the escherichia coli also involves many surprises because it has a notable complexity. The escherichia coli belongs to the group of flagellata, bacteria which have a filiform extension which is called a flagellum. The flagellum of the escherichia colli is not only the extension of the wall of the cell. It is also fixed to the wall of the bacterium by means of a kind of small cushion which enables it to rotate

on its own axis like a propeller. The rotary movement of the flagellum is created by the difference in potential which exists between the internal and external membranes of the cell wall. Here we encounter a mechanism which can be compared to that of an electric motor but which has exceptional capacities because it is able to perform 15,000 rotations a minute—a notable performance which is inconceivable for man-built electric motors.[5]

Even at the level of monocellular micro-organisms we find ourselves face to face with complicated and intricate functions which are made possible only by factors which are very different in character: the movement of the protozoan depends upon the rotation of the flagellum which in turn is determined by the way in which the flagellum is connected to the cellular wall. The difference in potential between the internal and external membranes must be such as to allow this movement and must be proportionate to the dimensions of the flagellum. All the information relevant to these characteristics is contained in an equally large number of genes present in the DNA of this protozoan.

The Complexity
of Life Processes

As in the case of escherichia coli, the increase in our scientific knowledge about biological processes demonstrates their extreme complexity with ever greater force. The different functions are possible because of extremely diversified functions and the action of innumerable enzymes which must act at the right moment and in the right place.

Let us take haemoglobin as an example and the accompanying transmission of oxygen from the lungs to the body tissues. We can take it for granted that here we are dealing with a very simple reaction: the haemoglobin becomes saturated with oxygen within the lungs which are in contact with the external air which is itself rich in oxygen, and proceeds to dispense that oxygen to the peripheral tissues. This mechanism in itself certainly permits the transmission of oxygen but its methods are insufficient for the needs of the body. Haemoglobin has certain special characteristics. Its affinity with the oxygen changes with temperature and acid levels. It reaches a higher level in the lungs and a lower level in the peripheral tissues. This means that there is an increase in the efficiency by which oxygen is transmitted.

The role of haemoglobin becomes even more complicated and problematical when one comes to consider a special stage in the life of man—that of the foetus.

During life within the womb the oxygen-carbon dioxide exchange does not take place at the level of the lungs in relation to outside air but at the level of the placenta through the blood of the mother. If the foetus had the same haemoglobin of the mother there would be a rather limited exchange of oxygen through the placenta—that is, until the concentration of oxygen in the haemoglobin of the foetus had not reached the levels present within the mother. During the womb stage man has a special kind of haemoglobin which is called foetal haemoglobin and this displays an affinity with the greater oxygen of the haemoglobin of the mother. For this reason it is able to achieve a higher level of saturation through the maternal placenta.

These facts and elements bring out the complexity of the whole question. The foetus has to have a haemoglobin which has an affinity with the greater oxygen of the adult but such affinity can not be such as to create a stable link which would prevent the transmission of oxygen at a peripheral level. It is rather difficult to believe that these two different kinds of haemoglobin—which correspond to such very precise needs and requirements—appeared by chance. At the moment of conception, within the fertilized ovule, we find that in this miniaturized archive which contains the programs for the production of about 100,000 different proteins there are also the programs for these two types of different haemoglobin. They have extremely specific separate characteristics and also contain the information which is needed to halt

the formation of foetal haemoglobin after birth and ensure its substitution by adult haemoglobin.

The Self-Organization of Matter?

Modern-day scientists recognize that we have here immensely complicated and intricate problems and questions and that everything is greater than the sum of the parts. For this reason it is a mistake to try to explain the whole as an aggregation of individual component parts. For this reason the theory that the origins of life and the development of living organisms is the work of chance also fails to stand up. Contemporary scientists, however, seek to propose other theories to explain the "natural" appearance of these complex systems. One of these is that of the self-organization of matter. According to this theory, matter from the very outset, that is to say from the moment of the Big Bang, contained within it the "idea" of its own organization, the very plans of all future developments.

This theory is certainly interesting because it recognizes that the development of life as it has taken place is not conceivable without the existence of an idea, of a precise plan. This certainly represents an advance on the more radical forms of mechanistic materialism. On the other hand, however, it sees self-organization as a physical property of matter.

The recognition by scientists that the observation and study of nature leads to the conclusion that there must be the existence of a plan or an idea constitutes an important turning point: within the universe the work of intelligence is recognizable. The question of the nature of this intelligence then arises, but this is a problem which is not the exclusive field of concern of the man of science, but which necessarily also involves the representatives of other disciplines.

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Notes

[1] BRUNO VOLLMERT, *Die Entstehung der Lebewesen in Naturwissenschaftlicher Sicht. Darwins Lehre im Lichte der Makromolekularen Chemie* (The orgins of living organisms from the scientific point of view. The doctrine of Darwin in the light of macromolecular chemistry) (Gustav-Siewerth-Akademie, Weilheim-Bierbronnen, 1995), p. 37.

[2] BRUNO VOLLMERT, *Das Molekul und das Leben. Vom Makromolekularen Ursprung nicht und der Arten: Was Darwin nicht Wissen Konnte und Darwinisten nicht Wissen Wollen* (The molecule and life. The macromolecular origins of life and species: what Darwin could not know and what the Darwinians do not want to know) (Rowohlt, Reinbeck Bei Hamburg, 1985), p. 63.

[3] FRIEDRICH REINBECK, *Caos e Ordine: la Complessa Struttura del Vivente* (Bollati Boringhieri, Turin, 1994), p. 131.

[4] *Ibid.*, p. 32.

[5] Cf., WOLFGANG KUHN, *Alles nur Zufall? Schopferglauben und Naturwissenschaft* (All a question of chance? Faith in the creator and the science of nature) (Johannes-Verlag, Leutesdorf, 1994), pp. 15-19.

PAOLO PANCHERI

Man in the Nakedness of His Madness and the Meaning of His Delirium

Delirium has always been seen as the essence of madness. To be in a state of delirium means to transform the world from a subjective point of view and thereby lose the borders between internal reality and external reality. It means an abandonment of the community of social thought to which one belongs and entrance into a fantastic universe which is detached from that same community. It means losing every ability and capacity for critical appraisal and evaluation about this subjective transformation of the world.

The person who is delirious loses his ability to adapt his own behavior to that of others, and as a result his own actions become bizarre, anomalous, deviant, unpredictable, and unforeseen. The abandonment of the social community and the withdrawal into a fantastic world which excludes critical judgment involves the delirious person's becoming seen as an anomalous element and a disturbing factor within the group, whether in a narrow or wide sense, to which he belongs. He becomes the object, because he is an "alien," of stigma and of social exclusion. Moreover, he also falls victim to demonstrations and expressions of aggression and violence.

During the history of humanity the person who displays what we today call the symptoms of delirium has always been the object of these reactions on the part of the social body to which he belongs. However, these reactions have expressed themselves in different ways and forms according to the sociocultural and historical context in which they have taken place and in which that person has lived.

What, however, has changed as a result of the context has always been the interpretation of the alienated state of the delirious person. At various times the interpretive model has been mystical, magical, or diabolical in orientation or has taken some other form. During the contemporary period and within Western civilization the dominant interpretive model has, however, been of a medical kind.

The medical model sees delirium as a mental illness or disturbance, it places it as a symptom within a wide range of psychiatric syndromes, and it describes its phenomenological characteristics, whose possible causes at the level of the biological mechanisms of the working of the brain are then studied, or at least an attempt is made to study them.

Of course, it does not necessari-

ly follow that the medical model of interpretation must be definitive in its understandings or even actually correct. We can only say that in our culture the medical models enable us, far better than others, to intervene in various ways and bring back the delirious person to the social community and promote the passage from an "alienated state" to a condition of "normality."

Obviously enough, the person who is delirious does not believe at all that his thoughts, his beliefs, his rooted certainties, and his forms of behavior are "alien" or the result of some form of "mental illness." As a result, he rejects this medical interpretation of his psychic life and thus resists every kind of therapeutic treatment.

The problem thus becomes a matter of seeing the medical doctor as a delegate of the social body who inquires into whether the beliefs of one of the members of the community have the characteristics of actual delirium or mental illness. He is also to decide on whether, as a result, steps should be taken to temporarily restrict the freedom of that person and whether the forms of treatment prescribed by the dominant medical model should be applied.

It is therefore of essential importance to define the contours and limits of delirium, achieve a description of its formal characteristics from a psychopathological point of view, and determine its "understandability" in relation to the context, in addition to carrying out an analysis of its component parts and essential features.

Everybody is well aware of the risk connected with a medical in-

terpretation of a subjective belief as being a phenomenon of delirium when on analysis its characteristics do not bear the features of "illness."

The "Formal" Characteristics of Delirium

All the major exponents of European psychopathology have addressed themselves to the complex and intricate question of achieving a definition of delirium through an analysis of its formal characteristics. Among these leaders in the field, Jaspers has made the most important contribution by establishing the three fundamental characteristics which enable us to identify the presence of a disturbance caused by delirium. These have been in large measure adopted by the psychiatric schools of thought of the English-speaking world and have also entered the texts and manuals of contemporary psychopathology, in addition to the glossary of the principal system by which mental illnesses are classified (DSM).

The three criteria which Jaspers employs are "subjective certainty," "incorrigibility" in the face of logic and evidence, and the "impossibility" (or falsehood) of the content of what is said. The DSM III-R defines delirium in the glossary on the classification of mental disturbance with the following sentences:

"Delirium. A false personal belief based upon an incorrect inference about external reality which is upheld with conviction notwithstanding the fact that nearly everybody else believes the opposite and which is in opposition to what constitutes incontrovertible or obvious evidence or proof to the contrary. The belief does not belong to those commonly accepted by the members of the same culture or subculture (for example, one is not referring here to a religious belief). When a false belief implies an extreme judgment of value, it is only seen as an example of delirium when it is so extreme as to be beyond all credibility."

It is important to point out that in the definition of the DSM III-R there are three criteria from classic psychopathology according to Jaspers: subjective certainty, incorrigibility, and falseness (impossibility) of the judgment. Whereas all the criteria of subjective certainty ("false personal belief") and incorrigibility are merely outlined or defined in summarized form, a great deal of emphasis is placed upon the definition of the criterion of the "falseness" of the judgment, which is altogether more problematic and difficult. In this respect as well, the DSM III-R is in line with classic psychopathology.

It is useful here to refer to the pages written by Jaspers to define the concept of "reality" (from which, however, it is rather difficult to extrapolate operative concepts) and to the attempt by Schneider to make the judgment about the "falseness of the contents" less problematic; in this endeavor he drew attention to the formal differential characteristics between delirious perception and delirious intuition.

The DSM III-R instead follows a criterion of a social kind which is based essentially upon the "extreme deviance" of the belief of the affected individual in relation to the context of the opinions of the people in the group to which that individual belongs. It seems obvious, therefore, that from the use of the DSM III-R it also difficult to establish absolute and valid criteria by which to achieve a constant appraisal of the falseness of a

personal certainty which is not amenable to correction.

The problem is complicated by the fact that there are "incorrigible subjective certainties" to which one cannot apply the rigorous but clinically acceptable criterion of extreme deviance in relation to the dominant certainties of the group to which the individual belongs. This is particularly the case when one comes to consider the subjective certainties about internal reality and the individual experience which is itself separate from external reality.

It is more than evident that in this area the criterion of comparison with the social certainties of the group is not possible because the statements about internal reality, precisely because they involve the singular experience of a specific individual, cannot in theoretical terms be considered deviant but must be seen as having their own uniform validity.

Those experiences, therefore, which refer to the inner reality of an individual—even though they have the characteristics of subjective certainty—should not be seen as examples of "delirium," but as "alterations of the person's experience."

It should be stressed that the whole question and difficulty of approaching the essence of delirium with reference to external reality has been well understood by the authors of the DSM III-R, who in their definition of delirium refer to the "incorrect inference about external reality."

In fact, this attempt to avoid the crucial question of the "falseness or impossibility" of the content of what is affirmed through a distinction between beliefs about internal reality and external reality raises a series of problems and difficulties which have still not been resolved. A broad range of internal experiences or "alterations of experience" exist which have always been classified as being of a delirious nature even though their level of inference about external reality is minimal or at least secondary. One needs only to think here of a delirium of guilt or a delirium of hypochondria as examples of a delirium which involves somatic transformation.

The crucial point is that in the delirious experience the concepts of internal reality and of external reality lose their usual reference point of meaning. The mechanisms which normally ensure that a distinction is maintained between the sphere of internal events and experiences, on the one hand, and that of external relationships, connections, and meanings, on the other, appears not to work. The universe of subjective experiences extends its range to include the world of objective experiences. Fears and wishes become external reality and there is a loss of the boundary between what is imagined (where everything is possible) and practical real experience.

The Fundamental Subject – Matter of Delirium

A preliminary analysis of the contents of delirium enables us to make two observations: the first concerns the relatively limited number of delirious ideas and concerns which can be ascertained in a clinical framework; the second relates to the presence of certain fundamental themes which belong to relatively homogenous groups of specific contents. When we come to consider the stereotypical characteristics of these contents, it should be observed that they are fundamentally narrow in number and repetitive and that they are therefore in evident contrast to the immense variety of the features and contents of nondelirious thought.

At the level of clinical observation, it is very striking that when thought undergoes a delirious transformation, its contents experience a levelling and a reduction of subjects referred to, and that this takes place within a framework of categories which seem to be already established beforehand. It is also striking that this process of reduction in the contents has nothing to do with intellectual or cultural inheritance or capacity, imaginative capacity or representation, or experiences which have been undergone before the onset of the appearance of delirious symptoms. Indeed, the low level of variability in the contents of

delirium seems to express the working-out of thought at a more elementary and ancient level which has nothing to do with culturally acquired individual differences but which seems, rather, to be connected to impulsive needs and drives which are present within all members of the human species.

The second observation involves the fact that the great majority of the contents of delirium can be traced to relatively simple basic elements and concerns which seem to be connected to certain pre-existing structures of emotional, cognitive, behavioral, and elementary organization which belong more to the species than to individual humans.

The first fundamental element is that of threat or danger. Many of the contents of delirium can be related to fear about external threats to the individual's life, to his physical well-being, or to his psychic integrity. This element seems clearly to involve an elementary "psychobiological program" directed towards achieving individual and personal survival. Culture, social organization, and individual mechanisms directed towards the management of external threats help to make rare or transitory this experience of threat and menace. In certain psychopathological conditions (delirium) this elementary and profound experience of fright and fear about one's own survival and security seems to

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emerge and become generalized in an inadequate fashion. The elements of persecution, reference, and external influence—and to a lesser extent of hypochondria—belong to this frequent set of delirious elements. In these states of delirium the fundamental drive towards the conservation of one's own life and the ancient, indeed ancestral terror, that one's own body and one's own mind can be altered, broken in their unity, and taken away or lost for ever emerge and become more than evident.

The second fundamental element is that of contents which are connected to sexuality, copulation, and reproduction. The "erotomanic" forms of delirium belong to this category, in addition to certain somatic forms of delirium centered upon one's own sexual organs, forms of delirium relating to sexual possession, those centered around hallucinations and accusation of homosexuality (above all, in males) or sexual promiscuity (above all, in females), forms of delirium relating to the false attribution of maternity or paternity, and those connected with pregnancy. These kinds of subject matter of delirium have the common denominator of reproduction and seem to emerge as a shared expression of an elementary psychobiological program rooted in the need to preserve the species.

It should be remembered here that in all living creatures the first level of genetic programming is directed towards the dual aim of defending the life of the individual and ensuring the survival of the species. These two programs have become ever more complex with the process of evolution in order to maximize the achievement of the evolutionary goal. In the case of mammals a large part of the cerebral structure is organized in such a manner as to ensure the survival of the individual and to protect his reproductive capacities. In the case of man this reproductive program retains its original biological importance and strongly influences his behavior.

The reproductive psychobiological program which works for the preservation of the species can undergo a number of major changes

in the ways it expresses itself in relation to the complicated and intricate educational, interactive, and contextual processes connected with the development of the cortical structures of the human species. In the particular case of social destructuring represented by the state of delirium it re-emerges—albeit in an elementary and distorted form—as an expression of a profound and biologically conditioned essence of man as a living being.

The third fundamental element is more complicated and intricate in its character and covers a spectrum of delirious contents which are organized in manifestations of seemingly opposed polarities. At one pole there are the so-called "depressive" manifestations represented by delirious feelings of guilt, death, negation, and ruin. At the other opposing pole are to be found forms of delirium which are defined as being manic, such as those involving grandeur and omnipotence. Their common matrix is represented in clinical terms by the fact that they make their appearance in the same grouping of symptoms (bipolar disturbance) in relation to pathological variations in the nature of mood.

But leaving aside their common psychobiological matrix, two essential elements of equally opposed polarity lie underneath these two kinds of contents of opposed polarity. In the case of "depressive" forms of delirium, the common subject matter is represented by turning one's back on life, by a loss of interest in planning for the future, and by a fascination for death. The "manic" forms of delirium, on the other hand, center upon such cardinal themes as the denial of death, the eternity of existence, the immortality of the physical structures, and the negation of the dimension of time.

Leaving aside questions of a clinical nature and the biological determinants which are involved, we should ask ourselves what the fundamental element might be which links these two poles of manifestations of delirium.

The common matrix can be identified in the knowledge of those endowed with self-aware-ness of the temporal limit to existence. The appearance of consciousness when a critical limit of cerebral development has been achieved makes the human being aware of the unstoppable passing of time, of the fragility of his physical make-up and supports, and of the precariousness of his ties and bonds, which are inevitably subject to the events of separation, loss, and mourning. This means that in the presence of consciousness the fundamental matrix of his life is essentially of a "depressive" character.

On the other hand, this basic mental orientation must be placed side by side with the fundamental psychobiological drive to live for as long as possible—something which is required by the millions of years of evolution of the species. From this point of view the acceptance of life can be seen as a special "physiological delirium of eternity" which nonetheless involves a constant oscillation between the basic "depressive" condition and the "manic" position which compensates it.

In the case of actual illness these oscillations which spring from the common matrix of human experience are accentuated and blown up and the contents of the delirium become an expression of this matrix. In this way depressive illness and its forms of delirium can be seen as a "hyper-realistic and pathological" expression of this shared matrix, while mania and its


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forms of delirium become a "hypercompensational" manifestation which is equally pathological even though it belongs to the other polarity. Both groups of forms of delirium can in this way be considered as a manifestation of another fundamental aspect of man which is generated by consciousness—a "need for eternity."

The fourth fundamental element is represented by delirious contents of a mystic or religious character. The forms of delirium which involve the belief that there is a direct and privileged communication of a total or partial nature with divinity, the bestowal of divine powers, and a belief in the magic powers of prayer or religious rituals all belong to this category.

What characterizes all these forms of delirium is, obviously enough, not a belief in the transcendent or an adherence to a religious faith but a subjective certainty, incorrigibility, a lack of social consensus, and, above all, the "self-centered" character of the contents of the delirious experience. In this example as well, underneath the essential subject matter is to be found a fundamental element which can be defined as a need for an understanding and comprehension of the absurd.

As in the case of the need for eternity, this also derives from the evolutionary process of self-consciousness. To be conscious means to look for a logical explanation, or, at any rate, a coherent interpretation of the facts around one, of events, and objects of knowledge. When such an explanation is not possible, anxiety increases and reaches such an intolerable level that it can only be reduced through the formulation of a coherent interpretive model.

A belief in the transcendental involves a process and state of existence where one finds an explanation to the seemingly incomprehensible reality that a conscious form of life is destined to become extinguished by death. It means, in the final analysis, an act of response to the fundamental drive to the comprehension of the absurd. This is why delirium often involves the dramatic emergence of this fourth fundamental aspect and trait of the human being.
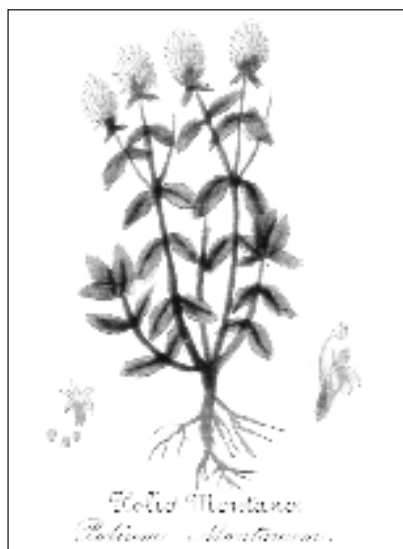
Man Afflicted by Madness and His Forms of Delirium

The analysis of the fundamental features of delirium and the elementary realities which underlie them brings us to a number of key observations. We have seen that delirium is the consequence of the functional mechanisms of the brain which, whatever their causes and origins may be, give rise to a subjective transformation of reality. The abandonment of the real—understood in the sense of social consensus—means that delirium becomes filled with contents which reflect fears, anxieties, and wishes which under normal conditions form part of the imagination, but which in the delirious transformation of the world become the new realm of reality.

However, when we come to consider and examine delirium, we are also struck by the fact that its contents have lost their richness, their variegated mutability, their flexibility, and the extreme variety of the contents of normal imaginative production. With regard to their poverty and the stereotypes of their concerns and orientations, the contents of delirium express, on the other hand, and in contrary fashion, a limitation and constraint of the imagination, the loss of imaginative creativity, and, above all, the destructuring of the social.

We thus come to the actual contents of the delirious experience and condition and thus encounter certain essential elements and features of life which reflect and are connected to the ancient and eternal fears or needs of man. The imperative need to survive, the need to perpetuate the species through reproduction, and the need for eternity and to explain that which cannot be explained, are all an expression of the two essential determinants of the psychic life of man: biological programming and consciousness.

Delirium destructures man regarding social life, it frees him from the conditioning influences of instruction, of his experiences, of sociocultural influences, and leads him to his most elementary and profound essence. The analysis of the contents of delirium thereby emerge as a window which has been opened by illness onto his deepest and inescapable inner features and character.

Such deeply-present elements are immanent in each and every human being. But under normal conditions they are able to express themselves in indirect form; they are masked and transformed. Only in states of delirium, or in special life conditions, do they emerge in a more direct, evident, and dramatic form.

In a state of delirium, therefore, man becomes more like other men. In this state, differences in instruction, race, and sociocultural orientation disappear. In a condition of delirium man displays his common matrix, which has been acquired through different historical phases from the first appearance of consciousness until today.

One may ask at this point whether it might not actually be the case that the man "naked in his madness" who has apparently reached in his state of delirium the very essence of his life in reality lives in a privileged condition which is very different from that experienced by normal people, who are suffocated and weighed down by sociocultural superstructures. Those who have maintained this thesis in the past for the sake of literary paradox or philosophical argument have forgotten or have deliberately denied certain fundamental facts and realities which emerge from clinical experience and observation.

It should be stressed, first and foremost, that *the person who is delirious is someone who is in deep suffering*. It should not be forgotten that education and upbringing, learning and acquisition, rites and conventions, and rules and laws have in all cultures and all historical periods had the function of reducing and managing the unbearable anxiety linked to an absent answer to the fundamental elements and needs of the human being. In the condition of delirium man comes out into the open and finds himself without protection in the face of these anxiety-causing elements and needs. He strives to provide an answer and a response to them through the content of delirium, but such a reaction is in-adequate and incomplete. Furthermore, he finds himself alone in a social community which isolates him, excludes him, fails to understand him and what he is, and has the effect of nullifying him.

The second observation to be made is that the person who *enters into delirium loses his freedom*. The principal formal characteristic of delirium is its inaccessibility to criticism, to evidence and proof, and to the logic of arguments which present a different view of things. In addition, as has already been pointed out, within the state of delirium there is an impoverishment of the normal activity of thought. Finally, in this condition the ability to control and manage the complexity of the interrelational network of surrounding social life is always compromised. Indeed, the delirious condition influences and directs behavior in the only direction which is possible and which is itself conditioned by delirious belief. The loss of freedom means that the delirious man is disadvantaged and undefended in relation to competition with other men who, unlike him, are not in a delirious state. And almost always he becomes their undefended victim.

Madness and its states of delirium, therefore, fascinate us but at the same time perturb us. They fascinate us because through the "experiment of nature" which is constituted by mental illness we can open a breach in the social armor of man and thereby peer into the essence of his being in its "nakedness." But we are perturbed by the suffering, by the loss of freedom, and by the exclusion from the social community which the tragedy of the illness always brings in its wake.

There can, in fact, be no doubt that when man is deprived of his coverings he displays the essence of his "corporeality," but it is equally true that he becomes the object of censure and derision, and that most certainly he is not destined to survive for long beside those of his fellows who have never thrown off such coverings.

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MARIANO GALVE

Accursed Circles:
The Dantean Vortex of Madness

I have always been struck by the suffering which is constantly engendered where madness has established itself. As Dante says in his first canto on hell: "It is... a wild forest, harsh and strong... Were it more bitter, it would be death." It is a place in the form of a funnel which is made of concentric circles which get narrower and narrower. To fall into it is dangerous. The circle captures you and whirls you round to no positive effect. The accursed funnel attracts you and makes you fall into it and thus you reach the vortex from which you cannot escape. It is for this reason that in this paper I have employed the phrase—"the accursed circles."

The First Circle:
The Family Space

"And so he placed me and so he made me enter into the first circle with which the abyss was girded"

(Dante, *The Divine Comedy*, Canto IV).

For families "everything becomes more complicated" when there is a mentally ill person in the home. They feel that they are alone in having to face up to their essential problems and difficulties.

The economic and financial problems which arise act to modify the structure of the family and to create new kinds of relationship between its members. Some of the family members, the father or the mother, find themselves forced for reasons of income to leave their jobs or to take up working again in order to deal with the economic and financial requirements of their mentally sick child. This situation

can engender a reaction involving frustration and can include a certain sense of resentment towards the sick member of the family and a feeling of injustice towards a society which does not assume its proper responsibilities. Furthermore, the illness causes constant financial difficulties. Often it is necessary to "come to blows" to obtain a payment and to advertise the burdens one bears to have one's rights respected.

When there is a mentally ill person in the home everything becomes more difficult. The family feels, and is seen, "in a different way" in relation to its social environment. The fear of "what they will say" becomes a kind of obsession. If these families manage to maintain some kind of relationship with the outside world, these links are often troublesome, superficial, and difficult. This isolation is an authentic trial and travail for these families.

Faced with these difficulties, different families react differently depending on their own particular contexts and characteristics. They can react with a sense of guilt— "perhaps I should not have worked during my son's childhood" or "perhaps he was too spoilt." They can react by adopting the stance of victims: "This illness has landed on us like a curse. Everybody has to bear their own cross." And they can also become accusers: "If he wanted to, he could make an effort to get out of this situation."

Second Circle: The First Contact with the World of Medicine

"So I descended the first circle, into

the second, with less space but more pain, which brings great woe"

(Dante, *The Divine Comedy*, Canto V).

The moment when the illness is recognized as being a mental illness depends upon how informed the family is, upon their limits and levels of tolerance, and upon the opportunities they have for coming into contact with a competent and efficient medical doctor.

Mental illness is not something which easily identifiable. Indeed, at the outset it is nothing more than a set of rare or unusual forms of behavior which are tolerated in one way another by the person's environment but which in the end become intolerable to those people who have to live around an individual afflicted by mental illness.

At the outset these asocial phenomena are seen as meaningless or banal but in time they come to worry the family. After seeking in vain to attribute these symptoms to one or other form of physical illness or to certain external causes (stress, physical tiredness), and after not achieving anything in the way of a cure, the family begins to become aware of the nature of the illness. At times the discovery of mental illness can be very dramatic—during a crisis the sick person can explode and then disturb the public peace, forcing the police to intervene. On many occasions, the family tries to avoid these kinds of actions on the part of the police, but to no effect—often it has no other choice.

When families begin to be aware of the seriousness of the situation they do not know whom to turn to, and abandoned to face new and un-

familiar problems on their own they find themselves having to deal with their sick member all by themselves. Moved by a feeling of urgency, they feel driven to turn to the only person whom they hope can help them (and whose action is socially acceptable)—the "family doctor." Yet when they do this they do not seem to worry very much about his competence in the field of psychiatry.

The chance nature of subsequent meetings will determine the future itinerary of the sick person.

Third Circle:
The Private Psychiatric Networks

"I am in the third circle of eternal, accursed, cold and heavy rain"

(Dante, *The Divine Comedy*, Canto VI)

The journey which the mentally ill person makes through the psychiatric circuits can take place in two kinds of context—the private and the public.

The choice is not a matter of mere chance. It is influenced by a set of factors specific to each family—its sociocultural level, its previous experience and knowledge, and its level of trust in its own doctor.

3.1. *Private Consultation*

When the disturbance of the sick member of the family is at a tolerable level he has the opportunity of consulting a psychotherapist and continuing to participate in his own work environment.

This kind of help is not without its problems—the psychiatrist has a special relationship with the sick person and the families are pushed to one side. They become substituted by a stranger who represents the positive side of things whereas they have to shoulder the daily responsibilities of the problem. They often feel that they have been deprived of their own sick member and become curious about what happens inside the consulting room. Indeed, they often become aggressive towards the psychiatrist. Furthermore, during moments of acute crisis, the families are not able to rely upon the help of psychiatrists, a category

which does not make home visits.

Despite all this, private consultation is a promising course of action in that it allows families and the sick to entrust themselves to the care of a "specialist," to take advantage of individually-organized therapy, and to show society that through the use of specialist help they are really facing up to their problem.

However, at times the part played by such forms of consultation does not suffice and the psychiatrist suggests to the sick person and his family that he should be admitted to a private clinic.

3.2. *The Private Clinic*

The importance of the sick person is directly proportionate to the amount of money he pays. He is recognized as a person in his entirety and he maintains his own rights and social status. He is a "consumer" of psychiatry who hopes that he will be well served. The sick person is offered a very welcoming environment. He is subjected to a special course of treatment and therapy in a situation of material comfort. The room in the clinic has less restrictions and the visiting times are more liberal. Because the number of patients is less, the patient's contacts with those who are looking after him and treating him are much easier and his therapy is therefore much more individualized.

Private hospitalization ensures that he is not a being deprived of his own history and pushed out of reality. This contractual position does not interrupt the continuity of his existence for ever,and after the critical period has been overcome it will be much easier for him to integrate himself once again into society. Some sick people receiving this kind of treatment make the following types of remark: "It was like a family (one patient observed) and we used the informal Italian "tu" with everyone. The sick people used therapy to help each other. I helped a schizophrenic woman and she helped me to walk. I entered into her world, into her fantasies. Little by little I followed her obsessions. She could come into my room. Everybody spoke to everybody else in the clinic. There was no barrier between the health

care staff and their patients. You could go out of the clinic when you wanted. You didn't need to ask anybody's permission and if you had trust in the clinic you always came back. Free time was very well organized and there were many things to do.

But most families sooner or later have to turn to public services.

Fourth Circle:
The Public Psychiatric Circuits

"So we descended into the fourth lake, suffering from the painful bank than all the evil of the universe can encompass"

(Dante, *The Divine Comedy*, Canto VII).

We can begin this section by referring to two principal therapeutic poles—mental health consultation and the psychiatric hospital.

4.1. *The Mental Health Center*

The mental health center is a part of the national health service. It is a public structure which is open to everybody and it is free. It offers medical, psychological and psychiatric consultations. It thus plays a very important role in the identification, management and treatment of psychiatric disorders. This consultation service can direct families in different kinds of directions. It can either direct them towards the psychiatric hospital—if it thinks that this is what the mentally ill person needs—or it can suggest forms of treatment within the same service through subsequent meetings with the center's doctors or simply through the administration of drugs and medicines.

4.2. *The Psychiatric Hospital*

"Some people lay supine upon the ground, some sat huddled up together, whilst others came and went constantly"

(Dante, *The Divine Comedy*, Canto XIV).

To these hospitals are admitted, on the one hand, those mentally ill people who come from the middle classes or the less privileged sections of society, and, on the other, the "very" sick who cannot be pro-

vided with the long-term treatment that they need at home or within a clinic.

When families enter a psychiatric hospital, they think that they will encounter intense forms of treatment which will cure their mentally ill relative; rather as happens in a general hospital. But little by little they soon become disquieted and worried because neither the health care workers nor the medical environment correspond exactly to what is usually expected of a hospital.

For these families hospitalization has its duties and they immediately find themselves faced with the rigidity of an institution which has its own impersonal laws which are often traumatizing. One patient remembers his own particularly painful journey: "One night I had to go by car into the city, I went from bar to bar with my brother in crisis. The psychiatric hospital was closed, and so I had to go back the next morning."

When they have dealt with the administrative side of things, the families often feel wrongly deprived of their own mentally sick member and of their role as relatives. They feel marginalized by the health care staff: "My brother agreed to enter the hospital, but he had an attack of panic and did not want to leave me so quickly. He followed me like a little dog. The doctor ordered me to leave the room and this provoked the crisis. My brother would have been able to deal with this meeting if it had been organized differently."

In such cases families often feel that their mentally ill member no longer belongs to them but to a team of doctors and health care workers.

At the outset these families and the majority of mentally ill people look to the hospital as a kind of "haven." But this is not the only face of the psychiatric hospital, and these mentally ill people soon discover a hidden face of the coin—"the hospital-prison." Although the psychiatric hospital is the only option available to a family which does not have the resources to look after its mentally ill member itself, it is precisely this mentally ill relative who soon becomes aware of the violence which takes place within the walls of the institution to which he has been admitted.

Within the hospital, in a more or less confined state, there are hundreds of imprisoned people, of mad people (or they were such at one time). They number as many as the inhabitants of a village. They live crowded together and they have very little freedom of movement. What strikes one most is how "calm" they are, how passive, how mentally and physically stiff; they are deformed and silent; they are sad. They spend their time without doing anything at all. They smoke constantly and can be found all over the hospital, on the ground, asleep (because of the boredom or because of the drugs which have been administered to them), or perhaps walking to and fro in a small and confined space constantly under the watchful eye of some nurse. Most of these mentally ill people seem to be completely indifferent to everything. They are expressionless and nothing seems to matter to them. Nothing has any impact on them at all. One could be led to believe that they do not even feel pain. Only rarely do they give voice to protests at something; and nobody is ever heard to complain.

And so it is for year after year, indeed for years, that the confined person turns his back on being a person; he loses his own self-esteem. He has no needs and ignores his wishes and aspirations. He merely survives, and this is almost the only thing that he can do. He has no prospects, no stimuli, and no disappointments. He loses interest in everything and everybody. Everything and everybody becomes the same.

One mentally ill person has left us this account of his own experiences: "I don't know how it happened. From morning till night I found myself confined and tied to a bed—I thought I was being placed under observation. They said that I was anxious and nervous, but in reality I was angry at them because they stopped me from leaving the hospital."

The relationship of the families of the mentally ill to the psychiatric hospital, and their position in relation to it, is always ambiguous. An evident dichotomy is involved— the hospital is seen both in a positive light and in negative terms. This ambiguity is the common experience of the families during the first stages of hospitalization.

The families of the mentally ill person feel guilty at having had him admitted to a hospital. They think that this amounts to rejecting him and thus involves a continuation of the exclusion imposed on him by society at large. At the same time, however, they are well aware that they do not have the means, the expertise or the resources with which to look after and to treat him themselves.

On the other hand these families are worried by the fact that their mentally ill member now finds himself in the hands of people who are strangers, being taken care of by nurses who look after him well or perhaps not so well. At the same time they do not like the idea that these nurses have established a maternal kind of relationship with the patients. They experience this fact as a form of competition. They are envious of the health care staff in the psychiatric hospital and they very often seek to impose their own evaluation of the situation on that staff in an attempt to demonstrate that the mentally ill person still belongs to them.

Indeed, it is possible to analyze the relationship between these families and the nurses who work within the hospital in terms of a sort of transfer. At the same time, and in parallel fashion, the nurses can perceive and evaluate the families in negative terms—as elements who are partly responsible for the illness and as rivals because the nurses and the families of the patient do not approach the treatment which is administered to the patient from the same point of view. For example, the frequent visits of one member of the family can be interpreted by the nurses as being a kind of protection which interferes with the independence of the patient himself.

The position and stance of the families of the patients is very changeable. The families shift between confidence in the doctor on the one hand and opposition to the treatment he prescribes and suggests on the other. They thus can alter this treatment in line with what they think is good for the patient— and this itself is based upon the

ways in which they themselves understand the illness.

With regard to the whole subject and question of the patient being dismissed from the hospital, the families oscillate between wanting to see their mentally ill member leave the hospital on the one hand, and worrying and being concerned about the crises and other difficulties which such a dismissal might involve on the other. There is also a temptation to allow the doctor in charge of the case to take their place in deciding that in fact their mentally ill member is "too depressed to be sent back home," a decision which if taken by the families might involve an intense feeling of guilt.

These families become very worried when the patient "does not agree" with the psychiatrist. They think that in order to be cured of his illness he should have a good relationship with the doctor in charge of his case. If things do not go as they should do (if the patient is aggressive, unhelpful, and fails to cooperate) then they become afraid that the doctor will lose interest in him. In the opinion of these families "being a good patient" means not putting up opposition to the requirements of the course of treatment. Some families even tell their mentally ill member "not to lose contact with the doctor after leaving the hospital." Indeed, the doctor in charge of the case should continue to follow the patient and to advise the family even after he has been dismissed from the hospital.

Fifth Circle:
Once Again the Family
and Society

"This swamp which gives off a great stench, girds the suffering city, and we could not enter it without feeling anger."

(Dante, *The Divine Comedy*, Canto IX).

Given the present-day approach to psychiatry, these psychiatric hospitals seem to be on the way out. In response to the general cry of "We need to reintegrate the sick into society," traditional psychiatric hospitals have been emptied

of their patients. As a result, these people now live on the streets, in homes or in hotel-homes, for the most part with their families or by themselves. They have to endure the protests of ordinary citizens and the complaints of the families themselves or their neighbors. Psychiatric hospitals have been replaced by a nonhospital system divided into areas or sectors. There are prevention centers or treatment clinics—psychiatric wards in general hospitals, day-hospitals, treatment homes, occupation centers, workshops, schools, and so forth.

Many former patients of these psychiatric hospitals have been sent back to their families, even though these families cannot really look after them. Many of these families are on the verge of desperation—they are defenseless and powerless. Some display their incomprehension of the situation, and their impatience and irritation with their mentally ill member. Others become tired and fatigued and come to abandon him altogether. In some cases they turn him out of the home and leave him to his fate. Such mentally ill people end up being victims of hunger, the cold, road accidents, suicide, violence and prostitution. Or they are picked up by the police and taken back to a psychiatric center or to their families. Such a stance and such forms of behavior on the part of these families engender a terrible sense of loneliness in the mentally ill person. He feels that he is a burden for his family and that not even his own family wants him. Fortunately enough, the majority of families are not actually like this.

On the other hand, society is unjust and cruel with those mentally ill people who were previously kept in such institutions. Until very recently they were seen as "empty and bad," and today they are believed to be "a danger for the safety of society." Society rejects them, it closes its doors in their face, it marginalizes them, and it is afraid of them. Until only recently they were subjected to discrimination on the part of the rest of the population because they were not even covered by the social security system. Today, luckily enough, such is no longer the case.

However, they often fall foul of bureaucratic procedures and by no means a small number of them end up without a home—they thus come to expand the ranks of the so-called "homeless." As a result we often find many of them on the streets, in the doors of churches or cinemas, in the entrances to underground stations, asking for money from passers-by. At times they use forceful gestures and employ strong phrases, seeking thereby to achieve a certain importance. On other occasions, we often encounter them on park benches, in rows on pavements or clustered together in shopping arcades, in hotels, or in charity homes, "dragging their rags behind them, their hallucinations, their physical pains, and their illnesses of the soul."

Like Dante, we have gone on a brief journey through the accursed circles of madness. We have seen how madness encloses, entraps, and destroys the mentally ill and their relatives. This is certainly a most horrible journey. At times, however, it is not like this and the version that has been given here is often exaggerated. But, on other occasions, such, indeed, is the situation. By the grace of God, not all mentally ill people enter these circles and fall into them. Let us therefore learn from the prudent Virgil: "It is better not to go in here." For this reason we must do our very best to develop the policy of prevention in the realm of mental health and health care at all levels—in relation to the family, to society as a whole, and in regard to the ideas, attitudes, and behavior of our culture. And if the mentally ill fall into these accursed circles, it is very important, indeed, that "they are not dragged down." For this reason we must raise walls of strength against this centrifugal force and act to promote and support forces which work in the opposite direction—namely medicines, services, research, and care. If all these instruments should fail, let us learn that compassion which welcomes, cares for, and watches over—a compassion exemplified by Dante's Beatrix.

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Round Table

Prevention, Therapies, and Rehabilitation

PIERRE F. CHANOÎT

Prevention and Mental Health

Introduction

Can we speak about prevention in a field where the results of treatment are still so often contingent?

This paper revolves around three principle subjects:

a) the many meanings of the term "prevention";

b) the evolution of this concept in relation to the limits of the discipline of psychiatry;

c) the arguments in favor of the policy of prevention and its various forms.

This paper is based upon the belief that psychiatry forms a part of medicine but no such certainty can be entertained in relation to mental health. This is more than evident from the information supplied by public health authorities that 80% of the factors which go to make up a state of personal health do not come within the province of medicine—at least, that is, as regards the latter's therapeutic functions. But illness, whether of a mental or physical nature, is one of the risks of life and our existence and remains a challenge to men of science - those individuals who must seek to predict or prevent the outbreak of illness.

This paper touches upon a very old philosophical discussion which was set in motion by the pre-Socratics at the dawn of Western thought—the debate concerning the nature of determinism and the role of time.

Common sense tends to believe that every event is caused by a preceding event and that for this reason every event can be predicted or explained.

Ilya Prigogine cites Epicurus when reflecting upon whether the universe is governed by deterministic laws:

The wise man laughs at destiny, that force which some people consider the master of everything. In fact, it is better to accept the myth of the gods than bow before the destiny of the physicists. This is because the myth enables us to hope that we will reach an agreement with the gods through the honor that we render them, whilst destiny has a necessarily inexorable character. (1)

From its very beginnings the duality of being and becoming has marked and shaped Western thought. For Plato (as we know from the Sophist) we need both being and becoming because if the truth is linked to being, to a stable reality, we cannot conceive life or thought without reference to becoming.

However, the proposition of the "laws of nature," exemplified by the law of Newton on the connection between force and acceleration, is both deterministic and reversible in time. If we know the initial conditions of a system subject to this law—that is, its state at a given moment—then we can calculate all the subsequent states. Karl Popper has the following to say on this subject:

I believe that Laplacian determinism—confirmed as it seems to be by the determinism of physical theories and their very great success—is the greatest and most serious obstacle in the way of an explanation and a defence of freedom, creativity and human responsibility.

The ancient Greeks provided us with two ideals which have guided our history—that of the intelligibility of nature through a system of general ideas which is necessary, logical and coherent—and by which all the elements of our experience can be interpreted—on the

one hand, and that of democracy, based upon the supposed existence of human liberty, creativity, and responsibility, on the other. This debate has been reactivated in the contemporary era by the discussion in physics and mathematics on chaos and instability.

Prevention should thus be placed in this context of the uncertainty of modern philosophical thought where individual description (trajectory) and the description of states are not equivalent. The interpretation of data does not involve certainties but possibilities and does not stop at being but extends to a consideration of becoming, and such will be the case in this paper.

1. The Many Meanings of the Term "Prevention"

The old Hippocratic adage that "prevention is better than cure" is still very relevant today even though advances in the field of prevention are more uncertain than their counterparts in the realm of treatment.

The term "prevention" has a number of meanings.

The classical distinction made by the World Health Organization is that which usually predominates in contemporary discussion of the question:

Primary prevention involves actions carried out prior to illness which aim at preventing its outbreak. One is dealing here with vaccination, the rules of hygiene, health education, and so forth.

Secondary prevention seeks to identify illness as soon as possible through systematic tests and a response to urgency, and thereby to engage in timely treatment.

Tertiary prevention is based upon

the recognition that many forms of illness, whether they are treated or not, leave long-lasting damage, functional weakness, and the perennial risk of relapse. For this reason efforts must be made in relation to rehabilitation, placing the individual within the community, the suitable organization of his environment, and providing him with help, so as to reduce his handicap and promote the achievement of his full remaining potential.

Another approach involves making a distinction between passive prevention and active prevention:

Passive prevention is based on medical principles and involves measures which do not require action on the part of the individual because such measures are the direct outcome of scientific knowledge about the aetiology and pathogenesis of illnesses. They provide an almost certain guarantee and one of the best examples of their effectiveness is to be found in the practice of vaccinations.

Active prevention is based on psychopedagogic principles and involves achieving the cooperation of individuals in promoting a change in their behavior in order to reduce the risks that they run. We are referring here to:

– the consumption of alcohol and toxic pathologies;

– tobacco addiction and cancer; and

– sexual behavior and sexually transmitted diseases such as AIDS.

During the history of the policy and practice of public health, great steps forward have been achieved by epidemiological studies. These have demonstrated that there is a close connection between ill-health and illness on the one hand, and the different socioeconomic levels of different parts of the population on the other. The work of prevention in this case is not of a medical character or to do with public information but concerns policies of a sociopolitical nature.

There can be no doubt that because of the complexity of their aetiologies, mental illnesses such as schizophrenia, chronic psychoses and obsessive neuroses cannot benefit from the methods and techniques of passive prevention or (at least in most cases) from primary prevention. On the contrary, they require early identification (secondary prevention) and the applica-

tion of readaptation and reintegration (tertiary prevention). Furthermore, epidemiological research has shown that mental disturbance afflicts the least privileged parts of the population (in intellectual, cultural and economic terms) and this means that psychiatry is naturally of key importance in policies relating to public health.

The term "mental disturbance" which I have used here for the first time in this paper is not completely identical in meaning to the phrase "mental illness."

2. The Development of the Concept in Relation to the Limits of Psychiatry

Psychiatry was born in a social-revolutionary context—which is often remembered—some two hundred years ago.

During the nineteenth century medical doctors were able to create a body of knowledge and information under the heading "mental alienation" and over a period of 150 years these alienists increased clinical observation and analysis without taking the "extreme" conditions of the context they were studying into account. The result of all this work was the creation of a "nosography" which found its highest expression in a work published by Emil Kraepelin in 1911. This work is now clearly out of date.

The increase in clinical analysis and in innovations in the sphere of treatment—and here reference should be made to the development of dynamic psychology (and in particular to the work of Sigmund Freud), of biology (and more specifically to the understanding of psychotropes), and of the human sciences (sociology and anthropology)—undermined the certitudes of the lunatic asylum style of psychiatry. The very concept of mental illness was called into question and the new classifications and terminology (D.S.M. III, then IV, C.I.M. 10) no longer referred to mental illnesses but to "mental disturbances." As a result the limits and boundaries of the discipline of psychiatry became rather more imprecise.

A number of statistics bring out the nature of this overall and long-term development:

In 1818 Esquirol listed not more

than 5,000 mentally ill people in the whole of France.

In 1960 the French Ministry of Health estimated that there were 140.000 mental patients in the nation's hospitals and 700 psychiatrists.

In 1993 65,000 psychiatric beds were occupied and there were over 750,000 mentally ill people within the non-hospital health system. In the same year there were 12,000 psychiatrists, of whom the majority exercised their profession in such a way as to render any quantitative calculation of their activity rather difficult.

The exponential increase in the number of individuals receiving specialist treatment has meant that a number of forms of disturbance which at one time would never have been defined as examples of mental illness have come to be placed within the psychiatric sphere. At the present time forms of mental disturbance which are defined as such by epidemiological surveys and inquiries no longer constitute that small one or two thousandths of the population which at one time inhabited the lunatic asylums. In the united States of America the Epidemiological Catchment Area Survey has employed a sample survey of the population over recent years to demonstrate that the incidence of mental disturbance reaches or exceeds 25% of the American population.

More recently Kessler and others (1995) have published the results of the National Co-Morbidity Survey carried out into a sample section of the American population. Mental disturbance over a lifetime accounts for 48% of those afflicted, and that lasting for a year, 30%. The most frequent forms of disturbance are an intensive period of depression, drug addiction or more often alcoholism, phobias, and anxiety.

It is thus more than evident that the forms of "mental disturbance" such as those revealed in these epidemiological surveys cannot be confused with traditional forms of mental illness. We must therefore refer to new approaches and emerge from the narrow framework of clinical psychiatry. Here we are dealing with the concept of mental health and its connections with public health. This is more than justified if we consider the importance of the problems of this whole area and

their intimate links with the social, economic and intellectual context to which they belong.

In general terms the following are the aims and goals of health policy and of those professionals whose task it is to ensure that these are realized:

– the promotion of health;
– the protection of health;
– the renewal of health.

It often happens that only the forms of treatment are taken into account. Even though they may be effected in an excellent way in terms of cost and accessibility, they only represent a part of the aims and goals involved. Treatment often neglects what comes before and after the illness and the whole dimension of the environment of the sick person.

We have traced the move from mental alienation to mental illness and then to mental disturbance. Just as in public health the term "health" has taken the place of "illness," is it possible that in psychiatry we will move from the concept of mental disturbance to that of mental health?

In historical terms the "biomedical" model lasted for a long time. Until the first decades of the twentieth century the most important causes of death were contagious diseases. The systems of control and response were those modelled on the methods and thinking of Pasteur. At the present time in industrialized countries more than two thirds of deaths are caused by chronic illnesses such as heart disease, cancer and mental disturbance. In addition it has been observed that these forms of disturbance are often correlated to behavioral risk factors such as tobacco addiction, alcoholism, drug-addiction and so forth or sociocultural elements such as poverty, migration, decultarization and similar elements. It should also be observed that the world of health and health policy has become a field of study for such social sciences as sociology and anthropology and in a more general sense for the human sciences.

The first contribution of the social sciences to this field of knowledge has been to show that a "social" dimension exists where on the whole only the individual aspect is usually perceived. Illness, suffering, death, and the relationship between the doctor and the patient, which at first sight seem to be private matters and events, come to be placed within the context of the social network which to a great extent determines them.

This is so for example in the field of suicide, a topic which has been the subject of one of the most famous works of sociology ever written. (3) When a suicide takes place attempts are made to find explanations in the history of the individual concerned, his relationship with his family, his friends, and his work. Every example of suicide is special. The considering of suicides as a whole, which are both individual and unpredictable, enables a new reality to emerge which is very different from the specific events which go to make up that general picture. The statistical relationship between the number of suicides and certain social variables can be emphasized—the number of suicides increases with age and the agglomerates vary according to country but the general levels remain very much the same over time. In other words, suicide—which is an individual act in the extreme—emerges as a social fact when it is seen in terms of a city, a region, or a country.

We can understand the "social field" of health with reference to two models which themselves lend legitimacy to the methods of the social sciences. These models are as follows:

– *illness as a natural and biological phenomenon* which is studied in a scientific way by biomedicine, epidemiology, biological anthropology, and population genetics;

– *illness as a social and cultural phenomenon* which is studied by ethnomedicine, medical sociology, and social anthropology.

3. The Justifications for, and the Methods of, a Policy of Prevention

Two recent reviews of the World Health Organization which are dedicated to the future of health services in the world (4,5) provide very useful information on new methods, successes and failures. Most countries are worried about the same phenomenon—the fact that health care costs now exceed what national income growth can cover. In such a context governments tend to diminish their commitment in the health field. The new directions in the sphere of economic policy which have tended to abandon a directive approach and to embrace free enterprise have acted to increase worries about whether complete health care is now economically possible. In far too many countries this has led to a marked fall in the quality of health care financed by the state. In some countries such as Germany, the United States of America, France and Switzerland quality, levels have been maintained but at the price of a rapid increase in costs which are now, however, considered unsustainable.

A health service is a complex and intricate whole which seeks to match needs with costs in certain given contexts which are of a political and economic nature.

From a general point of view there are two major areas which command attention:

– the respective responsibilities of those active in the health care field; and

– the location and the instruments of research and innovation.

When we reflect upon the future of health care we necessarily have to dwell upon the very great transformations both in relation to mentality and with reference to methods and practices which are now appearing on the horizon as we approach the twenty-first century. Given the ever more powerful resources of science and technology will we be able to cancel the inequalities which oppress our world? Or will these fascinating forms of progress merely increase our knowledge without it being shared? A certain number of salient features of modern development must be taken into account when we come to answer these questions and these are as follows:

– *the democratization of society* is a tendency which becomes ever more rooted, and it is a development which is accompanied by decentralization and the giving of greater responsibility to individuals;

– *fairness* is a value which is increasingly respected. Two ideas stand out—the provision of overall care and the application of treatment in line with needs;

– *ethical* considerations are becoming ever more important in the

sphere of health policy and care. They represent a bridge between politics and values. Questions are raised as to the moral value of certain choices which have to be taken involving the rights of man, the training of health care workers, the application of research, and what limits should be placed in relation to the treatment of the sick;

– *science and technology* are of great importance. Health care is intimately bound up with science and the advance in such care owes much to the progress of technology. What we have to do is to take advantage of both science and technology in order to promote the common good.

Most countries raise the same questions about the role and responsibilities of the various groups which are involved in the financing, production, consumption and regulation of different forms of health care.

3.1. The Protagonists of Health Services

In order to achieve a more effective analysis of the current situation we should take into account and examine the role and responsibilities of the various protagonists of health policy and care with special reference to governments and users.

3.1.1 The Role of the State

The domination of economic considerations in health care systems has given rise to two different historical models.

On the one hand, there is the Bismarckian model which was developed in Germany by Otto von Bismarck and adopted in that country in 1881. This model provided for a system financed in the main by insurance which protected workers against injuries at work, illness, incapacity, and old age. Such a model can achieve a very high level of quality without, however, guaranteeing treatment and care at a price which is accessible to everyone.

On the other hand, there is the Beveridge model, which inspired the system introduced by Lord Beveridge in Great Britain in 1948. This model offers everybody complete preventive and actual treatment but although it has fulfilled its purpose at a reasonable cost it has not failed to fall foul of the risk of low quality.

The French model of social security which is based on both these models has sought to look after the whole of the population from 1945 onwards but it also has not escaped the risks of increasing financial difficulties.

The state can not do everything but there are some things which only the state can do.

The first thing it should do is to assess the needs of the population. Descriptive epidemiology enables us to measure the incidence and the distribution of illness and to allocate resources accordingly. Analytical epidemiology forms the starting point for a strategy of prevention. These methods of research which are often expensive should occupy a prominent position of importance in annual government budgets.

The second thing the state should do is to produce clear rules and guidelines by which to organize and direct its health service, the aims and goals of that service, what it must do, and the nature and limits of its range of activities.

The third thing the state should do is to provide assistance whether in the form of prevention or actual treatment through a public service which should compensate for the failings or the inequalities of the private sector, and propose new and practical models for the application of the discoveries of fundamental or applied research.

3.1.2 The Role of Consumers

Among the various groups which are involved in the financing, the production and the organization of health care and assistance, the users—the sick and their families—play a pre-eminent part when they are aware and responsible citizens. Consumers can play this role in a correct way only if they are informed about the consequences of their requests both in terms of the costs involved and the suitability of what they are asking for. This means that campaigns of information have arisen which enable citizens to know about, and to insist upon, their rights (right to information, right to health care) and to perform their duties (hygiene, adherence to treatment). This process has given rise for some time to the creation of a large number of associations of consumers, that is, of sick people or people who were previously sick, or of their families. To

the first category belong Alcoholics' Anonymous, associations for diabetes sufferers, associations for hemophiliacs, associations for people suffering from AIDS, and so forth. To the second category belong such associations as the UNAFAM—the National Union of Friends and Families of the Mentally Ill—and the EUFAMI - the European Union of Family and Mentally Ill, and many other similar bodies.

In this way a new kind of dialogue between citizens and the public authorities can be established (campaigns of information on the results of research, on the origins of ill-health, and on the costs of treatment and care). A similar dialogue could be created between medical doctors and the sick (the duty of information) and between people at large (the hygiene of the environment).

3.2. Research Policy

3.2.1. In the field of mental health, for over half a century, *epidemiology* has constituted a method by which to understand the distribution of different forms of mental disturbance, their nature, and the context of their emergence. This method began in the Anglo-Saxon countries, was particularly developed in northern countries, and was then adopted by the World Health Organization. At the present time this method enables us to measure the distribution and incidence of the various forms of mental disturbance, and to calculate their economic costs (the statistics presented in section II give a good idea of what these can be).

Analytical epidemiology enables us to identify the conditions which give rise to mental disturbance both as regards individuals (those people at risk) and in relation to specific sets of circumstances (situations at risk). The results of these inquiries constitute a mine of information which is of great help in the work of prevention.

Epidemiology is thus an important tool of knowledge and as a result it is also a vital preliminary step in the drawing up of health and health care policy. Its past successes have been more than evident in the fight against contagious diseases (smallpox, cholera, yellow fever, polio, etc). In more recent times epidemiological studies have en-

abled us to tackle less simple health problems connected with lifestyles (heart disease and cancer) and to carry out campaigns of prevention whose effectiveness has been more than proved.

In the field of psychiatry recent research into the role of life events and social support open up new prospects for policies of prevention. Mental illness in the strict sense, or relapses, are often preceded by a disturbance of mental health and by physical suffering whose genesis is not well known, and these elements bring into play external, familial, social, professional, and cultural factors.

Epidemiology thus offers a tool and a set of methods well designed to develop knowledge about the questions involved, formulate strategies of prevention, and assess the effects of such prevention. But this also requires that psychiatry moves out of its relative isolation and enters the realm of public health, adopting its objectives and methods.

3.2.2. Advanced Technology for Tomorrow's Health

The contribution and discoveries of genetics are about to revolutionize our approach to certain illnesses. Soon every one of us will have a genetic profile drawn up at birth which will enable us to know to which illnesses and maladies we are predisposed. Over the last forty years scientists from all over the world have striven to understand how our genes manage to organize the complex symphony of biochemical reactions which enables our cells to function. But there is still a great deal to be done. A large number of studies carried out into schizophrenia suggest that metabolic imbalances are probably present which are most certainly not causes of the condition but constitute a factor of predisposition. In the same way manic-depressive psychosis seems to be favored by the presence of certain genetic anomalies.

At the present time we are using the first drugs and medicines capable of treating Alzheimer's disease. But within fifteen years we will undoubtedly know the molecule which will attack its cause.

However, this general development raises a large number of ethical problems and questions which cannot be solved without the direct

co-operation of the members of society. To this end governments and professional workers should take on the new and important responsibility of giving people broad and sufficient information.

Conclusion

Over the last decades our way of understanding health and life conditions has undergone major changes because of developments in the economy and in technology. The inequality in resources between the industrialized countries and their developing counterparts does not in itself explain the inequalities between different populations in relation to their standards of health. One might also think (in provocative fashion) that the importance of the intense resources of rich nations is an actual fact a handicap for the future when one takes economic costs into account. The fact that most of these countries have embarked on a policy of reducing the number of hospital beds and of medical doctors (one thinks here of restricted entrance into medical colleges), and have increased the training period for nurses, constitutes a clear change in health and health care policy. However, at the same time technological advance and a greater appreciation of medical research have given us greater and improved knowledge about serious illnesses and how they should be treated.

We now seem to have come to the end of a period of unprecedented economic expansion in the industrialized world. The experience of less favored countries has shown that the health standards of a population depend in large measure upon the conditions of life (infections, parasite presence, general hygiene, environmental conditions and so forth). And although it is true that the developed societies of the temperate zones have weakened most of the contagious diseases and increased life expectancy, they have not paid sufficient attention to psycho-social and genetic inequalities. At the present time they are becoming aware of the fact that health is a good which is not given and that many factors—which are for the most part nonmedical in character—have a decisive influence and effect. Now that they are faced with

structural economic problems in the management and programming of their national health services, our countries in the West are forced to think hard about a number of their fundamental principles and goals in the field of health and health care.

Although the "right to treatment and care" remains an essential formula and conforms to the duties of a state which is responsible for those of its citizens who are stricken by illness, it is clear that the "right to health" is now an obsolete slogan. This is because health (which is not only absence of illness) is often the result of forms of individual behavior at risk (general life hygiene, food hygiene, use of drugs and alcohol, etc.), of ignorance or neglect in the presence of alarm signals (obesity, arterial hypertension, relapse symptoms etc.), or of lifestyles at risk. The "right to health" thus becomes a "duty regarding health," the specific responsibility of individuals, which depends upon access to primary health treatment and to an awareness and appreciation of community health.

We thus have before us a new prospect in relation to health policy and care which bears the name "prevention" or "health promotion." The financing of this policy, which at one time occupied a secondary position, should in the future (in part) take the place of the financing of medical treatment and assistance.

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JANOS FÜREDI

Integrated Therapies for Schizophrenic Patients and Their Families

I sincerely hope that my presentation will not be disappointing to those of you who have chosen to attend this session rather than enjoy the beauties of this Holy City, the Vatican. Inspired by the extraordinary idea of the Pontifical Council and of Cardinal Angelini, together with their sensitivity and openness, I have dared to prepare a discourse in a manner contrary to the formula we have been taught to use through our education in present-day psychiatry. There will be only very few diagrams or tables, no correlations or factor analyses. Simply, I would like to share some of my ideas with you. I will try to think aloud, and instead of many figures I will show you some slides of patients in our clinic, which I hope will serve to reflect my thoughts.

My subject might be a little bit old-fashioned. To talk about the social psychiatric aspect of schizophrenia seems to be behind the times when we are in the midst, and rightly so, of the flourishing and predominance of biological psychiatry. Therefore, it might seem more appropriate to address you about serotonin, neuroimaging or neural substrata than to analyze social and family systems. However, encouraged by, and due to two most important scientific findings of recent decades, I feel compelled for the moment to draw our attention away from biological psychiatry and to remind ourselves of other factors dealing with schizophrenia.

The first point is that the studies of schizophrenia confirmed that cultural factors play a definitive role in the course and outcome of schizophrenia (Sartorius 1990).

The findings of WHO studies and of other studies repeatedly showed that in the developing countries a higher proportion of patients with schizophrenia have a better prognosis than in the countries of the industrialized world.

"And when the time of their imprisonment has expired, if any of them be of sound mind, let him be restored to sane company, but if not, and if he be condemned a second time, let him be punished with death."

Aurelius Cornelius Celsus (25 B.C.-A.D. 50), a most important writer and medical citizen in Roman times, responded to the issue of madness, even more harshly in terms of ongoing therapy. Celsus believed that rough treatment would frighten a patient out of mental illness. He chained patients, starved them, isolated them in total darkness, and administered cathartics in his efforts to frighten them into health. (Alexander-Selesnick, *The History of Psychiatry,* 1966).

Removal of the mentally ill from society was prevalent until the epoch of the Enlightenment, when the great reformers, Pinel, Tuke, Rush, and others, contributed important changes to the organization and administration of mental-hospital-reform programs. It has to be mentioned that Chiarugi was one of these persons who did not believe in maintaining a cold or indifferent attitude toward their patients. He travelled all around Europe, exploring the humanistic approach toward the mentally ill and tried to develop extremely modern mental health care here in Italy.

Despite the committed and heroic efforts of professionals and humane individuals we cannot say, even today, that segregation and condemnation of the mentally ill are entirely absent in any society.

We must ask, then, why does society recoil so dramatically from the mentally ill? Why do they create so much angst in the soul? There are interesting references in the Bible: the line "The Lord will smite thee with madness" (Deuteronomy 28:28) would indicate that although demons were considered the precipitating agent of insanity, the supreme controlling force was considered to be Divine. Saul's mental illness was thought to have been caused by an evil spirit sent from the Lord. (Samuel 1). The frightfulness of the phenomenon of mental disturbances could be traced back to the fear of mysteries. The so-called miracle was inexplicable in primitive societies. On the other hand, it could have been understood that certain phenomena like thunderbolts or thunderclaps could have come from the sky and from the gods, but there was no conceivable explanation why a human being who was completely similar to oneself could be so different.

This degree of perceived difference could be one of the key agents in the rejection of the mentally ill and especially schizophrenics because the manifestation of schizophrenia is so extreme when compared to the norms. If we are candid, we have to admit that in one way or another we are all a bit neurotic; at one time in our live most of us have

had problems with sleep or even with sex and so on. A Hungarian poem says, "If there is one day without depression in the life of a male over 55, that is a miracle." It is somewhat acceptable that we ourselves may experience disorders like panic, alcoholic intoxication or even dementia—in the distant future, of course—but it is completely unimaginable that we could suffer from schizophrenia.

Schizophrenia incarnates all the differences or deviant qualities that the average individual finds painful to confront. The average person perceives the symptoms of schizophrenia—perhaps above all—as a total loss of control: man's greatest fear throughout history, again and again, man's reaction has been to strike out against those whose beliefs or behaviour diverge from the perceived norms of his immediate society. Although most of the religions preach acceptance, religious and ethnic wars, past and present, are integral to our civilization. For the past let's remember the Inquisition, the case of Salem and the Holocaust, and lately Bosnia.

The great psychiatric changes of the era of Enlightment coincided also with the Great French Revolution, whose slogan was "Liberty, Equality, Fraternity." But our industrial and technological society, which is so proud of its logical thinking, has yet to achieve social fraternal equality among men. Different points of view, alone, are enough to threaten and divide individuals, no less the behaviour and belief systems. Difference is not acceptable socially—look to the nationalisms of Eastern Europe, and not acceptable personally—look to the cases of schizophrenia in the community and in the family.

In my many years of experiences with family therapy, I have found that, on the whole, family members react with complete denial to the onset of schizophrenia within their midst. I would like to recall two cases when after graduation from high-school the problems started. The first was a catatonic young man who was brought to my department accompanied by his father. I learned that after his exams our patient closet-

ed himself in his bedroom for nearly a year. His parents considered this behaviour as nothing more than a sign of tiredness. They refused to acknowledge any peculiarity. It was only when the young man started to refuse his meals that the parents sought medical help.

The second family visited me for the first time about a month ago. In this case a son, Tom, claimed that he never took his exams and that the certificate he received from the school was a phoney. He ceased all communication with his previous society and remained at home. His parents did not attach too much importance to this behaviour and so left for holiday, leaving Tom's younger brother in his care. During those two weeks Tom complained that people were spying on him from outside the house door and that they were reading his thoughts. These complaints were followed by a suicide attempt—a cutting of his wrists. It was this incident that on their return prompted the parents to seek advice from a surgeon friend. In contacting me, they claimed no urgency and requested an appointment for some time in the future.

To change this process of denial is a monumental task of psychiatry and one which is not always successful. The obstacle is the disbelief on the part of families that such a disease could occur in their midst. And, too often, tragically, the expectation they have of their child never diminishes, but remains as high and as fixed as before the onset of the illness.

Secondly, the time-worn thesis that stress influences the course of schizophrenia receives impressive current support from the literature on Expressed Emotion (EE). Through the developed semi-structured interview it has become possible to assess the emotional atmosphere in the home of the patients. The ratings reflected a number of critical comments, overall hostility and emotional over-involvement on the part of some patients' family members. However, the value of EE is not confined to schizophrenia, but the findings must now be regarded as secure. All in all, the majority of

studies add up to a considerable consensus about the measure in predicting relapse. (Bebbington 1990)

The aforementioned findings point to the task of social psychiatry as was expressed by John Wing in 1970.

"A social psychiatrist investigates social causes of psychiatric disorders..., studies social influences on the course of these disorders... The effect that mental disorders have on society and more particularly on family and friends is also a central concern." (Wing, Brown 1970)

Being still poisoned by the ideas of social psychiatry, I have shown great concern for many years about how to bring together the two findings above. What are the common factors in those two ideas? Although many aspects of those statements are true for other illnesses, why were they verified first in schizophrenia?

Despite obsessive preoccupation as well as exhaustive research, schizophrenia remains among the greatest mysteries of our civilization. Thousands of papers and books have been written about that topic and we find fascination with schizophrenia not only within psychiatric literature, but within literature a whole. Immediately the works of Aeschylus, Shakespeare or Dostoevski spring to mind. Why was schizophrenia so important in the past, and why is it still the crucial unsolved mystery of our time?

I think we have to go back hundreds of years for the answer, as usual to classical times, and as always to the ancient Greeks. Modern psychiatry owes much, for example, to the Hippocratic emphasis on clinical medicine. Hippocrates must also be given credit for his recognition that the brain is man's most important organ: "the brain is the interpreter of consciousness." He and his followers developed psychological thinking and put forth the first description of mental illness. Unfortunately, however, their attitude toward the mentally ill was generally rejection. This attitude was echoed by Plato, who regarded madness as nothing more than a lack of restraint of appetites, the opposite of

discipline and intellectual commitment and sanity. In his *Law* Plato proposed the establishment of a house of moderation, in which those who held their mistaken beliefs out of ignorance were to be held for five years in order to be given sound instruction.

This observation is the basis of our new research, which we refer as Expressed Expectation, as opposed to Expressed Emotion. Our hypothesis is that the high expectations families have towards their beleaguered member are at least as harmful to the future of our clients as is high EE.

To prove our hypothesis one of my colleagues, Assistance Professor Zoltan Danics and I conducted a study on 26 schizophrenic families with 91 members. As a control we used 25 so-called normal families with 63 members. The expression of expectancy was measured by means of a modified semistructured interview (Cum-

berwell) and by means of a set of questionnaires.

The interviews were rated for three dimensions: 1) the intensity of expectations, 2) the confusion (ambiguity) of expectations, 3) the unreality of expectations.

We found a significant difference between schizophrenic and normal families in the confusion and unreality scale, but no considerable difference on the intensity scale. This means that the so-called normal families express their expectations almost as intensely as the schizophrenic families do. On the other hand, the schizophrenic families in their expectations are considerably more ambiguous, confused and unrealistic than the normal families.

Thy study confirmed our long-standing therapeutic strategy that only the involvement of families—besides widely accepted antipyschotic medications—can lead to a long-lasting result. Aided by our own research, we can con-

centrate better on the special clarification of confusion and unrealistic expectations in the families.

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FRANCO IMODA

Psychotherapy

Introduction

The definitions of "psychotherapy" which are usually given are for the most part general and open-ended. We are told that the term refers to "every systematic effort to alleviate a mental disturbance by psychological means."[1] In this open-endedness and high level of generalization we encounter not a weakness but an opportunity. At a specific level of what does this help consist? What does it seek to do—achieve a cure, internal equilibrium, social adaptation? Personal identity as a form of self-fulfillment? Rehabilitation with a view to achieving and expressing human potential, including the image of God? All of these alone or other things as well?

It is certainly not possible here to enter into a general and detailed debate on the effectiveness of psychotherapy.[2] The aim of this brief paper is narrow in outline. Approaching the subject from an angle which is not of an exclusively functional character, and taking as its starting point certain practical and theoretical difficulties, this paper seeks to emphasize the importance of an anthropological approach which can be applied at a practical (psychological) level. The aim is not only to find a way out of a certain number of difficulties in which therapy may find itself immersed but also to act in a way which corresponds to the full to the richness of the reality of the human person.

1. Challenges

Faced with the host of questions which present themselves, here an attempt will merely be made to draw attention to a number of challenges and to point out a number of areas which are of importance in the drawing up of a correct approach to the subject of this paper.[3]

1. Psychotherapy is not primarily made up of theory. We have to face a challenge which is of a "practical" character. I will not dwell here upon the challenges involved in terms of professional codes of ethics and the recognition of qualifications and spheres of expertise. From the questions which are posed above, it is clear that we are often faced with a *wide range—but perhaps also marked confusion—in relation to the goals* which should be pursued, especially as regards their mutual inter-relationship. Should one be seeking to recreate a biological-physical equilibrium, a greater level of social adaptation, restore an interpersonal relationship which had previously been too difficult, or provide a world of meanings and values which can overcome the futility and the absurdity of a person's own life?

Some authorities have not only referred to expressive or support psychotherapy but have also held up as their aims such specific goals as pacification, unification, optimal disappointment, and interpretation (Gedo and Goldberg, 1975). But we are reminded of the fact—at least, that is, if we are Christians—that we are also dealing with renewing the reality that people are by their natures made in the image of the Creator (Col 3:3-4).

The pastor/educator reminds us that the disciple is sent on a dual mission—to heal and to preach the gospel (Martini, 1979).[4] And a pastoral theologian (Clebsh-Jaekle, 1964) refers to four principal goals: healing, support, guidance and reconciliation.

For some experts psychotherapy is the more or less indiscriminate application of a *technique* (perhaps of an analytical kind) which has been more or less practically tested. This demonstrates a hiatus between theory and practice in the sense that a technique which is held to be suitable and justifiable for a certain kind of difficulty and need comes to be applied more or less universally. For example a psychodynamic solution is offered to a spiritual need (or vice versa) or an "analytical" initiative takes place within a set of psychological answers where it would perhaps be better to promote an action of "synthesis" or vice versa.

Again in relation to practical implementation and action, the challenges which present themselves concern the "processes" which should be followed. Does one want to "illuminate" and render the unconscious conscious or does one want to "experience"—that is, relive something in a strong or new fashion? If the relationship is of importance in this process, to what extent is emotional involvement or neutral detachment to be welcomed or promoted? Is the element which interprets the disorder as demonic possession a declaration, a rite of propitiation, or, in extreme cases, an exorcism?

Is it possible to use one kind of language only and a sole theoretical model or should we use different forms of language which are suited to the various stages and situations of personal development?[5]

2. Given these brief references to challenges which arise in relation to the actual practical implementation of psychotherapy, it is not difficult to understand that there is also a strictly connected theoretical challenge which bears directly upon the question of the anthropological reality of the individual who is to be treated.

First and foremost there is an *epistemological* dimension. Recent decades have witnessed the emergence and the dominion within the scientific world—if not always in relation to culture—of a new "ethos" concerning the epistemological side of the question. The leaving behind of positivism and technical rationalism (Peterson, 1968, 1979, 1995; Macquarrie, 1989; Jeeves, 1976) has meant that human action can no longer be explained, and certainly not treated, with reference to purely "causal" factors. In the same way it cannot be solely "understood" through the study of the subjective—perhaps idiosyncratic—meanings of the individual. The hermeneutic approach has gained ground and this has involved a search for dialogue or critical conversation supported by interdisciplinary knowledge (Ricoeur, 1977, 1977a) which offers new opportunities by which to comprehend the complex choice of psychotherapeutic goals and processes. At a more specific level, we are faced with the emergence of the need for a dialogue between psychology as a human science on the one hand, especially in relation to its anthropological aspects, and theological and philosophical anthropology on the other.

The critical dialogue present within the hermeneutic approach takes two forms:

a. A more *critical* tendency which in its representation of a negative moment shows how every action dealing with human knowledge, including the psychological, is connected to its time and thus reflects the contingent and relative aspects of that time.[6] The critique of human motivations was for long a characteristic of a form of psychology which turned out to be in large measure reductive. Although in its most extreme and exclusive expressions this critique remains of a destructive character, it is nonetheless possible that the analysis of the hidden component features of human behavior can open new horizons of freedom and that religion and faith can be "purified" of less genuine elements.

b. It should also be observed, however, when discussing the epistemological side of psychotherapy, that there is another more *constructive* tendency. When positive in character this tendency provides a new appraisal of the contribution of phenomenology, and lays emphasis upon the importance of a recognition of those values which most fittingly correspond to the anthropological structure of the human person—and thus upon the importance of an anthropological vision—in order to define the aims of pedagogic activity in itself. The importance of an ethical dimension, of values, and of the religious realm as a reality which is also of psychological relevance not only is not denied but is actually actively and positively sought.[7] It is recognized that these forms of psychology which interpret our place in the world contribute to a wider and more intricate understanding of this whole area.

They help us to have a detailed vision of the "positions" which are experienced and which the educator must constantly tackle. These forms of psychology "serve" as menus of questions and answers by which certain horizons are defined, by which given answers and questions are formulated, and by which a certain kind of transcendence, of a more or less radical nature, is established. Precisely because such interpretations are a part of our culture, they thereby end up by imposing horizons which although they involve one kind of transcendence also act to exclude other kinds. At a more specific level, for example, recent studies on the development of the relationship have demonstrated that there is a close connection between the way of thinking about, and addressing oneself, to the otherness of the divine on the one hand, and the primitive and infantile experiences by which one learns to be and to live as individuals in relation to others on the oth-er. But all this has been brought out and discussed no longer within the context of an inevitable alienation or opposition between the psychological and the religious but rather in a process of legitimate and mutual enrichment (Rizzuto, 1979; Jones, 1991; Meissner, 1984, 1987: Spero, 1995).

These two tendencies are complementary and this quality can become especially helpful in the interpretation of psychotherapeutic change. Here the "positions" of people are a reality lived out by individuals who, because they are the children of their culture and of the interpretations that it offers of their human and religious experiences,[8] are also called upon to realize their vocation to the full.[9]

In addition to this epistemological dimension there is also an aspect which is of a more specifically theoretical and anthropological character.

The practical challenges that emerge within the therapeutic context involve and touch upon the anthropological reality of the human person. With Gabriel Marcel (1970) and an already existing rich cultural tradition, we do not want to reduce the mystery of the human reality of being in the image of God to a mere question or problem because in such a way the encounter expressed in therapeutic help becomes reduced to a technique. The necessary perception which prepares the way for and accompanies every form of "therapeutic" initiative can and must be done without ignoring the anthropological dimension.[10]

2. Areas of Anthropological Relevance

It seems that there are certain areas of especial relevance both in relation to the general way in which the human person is thought about and treated and in relation to psychological knowledge and action. Psychological and psychotherapeutic initiatives and observations at the very moment when they allow practical and experienced access to the individual also involve the taking of a position in relation to these fundamental anthropological dimensions.[11]

*1. The cognitive area,
    the question, otherness*

The individual is faced with the difficulty, whether of a pathological character or otherwise, of the uncertainty, the incapacity or the difficulty of finding meaning in his single acts or in the general direction and orientation of his life. For this reason it is easy for him to deceive himself, to shut himself up within himself, to avoid questions, to be content with his more or less immediate world, to dispense with that pursuance of "virtue and knowledge" which would more easily express the image of God. The recommendation "Know thyself" is very far from being simple and practiced. The "confused" self which psychologists analyze and seek to interpret is an individual capable of knowledge and in search of the whole of truth. What is the objective, the goal of my research which is implicit or explicit in my questions? What is the otherness within which I have been called to be present? Are we faced with autism, with schizophrenic fantasy, drugs, or merely new idols, the other used symbiotically or another or Another loved in the giving of oneself?

These questions define in more or less implicit fashion a horizon, a world. From one's own body, that is, to material things, to others, to economic, cultural or spiritual and religious values. The horizon or the horizons define the very purpose of life.

The schools of psychology which are at the base of every educational or therapeutic initiative specify certain horizons through their fundamental metaphors.[12] Is the other an object of instinct even when there is an intention to transform this into an instinct of life or death which is almost metaphysical (psychoanalysis)? Is it another which becomes reduced to what it is, another which must offer self-fulfillment to the ego, with the absolute supposition of a harmony between the various human tendencies and with the minimalization of conflict (humanistic forms of psychology)? Is it the principle of natural selection as we encounter in the case of the behavioral schools of psychology?

More or less limited in their con-

text, these schools can legitimate closures onto equally limited horizons and may produce forms of psychotherapy which exclude the exploration of the transcendental (religious) realm or they may involve a more appropriate achievement of the anthropological reality of the individual, the search for truth.

The psychological element which is phenomenologically accessible is to be found in otherness, in the different practical and real forms which are acquired during the course of the individual's development.

*2. The command area of action,
    the voluntary, and freedom*

As a free individual agent, the subject is faced with the struggle or the struggles of a conditioned freedom which through the taking of large or small decisions must "make" truth. Here we are dealing with the complex relationships between the voluntary and the involuntary, between different wills, between nature and person. In tension between the figure of Prometheus and that of Sisyphus there is the temptation of the flight from freedom—an aspect and expression not only of pathology but also of every form of human fragility. Should one accept the determinism of blind forces or base oneself upon a utopian (or Promethean) spontaneity in order to guide one's choices? How can we categorize the ethical obligation which derive from the horizon and the metaphors which express it as outlined in the previous observation?

Upon the fundamental metaphors (of the previous point) depend others which define in more or less implicit terms the ethical obligation—hedonism, ethical egotism, altruism, forbidden by the law, agapé love, the giving of oneself in charity. At a psychological level and thus also at a psychotherapeutic level, the human person always finds himself in tension between a received "given" and the ability to choose, to engage in creative self-positioning. He always ends up by being in some way a "result" (with a glance backwards to the past) but also a "project" (with a glance forwards to the future). The temporality expresses in the concrete present

moment what the will desires. Does not the human and therapeutic journey involve the resigned acceptance of the "character" which limits, constrains, and becomes a justification for non-growth, for not risking and becoming that which we are called to be? Has life become mere "result" (past) without being a "project" (future) or is it only a "project" which is not able to take on the historical "given" of its own history? Or is it a flight into imaginary illusions in a self-created world which flees from reality?

*3. The motivational affective area
    and its various internal
    structures, which are matched
    within the psychological sphere
    by the diversity and the
    integration of the different
    levels or stages of the person*

The person, a mental-physical-spiritual subject, is the object of a series of motivating forces, passions or "loves" which he manages with greater or lesser success to unify and to integrate. In the individual there are natural drives, social and human interests, and forms of affection which are culturally legitimated or appreciated, and a love which has divine dimensions.

The discipline of psychology which is at the base of every kind of psychotherapy cannot but be interested in the different *levels* which interact and overlap and express themselves in different forms of hierarchical integration. During his development how does the person emerge and how does he manage to unify and integrate these component parts? What motivations prevail so that some express or "serve" the others—the "inferior" at the service of the "superior" or, not unusually, vice versa? Is love for another person only at the service of sexual and hedonistic goals and are these psychosexual forces informed by an agapé love? More or less implicit in the same metaphors or specific visions of the human sciences can be found those conceptions of the fundamental motivation of the person, those basic tendencies which can freely or in terms of purpose determine, condition or motivate human action.

We are not dealing here with this or that *theory* which sees need, impulse, "libido," affection, the

propensity to fulfill oneself and one's potentiality, the finality of the love which may possibly lead to the unconditional giving of oneself as a fundamental motivation. One has before one, rather, the *practical working* of each individual according to one or other of these systems of motivating forces. The multiplicity of these levels which are connected to the bio-mental or historical cultural reality of the human person raises questions as to which fundamental needs must be justly and morally satisfied and how they should be integrated. This should be done, once again, not only with reference to a theory which defines an ideal but also as an expression of deciding upon practical action. This third area of anthropological concern introduces the question and the need for the greatest possible overcoming of *reductionism*[13] and the explicit admission of the existence of a complexity of levels which is present within the sphere of human action and its various motivations.

4. *To these three areas should be added that of psychotherapeutic processes. A series of factors and elements arise when one comes to consider the processes by which psychotherapy seeks to achieves its goals. Each form of psychotherapy requires a development, a change, and a transformation. By what routes does this change, this transformation, take place?*

For a long time criticism has been levelled at traditional forms of psychoanalysis and their view of the world. More recently this criticism has found clear expression in a form which is at once both anthropological and psychological. It observes three characteristic limitations in traditional psychoanalysis which require three corresponding corrections: a. a tendency to atomistic mechanism which sees the individual as a field of interacting forces; b. a tendency to enlightenment rationalism which gives rise to the idea that the process of "healing" or the answer is first and foremost to be achieved by cognitive means; and c. a tendency to an ethic based on the one hand upon rationalism which is thereby unable to rise beyond moralism/legal-

ism (Ricoeur, 1986; Kohut, 1980), and upon a norm/value of mutual respect and a certain reciprocity on the other which ignores wider values such as self-giving in love and a form of love which can be "sacrificial" in character (Browning, 1987).

In this sense the process of growth, of development and of the rediscovery of full human dignity as the image of god (based upon wider conceptions and horizons) could only take place through:

A broadening of the horizon which does not work through channels of pure knowledge and thus almost individualistically but through a "participation" where the relationship with the other and with an ever greater otherness (guidance, support) takes place in the full awareness of the fact that the choice of horizon is not merely a rational question. Psychotherapy thus becomes not only instruction but also a search for truth and in relation with an ever broadening otherness the acquisition of a sound way of thinking which knows how to ask and look for answers to the most radical questions.

Quite beyond every conception which involves a "hiatus" between "nature" characterized by its forms of determinism on the one hand and "spirit" characterized by extreme unconditioned freedom on the other, each form of psychotherapy moves towards the free taking on of reality through the responsible acceptance of the individual's own given and his own vocation to transcendental values. A purely "causal" model based upon the conviction that everything can take place through almost mechanical changes in nature—in the same way as a spiritualist model which ignores the biophysiological and mental laws and influences of nature—not only reveals itself to be anthropologically inadequate but is also positively ineffective. Psychotherapy should not be a desperate struggle to accept one's own destiny but in the same way it should also not be a flight from the reality of one's own history within a process of consoling illusion.

Quite beyond a mere restoring of the balance of the affective forces (healing), the psychotherapeutic action should render the person ca-

pable of reunification through a process of the integration—based upon a transforming motivation—of the various levels of the human existence understood in terms of "body," "psyche" and "spirit." Only in this way will it be possible to speak about an integration (reconciliation) of the various structures and component parts of the person and thus of an internalization of the values by which freedom determines itself beyond those influences and the conditioning effects which are merely external.

5. *Finally, the importance of being able to adopt the metaphor of "grace" in psychotherapeutic action*

The psychotherapeutic process depends upon the "vision" and the metaphors which express it. The psychotherapeutic process which seeks to lead on to healing, development and growth, but also on to openness to the richness of human dignity—precisely because it takes place within the reality of fragility—will always be marked by struggle and conflict. It will in practical terms never be a journey of easy passage and spontaneous openness without adversity. Not will it be able to reduce itself to a historical observation of the forms of determinism within which the individual lives. Even at the time of the ancients, development and growth encountered the reality of death connected to life marking their path. For Plato the child had to die for the young person to be born and the young person had to die for the adult to come into this world (see Schachtel's discussion of this point Schachtel 1959, pp.14ss.).

This is a struggle which would not find meaning—and thus in the same way would encounter difficulty in finding a place—in the humanistic universe expressed by metaphors of harmony, security and interdependence which in essential terms render a transforming moral action useless. It is a struggle which perhaps could find a place in the Freudian universe, but only at the extremes of a tragic and historical realism.

What meaning and thus what convincing and effective motivation can a psychotherapeutic

process find which does not have the means by which to accept in radical terms the aspect of limit, of fragility, and of death?[14]

In this sense, and quite beyond a conception of the therapeutic process as being unmitigated progress or the resigned acceptance of unavoidable regression, we must find a place for a conception of this process which is "transformation," a process where the negative—remaining realistically negative—becomes converted into being positive. This is what can be found in the law of grace, a law which presupposes the presence of a "redemptive" vision where the spirit is able to transform what is absurd into meaning, weakness into strength, and death into life.[15]

Anybody who has worked in the "psychotherapeutic" field knows that in the process of growth and change an encounter/conflict with irrational events which inevitably diminish a meaning and are evidently absurd is inevitable. Would it not perhaps be a more than reasonable hypothesis to interpret many halts in the process of psychotherapeutic growth, many failures and abandonments (the forms of impasse referred to at the beginning of this paper) as being caused by a lack of a "mediation" between purely "psychological" struggle and "spiritual" struggle? Does not the person in this situation find himself divided and reduced to a tragic psychological conflict which takes place at one level of his being and placed in a condition where he is unable to enter into a relationship or a connection with the spiritual/religious conflict, the only such conflict which can confer meaning and strength? In such cases the image of God does not remain abstract or a question of principle but is insufficiently directive and transforming.

Only *faith* and a theological and Christian faith can really take on such psychological elements which are inevitably tragic, and thereby confer a meaning even to realities which are characterized by the absurd. In the inevitable encounters/conflicts marked by limits and forms of determinism, only *hope* manages to satisfy certain necessities in a resolution which never ceases to be realistic. Only a *love* of

agapé and of charity, which is thereby sacrificial in nature, can overcome the inevitable injustice and imperfection which would otherwise be intolerable. In this way "grace" without in any way being the monopoly of the "religious" or becoming a mere psychological function, comes to play a part in the psychological game. With the characteristics which are typical of the paradox it makes a deeper realism possible through its transcendence. The image of God which is obscured but constantly restored is such precisely because it is truly, and ever more so, human.[16] In the light of what has been observed hitherto, a number of concluding remarks are now required.

3. Concluding Remarks

1. Psychotherapy can never be merely the outcome of the implementation of a technique. The human person in his reality of being mystery and the image of God can never be treated as a mere mechanical combination of forces.

2. Science alone does not suffice when we come to consider the challenges of psychotherapy. But in the same way religion alone, or in conjunction with philosophy, is not enough. Science is not sufficient because in the pedagogic/psychotherapeutic action there is an inevitable meeting of the themes of death and life but also of the themes of the origins (past) and the end (future), of flight and commitment, of fantasy and reality, of guilt and innocence, of time and eternity, of intimacy and loneliness, of pain and happiness.

3. An inter-disciplinary dialogue between psychology or the different schools of psychology and the philosophical and theological sciences is more than welcome when we consider the psychotherapeutic project, although we must of course abandon mutual suspicion and excommunications. There are signs that this dialogue is underway at both an epistemological and an anthropological level.

4. We are also invited to adopt a stance of humility—many studies

indicate that the results of psychotherapy, although certainly to be seen, are not so certain or widespread.[17] Following the line of argument of many authorities, it seems useful to recommend—at least with regard to the field of psychology—the promotion of training in relation to disciplined research (Holu, 1961; Davison and Lazarus, 1994; Peterson, 1995) and a systematic evaluation of change in individuals, groups and organizations rather than diagnostic and therapeutic certainty. In welcoming "educators who reflect" and who are trained to operate within uncertainty rather than therapists who are absolutely certain of everything they do, one could also welcome a renewed attention on the part of experts in the field of philosophy and theology to the questions posed by psychology when applied to psychotherapy. The mystery of the person requires an epistemology and a methodology which are both suited to its richness.

5. The importance of this anthropological dialogue is to be found: above all else in considering and defining goals, whether the ultimate, the intermediate or immediate (horizons), in relation to each other. But this importance is also to be found in the fact that freedom and thus an inevitable ethical norm are present in these processes of change. To conclude, it is also expressed in the fact that in the person the horizon (or the horizons) and the forces which are brought into play by the will or by inner impulses combine together to define the fundamental motivations and passions. It is these fundamental motivations or passions which are at the root of what we call maturity/immaturity or the personal human task including that of being in the image of God, or of what we call immaturity-pathology/failure and thus what amounts to the deformation of the image of God.

6. In relation to psychotherapy there is a clear need for the adoption of a "metaphor of grace" which tackles—and with the right means—the potentially tragic aspect of life; and which also translates a transcendental and Christian

reality onto a psychological level and thereby ensures a deep and stable transformation which is of this character because it is true and free.

7. There must be an attempt to recover the original meaning of "therapy" and therapeutic through broadening this term to include the formation of the person employing an "overall" vision. The Greek word "therapon," indeed, means in essence "servant." A variety of reasons linked to the history of science and culture have acted to confer meanings which are too narrow on this concept. We have to recover its deepest meaning such as that which one finds applied to Moses in the letter to the Hebrews 3-5 where we read that "the loyalty of Moses in the management of God's house was the loyalty of a servant," almost a preparation and image of he, Christ, whose loyalty "was the loyalty of a Son in a household which is his own" (3-6). We should also connect it to the mission given to the disciples and described in Matthew 10:7-8: "And *preach* as you go, telling them, The kingdom of heaven is at hand. *Heal* the sick, *raise* the dead, *cleanse* the lepers, *cast* out devils."

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Notes

[1] *International Dictionary of Psychiatry* (1989). Or "A form of treatment concerned with problems of an emotional character where a qualified person deliberately creates a professional relationship with a patient (client) in order to remove, modify, or retard the symptoms which are present, to moderate disturbed forms of behavior, and to promote the positive growth of the person and his development" (Wolberg, 1954, 1988).

[2] It is taken for granted that psychotherapy has positive effects even though not all authorities are agreed on this point. In a large program of research carried out by *Consumer Reports* in 1995—a program which was carried out by people moved first and foremost by economic criteria—one of the chief conclusions was that the treatment carried out by these professional practitioners works. Of 426 people who were "very bad" at the beginning of the treatment, 87% were "very well" or at least "quite well" when the research was carried out. Of the 786 people who were "quite bad" at the outset, 92% were "very well, well, or quite well" when the research was carried out. As Seligman (1995) observes, these data correspond well with other major works of research carried out into the effectiveness of psychotherapy (Lipsey and Wilson, 1993; Shapiro and Shapiro, 1982; Smith, Glass and Miller, 1980).

[3] One way of approaching this variety (reference is commonly made to dozens and perhaps more than a hundred different systems) is to discuss the "models" which are employed (medical model, psychodynamic model, cognitive model, psychosocial model, moral model, existential model, and so forth). In this way, however, and especially if one remains at a descriptive level, the question for the most part becomes postponed but with the advantage that one immediately encounters the variety of approaches which are available as forms of response to therapeutic requirements and which constitute an expression of partial truths. The danger of reductionism emerges when the adoption of a model in an exclusive fashion seeks to be applied to the different forms of the disturbance, problem or question with the same answer and methodology (spiritualism, psychologism, or biologism).

[4] With reference to the Gospels: Matthew, 10:7-8; Luke 9:2; Mark 3:14-15.

[5] In the general debate upon psychotherapy a wish for an integration of the various perspectives is more than evident (Bietman, Goldfried, and Norcross, 1989; Pine, 1990; Tyson and Tyson, 1990).

[6] A number of voices have been raised to "criticize" the strongly individualistic character of nearly all current forms of psychology. Because they were born in an individualistic culture, their horizons not only reflect this "ethos" but are also thereby inadequate when it comes to supplying an answer to more existential and more radical questions (Bellah *et al.*, 1985; Bevan and Kessel, 1994; Rieff, 1966; Cushman, 1990; Sampson, 1985, 1988, 1989; Smith, 1991; Vitz, 1980; Wallach and Wallack, 1983). Other observers have stressed the lack of attention paid to existential problems by the various contemporary psychological theories (Vandenberg, 1992; Bevan, 1991; Browning, Jobe, Evision, 1990; Chessick, 1993), to the frequent reductionism of psychology (Eidelberg, 1992) and to the attempt by psychology to take the place of religion (Butt, 1992; Menninger, 1973; Rohr, 1991). In various ways these and other possible voices point out the limits which contemporary psychology places on human horizons and thus on psychotherapy, involving as they do reductive visions of the "world" in which the individual is called upon to live and operate.

[7] Bergin, 1980, 1991; Jones, 1981, 1991; Lake, 1966; Jones and Stanton, 1994; O'Donohue, 1989; Rulla, 1985; Rulla, Imoda, and Ridick, 1986; McDargh, 1984, 1985; Sims, 1994 and others.

[8] Some adults approach the affective aspect of their lives as Freudians; others, as adolescents, embody humanistic psychology in their almost exclusive search for self-fulfillment. Others are pragmatic in being more or less utilitarian behavioralists and are guided by the law of success and by the principle of functionality. The questions and difficulties are so rooted in one or other of these "systems" that they condition in large measure the position itself of the question and the kind of struggle or obstacle which must be overcome.

[9] Forte (forthcoming, in press) has observed in relation to theology and psychology how a three-sided order of epistemological, hermeneutic and experiential factors can contribute in their various mutual relationships to certain basic positions such as resistance, indifference, surrender or integration.

[10] "Whatever the difference may be between these new kinds of psychology and the Judeo-Christian tradition, it is not the case that the different schools of psychology are without a metaphor of purpose or goal and without principles regarding ethical obligation and that on the contrary the different expressions of theology are weighed down by such ancient baggage. The differences are more a question of alternative decisions and of attitudes towards these metaphors and principles of ethical obligation. There is indeed a process by which psychology is gradually and insistently becoming religion and ethics" (Browning, 1987, p. 89).

[11] De Waelhens (1972) has pointed out how contemporary doctrines regarding the human person lay great stress upon the importance of defining the human being as a "being in the world" thereby leaving behind—and not only at a theoretical level—the opposition between "for itself" and "in itself." As "pure consciousness" (for itself) or as a "thing" (in itself) the human being would no longer be in the world. It is, however, difficult to find, observes Waelhens, an authentic recognition and a description of human consciousness which pays serious attention to the practical and historical "how" by which the two poles of his being in the world come to be combined. The being in the world of the person is therefore taken for granted at the same time at which he experiences its difficulties and vulnerability. It is my belief that psychological observations can contribute in a critical dialogue with the anthropological elements to this definition of the being in the world, not least with a view to rediscovering the image of God.

[12] It is interesting to note that a clearly technical analysis carried out by Gedo (1995) on a therapeutic process considered fundamental ("working through") concludes by asserting that in essential terms one is dealing with an attempt to educate the person to sound thought.

[13] Understood as the tendency of a discipline to reduce the phenomenon which its studies to the metaphorical model it prefers. In this way a psychic process becomes reduced to a biological or mechanical phenomenon or a religious phenomenon becomes reduced to a psychological process. Side by side with these tendencies which can be seen as reductionism "from below" there are also many forms of reductionism "from above," as happens when an illness is interpreted as an immediate effect of a moral disorder, or when a mental problem is perceived and treated as a spiritual problem which should be dealt with if not by an exorcism as least with an *exclusively* spiritual form of pedagogy.

[14] With reference, for example, to the eight situations discussed by E. Erikson as being the eight crucial periods of life, one could observe that in each of these phases or periods a pole of the binomial or conflict represents the situation of absence or negativity and another pole the situation of presence or of positivity. The eight periods which are all characterized by their own form of conflict or tension, as many will remember, are the following: trust/distrust, autonomy/shame and doubt, initiative/blame, application/ inferiority, identity/diffusion of role, intimacy/isolation, fertility/stagnation, personal integrity/desperation (Erikson, 1959, 1960). Each person lives the presence of the pole of absence in a certain way in the sense that (for example) distrust is never completely remedied and trust is never so great as to eliminate all shadow of distrust, and so on in the same way for all the rest. Of especial interest is this insistence by a great psychologist on the need to re-evaluate the role of the so-called "negative" moment of each polarity. What kind of maturity could a person display if he did not have a certain distrust towards himself and towards the rest of the world, if he did not doubt etc.? (Wynne, 1984).

[15] See the law of the cross in Lonergan (1964, 1974) and those which Ricoeur (1966, pp. 505-526) in a more specifically psychological context has described as being the transforming power of certain figures of the spirit.

[16] "To know man, the true man, the whole man, one must know God;...to know God one must know man" (Paul VI, *Address to the Concluding Session of Vatican Council II*, n. 8).

[17] Seligman, 1993; Strupp and Hadley, 1979; Peterson, 1968, 1995; Dawes, 1994; Arle and Goldberg, 1984, Liberman, Yalom and Miles, 1973.

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EUGENE WOLPERT

Psychological Therapies

The theme that I was asked to speak about can hardly be exactly defined. The questions as to what belongs to psychosocial therapies, what has to be excluded, and where there are larger overlappings with other themes like prevention and rehabilitation cannot be answered properly. Too many versions of defining "psychosocial" are used. I restrict my subject to two different core areas of "psychosocial": 1) I will concentrate on psychosocial treatment and care by extramural community facilities and 2) on therapies with families and couples (partners) as very useful and effective in many aspects, mainly for schizophrenic patients and their families. 3) I will not describe therapies in detail but try to show how far the psycho-social therapeutic approaches are confirmed by modern scientific evaluation of their outcomes.

Community-centered care as the alternative to traditional hospital-centered treatment of mentally ill was postulated by different professionals and political authorities, by the Joint Commission on Mental Illness and Health in the USA (1961), the Royal Commission on Mental Health Law in Great Britain (1977) and the so-called German Psychiatry Enquete from 1975, along with law 180 that laid the ground for the Italian Mental Health revolution. All these steps demanded that, wherever possible, hospital treatment should be replaced by extramural or community-centered treatment, and that authorities should provide facilities for such alternatives to hospital treatment. Much could be said about what happened worldwide as a consequence of these proposals. Up to now the programmes of renewing psychiatry and mental health care are concentrated on reducing beds and replacing them by community care, as far as possible. But what happens in detail with the patients in the communities and how effective is the so-called extramural community-oriented care? I will present a meta-analysis of the most reliable outcome studies on this question, performed by Häfner and co-workers (1989) of the Central Institute of Mental Health in Mannheim, where I worked for about 10 years before moving to Darmstadt and continuing modern community-oriented psychiatry.

TABLE 1			
Study	Effect of extramural (community) care		
	positive	no	negative
An der Heiden et al. (1989)	X		
Antohony e Buell (1973)	X		
Beard et al. (1963)	X		
Beard et al. (1978)	X		
Bosch e Pietzker (1975)	X		
Byers et al. (1979)		X	
Christensen (1974)			X
Claghorn e Kinross-Wright (1971)	X		
Cottman e Mezey (1976)		X	
Dincin e Witheridge (1982)	X		
Franklin et al. (1975)			X
Hornstra e McPartland (1963)	X		
Kirk (1976)	(X)		(X)
Mayer et al. (1973)		(X)	(X)
MaCranie e Mizell (1978)	X		
McNees et al. (1977)	X		
Nuehring et al. (1980)			X
Orlinski e d'Elia (1964)	X		
Purvis e Miskimis (1970)	X		
Sheldon (1964)	X		
Solomon et al. (1984)	(X)		(X)
Tessler e Mason (1979)		X	
Vitale e Steinbach (1965)	X		
Winston et al.		X	

Meta-analysis of 24 evaluative studies on the effectiveness of extramural (community-centered) care of mentally ill.

Source: An der Heiden, W., Krumm, B., Häfner, H., 1989 (modified).

Most of the studies showed that community care can reduce the hospital admission frequency by allowing patients to stay longer outside the hospital than with traditional care by general practioners or psychiatrists in private practice. This is the case mainly for schizophrenic patients but also for numerous other conditions of mental illness, whose outcome is not yet clearly evaluated.

The effectiveness is highly dependent on the variety and quality of the extramural facilities. I regret that I cannot point out in detail this important aspect.

Now I will come to the second part of my presentation.

As you heard from Dr. Bertolote yesterday, about 25% of the world population suffers from psychologically prompted behavior disturbances that need treatment. When, as Dr. Bertolote pointed out, one takes into account that the families or related persons have to share with them the burden of mental illness, about 75% of the World population is in some way influenced by mental illness or handicap. This gives us the right to see family-oriented interventions as a needed and effective therapeutic approach.

In the early 60s, beginning with the investigations of Wing, Brown, Burley, Castairs and others in the United Kingdom and of Zubin and others in the United States, the hypothesis got evidence, that schizophrenics are highly susceptible to emotional stress and that the reduction of stressful living conditions, mainly within the patients' families, can prevent relapses and hospital admissions. What I briefly want to show you is how far this hypothesis has stood the test of evaluative outcome studies up to now, and second, how far family-oriented therapies in similar forms and settings can be helpful to other mental illnesses in addition to schizophrenia.

TABLE 2 - RELAPSE RATES OF PROSPECTIVE OUTCOME STUDIES ON THE INFLUENCE OF THE FAMILY CLIMATE; TWO-YEAR FOLLOW-UPS

Source: Wiedenmann et al. 1996 (modified)

|	Vaughn	Leff	Tarrier	Budzyna	Median
low EE	20	33	33	15	27
high EE	62	50	59	72	61
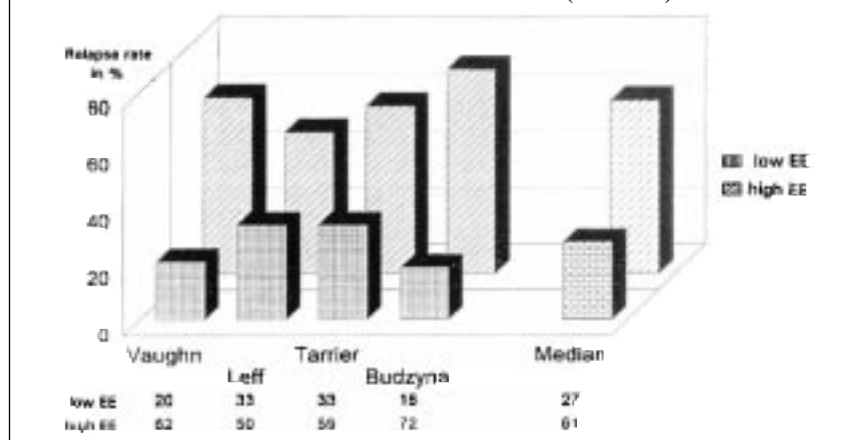
This picture shows that high expressed emotion in families of schizophrenics, when the latter have a certain amount of contact with their families, enhance the relapse rate significantly, compared to patients of families that reveal a low rate of expressed emotion. "Expressed emotion" is measured in these studies generally by the Comberwell Family Interview of Vaughn and Leff and is predictive for high EE when critical comments, hostility and over-involvement are high. Therapeutic interventions on the basis of the EE-concept try, in family settings, to reduce the harmfully high level of expressed emotion.

This figure may convince you that a fairly simple, pragmatic approach, partly consisting of information about the nature of the illness and the need for continuous treatment, partly of educational elements, partly of behavioral and cognitive therapeutic elements, is highly effective, when linked with appropriate medication.

In a further study of Bebbington and Kuipers (1994), re-evaluating 24 EE-studies and the basis of the original data, it was shown that frequent contact of patients with low EE families can have a protective effect in the sense of relapse prevention and that there is no gender difference, either in the EE level, or in frequency of occurrence.

TABLE 3 - RELAPSE RATES OF SCHIZOPHRENIC PATIENTS:
Family care (each left column) vs. individual care (each right column);
one- and two-year follow-up data from patients out of high-EE-families.

Wiedemann et al. 1996 (modified)
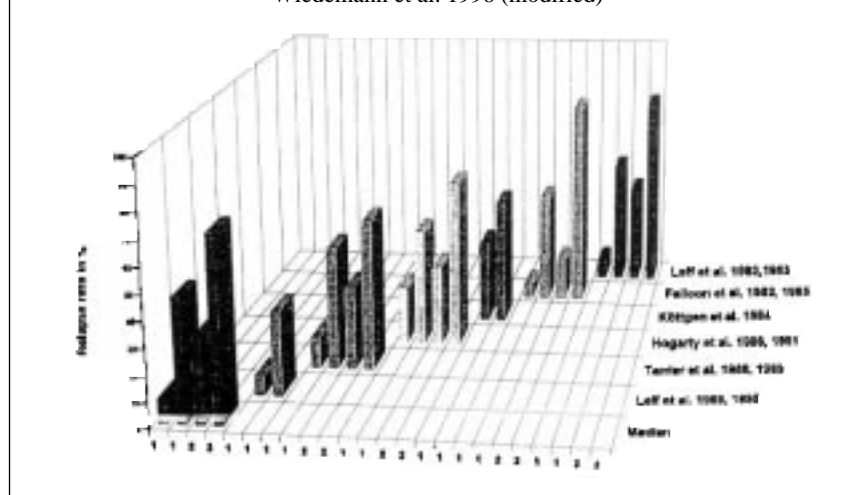
Family intervention approaches, either including the patient in the therapeutic sessions, or working with the families alone or putting family members together in groups for counselling and therapy, effective in reducing the illness of the patient and reducing the burden for the family in other mental illnesses such as affective disorders, eating disorders, chronic pain, anxiety states, personality disorders, diseases of the elderly and of children. Most of these approaches have been shown as effective, but still need further evaluation (Wiedemann *et al.,* 1996).

Compared to similar family and group approaches, mainly the systemic approach (according to Minuchin, Selvini-Palazzoli and others) and the psychoanalytical approach (Stierlin, Singer and others) the more structured, behavioural and cognitive, approaches seem to be superior, not only for schizophrenics (Massi and bells, 1972, Gurman *et al.* 1986).

Almost all the studies mentioned above have been performed and the related therapies have been developed in the United States or Western European Countries, mainly in big cities with their special socioeconomic conditions. How far are the proposals, valid for these societies on the basis of the reported evaluative studies, transferable to societies with different conditions? What does "family", "partnership" or "career" mean in African, Indian, or Asian societies? What does "Expressed Emotion" look like there? By which interventions can it be reduced? What I want to stress at the end of my comments is that we have to be cautious with generalization and uncritical transfer of therapeutic measures from one society to another before having investigated how far this is useful and appropriate—and economically realistic.

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Rehabilitative Therapies in Psychiatry

Civilization can only exist when the weak, suffering or sick person is seen as a human being in the full sense of that term and when he is perceived as an individual who requires and deserves special attention and care. In other words, civilization can only exist when there is real human solidarity expressed towards those people who are most afflicted by fragility and vulnerability. For centuries the mentally ill were excluded, marginalized or even suppressed—that is, physically eliminated. This shameful reality—which has burnt the mark of Cain into the forehead of humanity—is not something which belongs to remote antiquity. Only fifty years ago the Nazis engaged in the systematic execution of the mentally ill and in this undertaking they were helped and supported by a significant number of psychiatrists who in reality were not worthy of such a name.

Like every other sick person, the mentally ill person has the right to be treated—not only in his own interest but also in that of his family and of the community at large. Indeed, mental suffering afflicts at one and the same time the sick person himself, his economic productivity and the life of his family. At one stroke it impedes the development and/or the productivity of all the members of his family. It has been demonstrated, for example, that children in the shanty towns of third world countries who suffer from malnutrition are more likely to have mothers suffering from mental disorders than their counterparts in the same places who do not suffer from malnutrition. In this way chronic poverty and its physical and social consequences are ag-gravated by mental disorders which in their turn act to aggravate the impact of chronic poverty. By such a route is a devilish vicious circle is established.

The treatment of every sick individual, and even more of every person who suffers from mental illness, has a triangular base which is:

—biological in character, (in particular involving medicines);

—psychological in character, (involving a good relationship between the sick person and his medical doctor and the practice of psychotherapy);

—social in character (basing itself upon the social rehabilitation of the individual).

The principal concept of social rehabilitation is expressed in the phrase "the human dignity of the patient." The reintegration of the mentally ill person into the community does not only involve the maintenance of his social rights and making sure that he is given a job. It amounts first and foremost to guaranteeing that he is given and attributed esteem and dignity within his social environment. This latter process takes many forms which are heavily determined in their character by the cultural context of the patient.

This whole question is intimately bound up with the cultural perception of mental illness and the prejudices (something which is very characteristic of English-speaking experts) which are applied to patients who suffer from mental disorder. It should be remembered that the vast majority of mentally ill people suffer from depression and anxiety disorders of light or middling intensity. In essential terms they are treated by basic and stan-dard forms of health care. They have to be taken care of by health care workers and must be the objects of an understanding attitude on the part of their employers. The seriously mentally ill need far greater levels of family and social support but luckily enough they are only a small proportion of all those who are afflicted by mental disorder. About 10-15% of schizophrenics are cured of their illness, at least at a social level. But about 15% of this category develop their pathology along very serious lines. It is exactly such people who deteriorate both mentally and socially, who are repeatedly admitted to hospital, and who often become violent. It is these people who furnish the mass media with their negative image of the mentally ill and of the discipline of psychiatry—something which lies behind the contemporary "condemnation" and the marginalisation of the mentally ill.

In order to achieve and promote the social "reinsertion" of such people contributions are required on a broad front—that is, from health care workers active in the sphere of mental illness, from the families of these patients, from society at large, and from employers.

1. It is obvious that responsibility in the first instance falls upon *health care workers active in the field of mental illness.* Indeed, it is of fundamental importance that psychiatrists, psychologists and social workers bestow the fullest possible dignity upon psychiatry and thus upon the people which this discipline sets out to cure. In this undertaking they should employ to the full their human and professional qualities and skills. This is the

route by which it is possible to create a climate of trust which in turn allows the mentally ill and their families to ask for help without being afraid to do so and in addition to maintain their relationship with health care workers over a sustained period of time. In contrary fashion, the mentally ill themselves often break off the treatment that they are receiving, undergo a relapse as a consequence, and thereby destroy the bonds which link them to their families and society. The people who really benefit from these kinds of situations are charlatans of every kind and color.

Health care workers in the field of mental illness should also strive to convince health care workers more generally to adopt a more human approach towards all sick people but in particular towards the mentally ill. It would be superfluous to remember that about a third of sick people who consult a general practitioner or a specialist in areas other than psychiatry suffer from psychological or psychiatric forms of disturbance. This is true both of industrialized countries and of developing countries. It is certainly true that information alone is not enough to change people's attitudes. The remedy lies in training in the field of theory and practice of a more intense and specialized kind for all those health care workers who work and practice in the area of mental health.

The correct and sound treatment of the sick is equally imperative. Indeed, hospitals or facilities dedicated to mental health which become morally and/or materially damaged cause great harm to patients and to the discipline of psychiatry itself. The problem is not one solely of economic and financial resources. The sick person and his family must feel that the doctor or other kind of health care worker who is taking care of the case is fully involved in, and concerned about, their suffering and their future.

We need to provide the best possible forms of treatment and care to the sick person. In order to achieve this the latest discoveries at a clinical and therapeutic level must be followed and understood. For example, it is more than clear that the social integration of the psychotic patient is impeded and obstructed when there are extrapyramidal effects involving delayed dyskinesia or acathexia caused by an excessive prescription of neuroleptics which in turn is promoted by an inappropriate use of synthetic drugs to treat Parkinson's disease or by the prescription of neuroleptics which are not really suited to the condition of the patient. It is also of fundamental importance that patients are taught how to get dressed and to dress, how to look after their personal appearance, how to manage their personal hygiene, and instructed in how to behave towards other members of society.

2. It is also very evident that the *family* has a very important role to play in this area. We have before us a process which is undermining the industrialized world and having very serious social and psychological consequences for the whole of mankind. The progressive dissolution of the family, and thus of social solidarity as well, is corroding the industrialized countries and gradually contaminating third world countries at the same time. All this has very destructive results for all members of society and in particular for those who are most vulnerable. Indeed, in some northern countries divorce afflicts more than a half of married couples. Thus, for example, one town in the United States of America of 16,000 inhabitants has over four hundred people sleeping rough. It comes to be thought that each individual must rely upon his own efforts and his own work. When something very harsh occurs, when there are social or professional difficulties, and in particular when mental illness breaks out, the individual has before him only begging or suicide.

The very deep socioeconomic transformations which the world is now undergoing—and this is especially true of the industrialized countries—are perhaps tipping the scales towards the side of reason. Indeed, economic developments in the direction of a extreme free market methods and policies, in addition to important developments in the sphere of technology, have turned unemployment into a structural feature of all societies. This is also true of those economies which are especially strong, as indeed is well borne out by the experience of Japan. When public opinion comes to realize that unemployment is not a question of a mere aggregate of individuals and that there will never be enough work for everyone, perhaps there will be a move towards a stance of greater solidarity towards the most vulnerable, and this latter category includes those who suffer from mental illness. It should be observed at this point that in Great Britain more than a third of psychiatric patients admitted to hospital never receive a visit from members of their families. Furthermore, we are now beginning to see examples in developing countries of children who want to abandon parents who are suffering from Alzheimer's disease and wish to consign them to medical institutions.

In industrialized countries there is a clear move in the direction of creating ever more structures and facilities which deal with the problems caused by the absence of the family. This is true at many levels and involves clubs, trade unions, associations and so forth. This well confirms the old adage that "friends are the family you choose." In the same way we are also witnessing various forms of alteration in family organization caused by divorce, new marriages, and the practice of living together. The various protagonists of these new configurations are involved in ever more intricate and complex kinds of relationships.

It is more than evident that the families of mentally ill people are themselves in need of help in order to allow them look after their mentally ill member. For this reason they need the constant aid and support of a medical and support team which should supply them with the information required to help them during the various stages of treatment that the mentally ill person has to undergo.

3. *Society* itself has many duties towards the mentally ill person. Wherever possible the mentally ill should be able to work both in a protected place of work and within the community at large. This is especially the case in industrialized societies where work is a kind of "religion." Indeed, in many devel-

oping countries and nations of the third world those people who do not work are not condemned by society. This is because there are so many unemployed people in these countries that unemployment actually represents the norm. At the present time there are more than a thousand million unemployed people in the world—that is, a third of the active potential workforce on the earth. However, in developing and third world countries small jobs which do not involve great responsibilities or duties are available to all those who want to make a contribution to their society. On the whole, it is possible to observe that the mentally ill are not excluded from this reality.

4. *Employers* also have a great deal to do in this field. They have the duty to defend both the mental health and the physical health of their employees. In the same way as every year vaccinations are insisted upon in order to avoid influenza, so preventive action should be taken in the field of mental health. If nec-

essary the employee should be helped to overcome difficult moments in his life in order to ensure that he can return to his work at a later date. This is important both from the point of view of the health of the worker and in terms of the well-being of the company where he works. An anxious or depressed worker demotivates his colleagues and gives rise to lower levels of personal productivity.

A recent study on the origins and patterns of illness in the national French electricity and gas company shows that a half of those employees suffering from depression were not treated as such. The consequences at the level of behavior of the condition of depression can have a notable social and professional impact (repeated late arrival at work, lower levels of productivity, threats of resignation, divorce and so forth). The adjectives which are stuck on these people like labels (lazy, moody, difficult) are totally unrelated to their actual personality and to how they behave normally in their usual relationships with other

people. If we become aware and conscious of their suffering we can establish an approach towards them which is based upon help and support rather than upon condemnation and sanction. This in turn will allow them to obtain treatment and to regain their peace of mind, achieving thereby a state of normal levels of work performance.

To conclude this paper, it should be observed that the integration of mentally ill people into society is the concern and responsibility of everybody. It involves solidarity towards the most vulnerable of the vulnerable—those afflicted by mental disorder and disturbance. This is not only something which should take place for ethical reasons. It involves great savings on a broad front, both in terms of individual suffering and in relation to economic performance. Here, more than in other spheres, ethics pay.

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JOAQUIN NAVARRO-VALLS

The Image of the Mentally Ill in the Mass Media

The mass media of the present age are in love with the mentally ill. This has been going on for some time—indeed since the beginning of the 1940s. The comparative hemerographic studies into the question show *first of all* that there has been great interest on the part of the mass media in a very broad range of psychiatric illnesses; *secondly* that this interest is now growing; and *thirdly*—and this is even more significant—that this interest goes beyond the usual space that these different forms of mass communication—the television, the daily press, reviews, etc.—devote to health and health care. The mentally ill person—and this is a fact which in itself is relevant—is not in the mass media just *one more sick person*. The mass media place him outside the general areas dedicated to human illness and emphasize his anthropological singularity.

At the outset, a word about the methodology employed in this analysis. When in this paper reference is made to the *image* of the mentally ill person in the mass media, in fundamental terms reference is being made to the *dominant image* of such a person. This is something rather different from the more elaborate and subordinate images which arise from the *dominant model* which is found in most of the European and American examples of mass media which have been subjected to study.

The Mass Media Discover the Mentally Ill Person

Although the mentally ill person is a long-standing figure of nonscientific literature, his frequent presence in the mass media is a relatively *recent* phenomenon. It is certainly true that when the mass media acquired the vitality they now possess, the mentally ill person was not a special, or even a suitable, object of attention. His presence was therefore markedly rare. We will discuss the possible reasons for this later on in this paper. What should be emphasized here is that the discovery of the mentally ill person by the mass media is something which is of rather recent date.

This fact is rather mysterious. Whatever its origins, it cannot be attributed merely to the developments of diagnostic or semiological techniques within the discipline of contemporary psychiatry. In the same way it does not seem to be a result of the importance and influence of some epistemological framework. The way in which the mass media approach the mentally ill person—and this is not something which should surprise us—is not strictly scientific in character. The mass media deal with this subject more in terms of "meaning" than with reference to description or treatment. It is not unusual for the mentally ill person—and this is something especially true of the American cinema of the 1940s and of the European Press of the 1950s—to be presented as though he were a *key by which to understand* contemporary man: a sort of hermeneutic parameter with which to approach mankind.

The mentally ill person for a large part of our century has been portrayed by the mass media not so much as the carrier of an illness but as the bearer of a message. He is seen *as somebody who has something to say*. One need only study the image of the mentally ill person—which in fact is almost absent, or, rather, deliberately absent—in the mass media seventy years ago to realize that this new perspective is not the outcome of changes which have been brought about *within* the world of the media alone. In reality, we are dealing far more with a change in collective sensitivity and sensibility; with a change in social appraisal and approach.

At the present time—as will be shown later in this paper—this image is undergoing a development along lines which will be discussed subsequently.

Here we encounter an important aspect of how things evolve in the mass media—the image of the mentally ill person is dynamic—it changes and in a few years can change radically. If we were led by an interest in how the mass media portray the mentally ill to study what has happened in this area over the last hundred years, we would find that these attitudes have moved back and forth in pendular form and that this process is still in full swing.

At the outset, the image of the mentally ill person was what we might term "mute"—he was portrayed as being alone with his illness. Mental illness was in a very literal sense seen as a kind of "work of fate" with which dialogue was not possible. It brought no ray of light into the history and experience of man. In more specific terms, it was thought to be an accident to be located on the outer margins of anthropological meaning and significance.

In the space of a few years, however, this image gave way to another by which the mass media approached mental illness as being something of *human interest*. The mentally ill person appeared as a being to be valued, explored, and interpreted. At a specific level he could express the meaning of his illness in his own life-history. On by no means rare occasions, films portrayed the mentally ill person as having a relationship with his illness which was akin to the experience of falling in love. In this way, the mentally ill person became a subject for cinema, a source of information.

What changes can explain this shift in the public—rather than scientific—image of the mentally ill person?

Three Changes Which Explain This Change

In the second half of this century

the public image of the mentally ill person has changed as a result of the impact of three factors: the development of scientific medicine, changes in social awareness and concern with the subject, and changes in anthropological models of the human condition. These three factors have undergone a very great change during the present century and have had a great influence on the way in which the mass media have portrayed—and still portray—the image of the mentally ill person.

At the beginning of the century the first image which the press presented of the mentally ill person was that of an alienated being described with the popular term "mad." His image was disquieting because it contained more than one element of threat for the community. The mentally ill person was portrayed as being at the summit of a deplorable human condition which in most instances required a policy of isolation on the part of the community. For this reason such a person very rarely constituted an item of news for the mass media unless there was a question of him being—or allegedly being—a danger for society. Unlike any other illness of our century, mental illness bore a stigma which society imposed in order to isolate those who suffered from it and which meant that the mass media remained largely silent on the whole subject.

In this image the mass media gave a paradigmatic form to the idea promoted by one school of psychiatry in particular that "every mental illness is a cerebral illness." As such, it was as lacking in anthropological meaning as any other episode which had physical origins.

It is more than evident that this image was the outcome of an extremely reductionist approach to psychiatric illness. For the mass media the "mentally ill person" of those days was almost exclusively a schizophrenic, a patient with physically-rooted mental disorders and the most severe examples of bipolar disturbances of mood. Most of what now goes to make up clinical psychiatry was excluded from that image by statistical elimination—namely, pathological conditions involving anxiety disturbance, mood disturbance, sleep disorders, and disorders caused by the use of psychoactive substances, and so forth.

The "Human Interest" of the Mentally Ill Person

The great change in the attitude of the mass media towards the mentally ill came about at the same time as the popularization of theories which addressed themselves to the question of the etiology of mental illness. Outside the field of academic psychiatry, none of these theories had as much impact as psychoanalysis in shaping and determining the image of the mentally ill person. Its impact on the mass media and in particular on the press was enormous. Naturally enough, this process of popularization took place at the cost of the vulgarization of Freudian insight. However, the result in terms of the creation of a new image of the mentally ill was of decisive importance.

Psychoanalysis—or, rather, its popular version—provided the mass media with the illusion that they were portraying clinical symptoms from an "overall" perspective even though this was done by people who were not specialists in the field. Its claims to "interpret" both normal and abnormal mental processes conferred on the world of the mass media for the first time an ability to focus on the mentally ill person as somebody of extraordinary "human interest."

With the spread of psychoanalysis the image of the mentally ill person as projected by the mass media changed. This change took two forms. On the one hand, the mentally ill person abandoned his lifestyle of isolation and became a being whose illness could be grasped, interpreted, appraised, and understood. On the other hand, the mass media discovered that the range of mental illness had expanded in extraordinary fashion and had opened up spaces for the great pathology of "neurosis"—medicine now covered areas which hitherto popular opinion has excluded from the category of "mental illness."

In the first stage the mass media adopted the general etiological idea that "every mental illness is a cerebral illness." In the second stage the etiological approach was much more dynamic—indeed, psychodynamic—and was expressed in the slogan "every mental illness is the expression of an unconscious conflict." In the world of the mass media there was a shift from the concept of *cerebral* disturbance to the notion of a category of disorders of the *spirit*.

An Orphan Image

During the next stage—and here we come to the present-day situation—the image of the mentally ill person underwent another development. Although it maintained many of its previous characteristics, it included a new dimension which was not strictly connected to the two categories which preceded it and which are discussed above. This new image of the mentally ill projected by the mass media involves certain new parameters which are in fundamental terms more social than etiological in character. Mental illness is defined with reference to its *frequency*, its *ability to be treated* in therapeutic terms, and *its lack of biographical background*. In other words, the mentally ill person is often to be found and at all levels of society can be cured through the use of drugs and medicines, and because of this last possibility—or in proportion to its feasibility—*biographical* research into the origins of his illness acquires less importance.

In this popular image of the mentally ill person we can see that the *reductionist etiological models* which characterized the period from the 1940s to the 1970s in America and the war years in Europe are much less important and influential. With the decreased popular adherence to Freudian psychoanalysis and its accompanying theories, there was a fall-off in medical circles in the illusory belief that it was possible to find an overall and complete answer to psychiatric problems and conditions and to understand the mentally ill person with reference to a single causal-theoretical framework of interpretation. Indeed, at the present time, it is not unusual to find the mass media laying stress upon the inability of psychoanalysis to provide valid explanatory hypotheses which can be verified by empirical evidence.

At the same time, the mass media have spread the idea of the *widespread presence* of the mentally ill person. This has probably been achieved through the systematic use of the statistics and techniques of social research. The very large space which the mass media now give to the mentally ill seems to go beyond the approach of scientific psychiatry. Above all, what we encounter here is the same problem which occurs in other areas where the popularization of science employs statistical methods in the wrong way: the widespread presence of mental illness is considered the norm, and the next logical step in this process is to try to distinguish between what is "normal" and what is "abnormal," or to understand health with reference to illness. This attempt is what was meant in this paper when reference was made to the mentally ill person becoming a hermeneutic parameter by which to understand human be-

ings. Whatever the truth of the matter, at the present time the mass media describe the "extreme" behavior and the character features of the mentally ill in such a way that the boundaries which clinical psychiatry employs to define mental illness become blurred.

In the world of practical medicine the *development of the treatment* of mental illness has been understood first of all in terms of the evolution of psychopharmaceuticals. This reality has radically changed the image of the mentally ill person as portrayed in the mass media. At the beginning of the century, this image involved the picture of a person who was alone and isolated and was based upon the notion that "every mental illness is a cerebral illness." Subsequently, the diffusion of psychodynamic theories transformed this image into one which involved an enigmatic being who was nonetheless full of "human interest." Here the notion was that "mental illness is an illness of the spirit." Today we have the image of a mentally ill person whose condition can be cured by pharmacology without there necessarily being a need to consider the biographical background to his illness. The modern-day dominant image of the mentally ill person involves the idea that the fundamental treatment of his condition—and at times the only treatment for his illness—lies in the application of drugs and medicines. As a result of this line of thought, inquiry into the *biography* of the clinical syndrome becomes of secondary importance and at times is even seen as being useless.

This is probably the new element which is to be found nowadays in the ascendant popular image of the mentally ill person. The tendency is to portray illness as an *orphan* without a biography and without a past. The image is one of a chance visitor whose arrival is not in the least foreseen from the past life of the patient. The supposed ability to treat the illness with drugs and medicines and the lack of interest in etiological models which at one time provided the mass media with a fictitious and facile conviction that they could understand mental illness have both given rise to this approach.

At the present time the mentally ill person seems to be the bearer of an illness which has no roots in the past. The interest in describing his condition and his behavior excludes inquiry into the possible influence of the life experience of the mentally ill person on his condition—his preferences, upbringing, systems of values,

expectations, and so forth. The mass media in their descriptions assert that mental illness is a *situation* and not a place which is frequently reached from certain starting points such as habits, behavior at risk, etc.—elements which are all very instructive from the point of view of clinical psychiatry.

Over and over again we encounter disturbances caused by the use of psychoactive substances being discussed without reference to the social context of these disorders, the social factors behind their development, the role of social and cultural forces, the attitudes of the individuals concerned, the previous beliefs and expectations of the mentally ill person, the stability or instability of the family background, and so forth. Without a discussion and awareness of the human context of the mentally ill person—a context which is *clinically relevant*—the drug-addict who is also mentally ill ends up by being constantly consigned to the "crime" pages of newspapers. In addition, his image is very often linked to the concept of "criminality."

A reductionism of this kind is often present when the organs of mass information deal with other psychiatric pathologies. The image of the depressive mentally ill person—for example, in films, television, or the press—is often effective from a *descriptive* point of view. But the lack of discussion of the causes of the condition places the illness on a level of total discontinuity with the past life-history of the mentally ill person. Nothing can be more deceptive than the image of a depressed person which is detached from his biography. Without reference to his usual way of reacting to *stress*; without a knowledge of his habits or the risk situations which are present in his life; and at a more specific level, without a suitable light which can illuminate the general configurations of his life, the depressed person cannot be understood and is not even recognizable as a figure from real life.

The *biographical amputation* of the mentally ill person is perhaps the common evil and probably the most regular feature of the way in which the mass media transmit his image in today's world. This is what we should term an *orphan* illness—without genealogy, without paternity, and without biography. It is assumed—and this is something which is not always the case—that mental illness is a mere question of fate, a chance occurrence which arises without any connection with anthropological

facts or with the past or life history of the person concerned.

In the case of other physical illnesses such as contagious or neoplastic pathologies, the mass media tell people about the preventive and health measures which can be taken to avoid falling ill. In the case of mental illness they very rarely give information about behavior at risk, about elements of lifestyle which are factors which predispose people towards such illness, bring it on, or perpetuate it. In this way, the mentally ill person is portrayed not only as being beyond the parameters of an anthropological framework, but the patient himself is deprived of knowledge about those elements which could be utilized to achieve a suitable *life hygiene* in relation to his illness.

To conclude this paper, we can now ask questions about the relationship between this image of the mentally ill person which is conveyed by the modern mass media and the way in which he is currently considered by scientific psychiatry.

There can be no doubt that the image of the mentally ill person held by the mass media and its evolution during the course of this century have followed—at least in general terms—the various conceptual configurations of mental illness adopted by academic psychiatry. Here we are dealing with diagnosis, classification, and treatment. Psychiatry is one of those areas of medicine which have always had good popularizers. But the osmosis between scientific psychiatry and the mass media still fails to produce the results we would like.

Certain forms of reductionism which are present in the image of the mentally ill person conveyed by the mass media were already latent in certain ideas of psychiatry itself. Other such forms—and indeed most of them—were introduced and promoted by the mass media themselves, and this is something which brings out the extent to which the process of popularization was flawed.

The most notable of these forms of reductionism, in my opinion, is of a deterministic character and its most evident expression involves the mentally ill person being divorced from his own biography. Its greatest limitation and its greatest risk is a *depersonalization* of the mentally ill person through a separating of his psychiatric syndrome from its anthropological roots.

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Ethics and Psychiatry

Interest in moral problems and questions has always been keenly felt in the discipline of psychiatry not only with reference to the subject matter of medical deontology—which goes back to Greek medicine and Hippocrates and Galen—but also in relation to the special characteristics which distinguish mental illness from physical illness. In recent times, it should be observed, a special impetus to this concern has been supplied by a phenomenological orientation first and foremost but also by a sociogenetic impetus—both can be described with good reason as being the precursors of contemporary bioethics. But in reality one cannot relate ethical problems to single theoretical models unless, that is, there is not in addition an employment of great emphasis on, or an examination of, underlying philosophical principles. Such concern with ethical questions, in fact, is present in all schools and directions of thought when applied to real clinical practice.

However, there can be no doubt that research of the last twenty years has created a new discipline which takes the moral aspects of the biomedical sciences as its subject matter. Such research, in turn, has had important consequences in the narrower and more confined field of psychiatry.

According to the classic definition offered by the *Encyclopedia of Bioethics*, bioethics is "the systematic study of human behavior in the field of the sciences of life and of the care of health where such behavior is examined in the light of moral values and principles." For this reason not only can we grasp the close connection be-

tween clinical psychiatry and bioethics but (and above all else) we come to realize the benefits which bioethics brings to psychiatry through its ability to move ethical requirements from their original location in the spaces of ideological beliefs or the intuitions of moral common sense to an organic system of principles which in turn gives rise to individual rules of conduct, and this through the employment of an intricate and rigorous system of lines of argument. From this point of view it becomes clear that bioethics is the fundamental basis of psychiatric deontology.

Before outlining the cardinal principles of bioethics and establishing their individual effects and meaning for the world of practical psychiatry, it is useful to observe at the outset that the search for a rigid and guaranteed system of deduction by which one can move

from the level of principle to that of individual sets of approaches of practical implementation is not in actual fact valid. This is so for two reasons:

1) In the first place because ethics is not a science in the strict sense of the term because moral reasoning is chiefly, if not exclusively, characterized—in relation to comprehension and interpretation—by a tradition which began with the Aristotelian concept of *phronesis* with its idea of a practical wisdom. This bears a line of argument based upon a rationality which is different from scientific rationality and which does not involve processes of causal explanation.

2) In the second place because there is a structural difficulty when we try to apply a universal principle to a specific case. There emerges an essential divergence between the irreducible specific features of the single example and the universality of principles, and this divergence means that there can not be a mechanical and uniform application at the practical level of actual conduct. This does not in the least mean that a relativistic lapse is at work because the universality and the objectivity of the law is not called into question. It merely means that the law itself should be adapted to each individual case and studied in its complex situational context so as to avoid the promotion of arbitrary abstractions and devastating examples of reductionism.

After this epistemological premiss, it should be observed that the severe criticism made by Jaspers of the reduction of a mentally sick person to a mere clinical case with

a consequent compromising and loss of subjectivity—something which constitutes a real and authentic break with the organicist orientation of Griesinger, Kahlbaum, Wernicke, and on to Kraeplin—can and must be revisited and reconsidered today in ethical terms. This should be done in such a way as to complete and extend the significant contributions of an anthropological-existential and phenomenological-existential character made by Binswanger, Minkowski, Gebsattel, Straus, Schneider, Blenkenburg, Tellenbach, Zutt, Wyrsch, Rumke etc. In particular it is my belief that the question must also be tackled from the point of view of the principles of benefit and autonomy which are the mainsprings of contemporary bioethics—without, however, abandoning the psychopathological approach.

A first reading of the relevant evidence is of an ethical-deontological character and constitutes an appeal to respect the personal dignity of the sick person, who is firstly and always a man and as such has an absolute value, the recognition of which is absolutely obligatory. But one would remain fatally vague and general, or one would even fall into the rhetoric of an uplifting speech, if one did not really face up to the meaning of the concept of the guardianship of subjectivity. And here especial attention should be paid to the definitive decline of faith in the possibility of a scientific nosography involving a substitution of the awareness of the practical-economic need for the relevant classification of theoretical questions and hypotheses.

We thus come to a psychopathological consequence from which one can and one must draw ethical conclusions. What I mean by this is that a mental illness of whatever kind, but, above all, if it is chronic or long-term, afflicts the sick person in his entirety and creates a complex dynamic not only in a pathological sense but also in an existential sense. Indeed, we should not proceed to an abstract isolation of the syndrome and its symptoms from the sick person who not only is involved in that syndrome but responds to it at a level which rises above the merely biological. To put it differently, the illness should not only be diagnosed and addressed at a clinical level but should also be interpreted within the context of the individual's personal history, of the inner history of the patient (to cite the definition of Binswanger and Zutt), and of the world of the life and the experiences of the individual in an overall sense and not only in psychological terms.

There is thus a dialectic interaction between nature and existence (I refer here to the famous distinction made by Jaspers and Binswanger) according to which the psychotic experience has its own meaning which should be understood, a meaning which although it is present in the furthest reaches of the existential level (which, however, is neither transcendence nor dualistic division) when compared to the biological and biopsychological level, exists in a relationship of unity and circularity with this latter level where the function of the bestowal of meaning is in turn correlated to the physio-pathological processes. When we see and interpret mental illness from this point of view as an event rooted in the existential singularity and totality of the person of the sick individual, we thereby understand and recognize the mind-brain structural unity which is the final limit but also the point of arrival of every form of anthropology whether scientific or philosophical in orientation.

In this sense the defence of the subjectivity of the mentally disturbed person which refuses to see him as a clinical case or an object, and this in order to stress the fact that he is a person, has an essential ethical meaning. This is because, following on from the Kantian postulate that the human person is an end in himself, it belongs to the category of values. And this is so both in a negative sense as a moral obligation on the part of the psychiatrist to respect the dignity of another person (one thinks here of the ideas of Cargnello, derived from Binswanger, of altered states and alienated states) and in a positive sense as a condition of moral progress of the clinical experience. By this means one achieves a solution to the dichotomies present in the recognition of the unity of the person and the interpersonal relationship which from a philosophical point of view is awareness of totality—that sense of one/all which in lyrical form is expressed in sublime fashion in the quartets op. 132 and 135 by Beethoven and which is both a poetic moment and ethical-mystic feeling as expressed in the Amor Intellectualis in Deum by Spinoza.

The defence of the subjectivity of the psychotic person aims at the return of the communication which has been compromised or interrupted by the psychosis and which thus renders listening possible. Beyond the diagnostic-clinical approaches to the case history, listening and knowing how to listen also have a very high ethical value because they involve the perception and recognition of the sick person not as somebody different from me but as another who gives meaning to my relationship with him and thus with myself. The ethical value of listening thus lies in a choice of self-limitation which the psychiatrist makes by abandoning the recurrent temptation to narcissism and to a feeling of omnipotence and by placing himself in contrary fashion in the dimension of encounter and love. Without abandoning his own role as leader in the therapeutic reaction or the deontological responsibilities which come from his own scientific-professional expertise,

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the psychiatrist dedicates himself to the conventions of humility—that humility which is also truth (St John the Evangelist)—and thereby creates a parity of a moral character without however in any way denying the disparity of functions and knowledge which is also present in the relationship.

The defence of the subjectivity of the sick person also and above all else acquires an ethical significance because it is the pre-condition to freedom. It is certainly very difficult to speak about freedom. It is, indeed, evident that the improbable hypothesis of a faculty for self-determination of the finite is obscure from a philosophical point of view and at the very boundaries of the unproposable, and in a similar fashion the qualitative and quantitative importance of the biological, psychological, social, and cultural influences of human behavior is also more than evident from the point of view of scientific anthropology. But if we abandon the unsafe terrain of metaphysics and the ambitions of a science which is unaware of its own limits, the problem can be solved through the bestowal of an exclusively ethical connotation and by acting from the starting point of the human awareness of feeling free which is the precondition and meaning of moral life. Jaspers has observed with great prescience that: "the question of whether freedom exists has its origins in myself for I want it to exist." In this sense because it is a "fact of consciousness like the passing of time" (Bergson) freedom has an essential and exclusive ethical value in the sense outlined by Kant—it is a pure formalism without objective contents which is a practical principle of will when faced with duty.

Furthermore, freedom is an essential attribute of the individual and for this reason the defence of subjectivity is the defence of freedom. Such a concept of freedom is strictly bound up with the bioethical principle of autonomy to the point of being actually identified with it. This principle refers to absolute respect for the human person. But in order to avoid dangerous misunderstandings it should be pointed out that the defence of

the subjectivity of the sick person does not involve the belief that he is free (which is against the evidence of the pathological influences of his cognitive or affective nature) but involves, rather, helping him to become free. And if freedom—and here I adopt the definition offered by Jaspers—lies in the need to be free then the psychiatrist who is loyal to the principle of autonomy will make such a need emerge where it is absent or will actually strengthen it. He will also integrate it into the personal dynamics of the disturbed and mentally ill person.

We should however abandon easily-held illusions because the daily experience of encounter with the sick man is in reality a challenge to widely-held theories and is a source of unceasing perplexity. This requires if not the revision at least the questioning of the methods and ways by which principles are applied, including that of the bioethical principle of autonomy. A rejection of the objectifying model by which the patient is approached is certainly absolutely binding but it should not involve an abdication on the part of the psychiatrist of his own deontological, ethical and professional responsibilities. One should not therefore give a sense of myth to the freedom of the sick person and thereby debase the concept of freedom. There is in fact an authentic freedom and there is a false or degraded freedom.

The first form of freedom is chosen from alternatives which are rationally understandable within the context of an underlying rationality. False freedom, on the other hand, is an uncontrolled and indiscriminate choice which takes place beyond all ties and limits; it is therefore an arbitrary decision, a whim, a foolish option. To prevent the bioethical principle of autonomy—which is the deontological norm of psychiatric intervention—from degenerating and to stop the defence of the value of the person from falling into dehumanizing systems of practical implementation the following must take place. The psychiatrist should defend with the utmost vigor the defence of the interests and the primary rights of the mentally-

ill person and of his life and health, and in so doing he should if necessary take unilateral decisions in the case of exceptional circumstances. This, of course, should take place when that mentally-ill person is not able to make coherent and rational decisions.

The defence of subjectivity, therefore, does not involve letting the patient do what he wants or what he thinks he wants but rather in leading him to acquire the ability to choose in a way which conforms to the values and real interests of his own personal life. We should therefore rediscover a relationship of harmony between the principle of autonomy and that of benefit by going beyond possible immediate situations of conflict and embracing the principle of respect for the priority of benefit within the hierarchical order of bioethical principles. Freedom, in fact, is not an easy process within the reach of everyone in indiscriminate fashion. It is, rather, a difficult conquest which requires maturity and knowledge. Freedom, therefore, is not a point of departure, a fact—it is a point of arrival. In other words, freedom is essentially a process of liberation based upon an ethical need which is fundamental to the human person.

The defence of the subjectivity of the mentally-ill individual thus has an ethical connotation because it is an encouragement and an orientation to feeling free and to wanting to feel free. It is, therefore, the promotion of authentic freedom (one thinks here of the greater *libertas* of St.Augustine). Freedom, for this reason, should be placed between an objectification which exasperates and absolutizes the relationship of dependency on the one hand, and an anarchic self-abandonment to a spontaneity polluted by pathological factors on the other. And it is in this way that the clinical-therapeutic relationship becomes in essential terms an active recognition and a construction of the dignity of the human person of the sick patient.

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The Role of the Church in the Treatment of the Mentally Ill

Introduction

The religious orders which form a part of the Church and are dedicated to serving humanity in various ways have in the past distinguished themselves for their ability to attend to the needs of men in all historical contexts. They now look at the present in an attempt to render the richness of the charisms of their foundation ever more contemporary. In so doing they defend and promote their own special traditions but often have to fight against legal-administrative systems which are very distant in their character from the Christian sensibility. The most worthy initiatives which they engage in are those directed towards helping the incurable, sick people drawn from the ranks of the poor, the afflicted and the diseased, and defenseless children who are judged abnormal or are not wanted.

Today, amongst those who are most in need, members of religious orders, with the help of many volunteer workers, take care of those people who are terminally ill, those who have AIDS or are drug-addicts, and people who suffer from mental illness. I must observe, with great regret, that I have not been able to gather data on the many-faceted presence of the Church in these fields of health care. I sent a letter last May to a large number of religious institutions on the question but I have not received even one reply.

I would like to take this opportunity to invite the various episcopal conferences and the Pontifical Council for Pastoral Assistance to Health Care Workers to launch a campaign of information gathering on the different forms of health care provided in this sphere by male and female members of religious orders and by the very large number of Catholic voluntary organizations throughout the world. A census of these initiatives could also act as an appeal to those who wish to dedicate their lives totally to serving the most forgotten of the sick and ill.

1. A Look at the Past

Drawing upon my own personal experience as a member of the Hospitaller Order of St. John of God, I would like to speak about care for the mentally ill. Long ago the "Fatebenefratelli" made their decision in favor of the method of tenderness in the treatment of the mentally ill. A large number of important figures stand out as examples of this approach who should be taken as models to follow.

By 1632 St. Vincent De Paul had already founded the House of St. Lazarus in Paris—hence the name "Lazzarists." This was an authentic model of charity, even of tenderness and love, towards those mentally ill people who resided in that compassionate asylum.

In France by 1600 there were ten homes where the "Fatebenefratelli" offered a refuge to the abandoned and desolate mentally ill. Engaged in the same activity there were also Franciscans, Brothers of the Christian Schools and Marists for the males; and Sisters of the Good Shepherd, the Ursulines of Saint Pelagia, and the Penitents for the women.

The work of the "Fatebenefratelli" was a practical mission inspired by the action of St. John of God who through personal trial had to undergo those forms of treatment which at the time were applied to the mentally ill or those who were thought to be such.

Roundabout the year 1700 we encounter the rise of the scientific belief, which was itself the work of the hospitallers, that madness could be the organic outcome of brain malfunction or damage. It was for this reason that it began to be thought that the mentally ill could be treated. There was an abandonment of the idea that madness in some way was connected to diabolical possession. I would like to lay great stress upon this point because although based upon different premises it is the same belief as that which now underlies the modern neuropsychiatric approach.

St. John of God, like St. Camillus De Lellis and St. Vincent De Paul after him, sought to humanize health care by restoring the appropriate respect that was due to sick people drawn from the ranks of the poor and the abandoned.

As the Italian historian Cosmacini has observed, hospital assistance was seen in the sixteenth century in Europe as an ambiguous practice caught between zeal and detachment. The doctors and nurses often saw a sick person as something alien. Different from the normal and from themselves. Hence the forms of behavior marked by absenteeism and indifference which gave rise to a lack of care and even violence—ele-

ments which served to add suffering to the existing illness.

St. John of God emerged against this kind of background in relation to hospital care. He wanted a hospital where the sick could be looked after as he wanted, that is to say without obscurantism and with the belief that the sick person was a neighbor and not an alien.

Through him there was established an anthropological model for interpersonal relationships whereby a neighbor cared for his neighbor, a nurse looked after those to be nursed, and a man did the same for another man who was sick or less fortunate than himself.

The madness of St. John of God thereby acquired a symbolic value of enormous spiritual interest because it set in motion a process by which the mad who were poor were reclaimed in a way which saw them as human beings in the full sense of the term.

The movement of care and concern for the mentally ill which the "Fatebenefratelli" began gave rise to a system of hospital service which was to guide Catholic health care institutions for centuries to come. This system involved the following key principles:

1. Service to the sick is something which comes directly from such principles of the faith as the universal love of the Father and the dignity of man.

2. Service is thus a right and a duty of the Church with full respect for different cultural realities; and this approach involves the announcement of salvation in the face of illness.

3. Each hospital mission is a work of evangelization and thus involves the bearing of witness to the loving mercy of Christ.

From the French Revolution until the present day many profound changes have transformed the various health care systems of the world. But the members of the religious orders, although much reduced in numbers, have never ceased to serve the sick in a spirit of denial and with their faces fully directed towards their evangelizing mission.

2. The New Frontiers of Care for the Mentally Ill

Like many other members of religious orders, the "Fatebenefratelli" have directed institutions for the mentally ill which for many years occupied an auxiliary role in relation to the field of activity of the state. With the passing of time they recognized, and often well before the public authorities, at least in Italy, the need to reduce the number of those kept within an asylum and to place the psychiatric patient at the center of a multidisciplinary system of care.

But I could say the same about Portugal, Spain, Ireland, or Columbia. The Hospitaller Order of St. John of God has produced a series of studies and programs of research to draw the attention of those who are concerned with this field to the need to pool their knowledge and expertise not only for reasons of approach and method but also on humanitarian grounds. An authentic cultural battle has taken place both outside and within the Order to understand how mental illness can be prevented, how its lapsing into a chronic state can be impeded, and how more flexible methods of rehabilitation can be developed.

One son and follower of St. John of God, Padre Benedetto Menni, who was recently proclaimed blessed by the present Supreme Pontiff, established a female religious congregation which carried on in his footsteps in a special and heroic fashion in caring for the mentally ill. Padre Menni himself, in his restoration of the Order in Spain, laid especial emphasis on psychiatric care and to this end created a large number of psychiatric institutes.

Basing ourselves upon that therapeutic model which has been termed the "method of tenderness" by historians, we have sought to see rehabilitation as a tool of authentic humanization and not merely a technical process of the carrying out of dry conventions. We have run the risk—and this is something which we have been pointing out for ten years— of believing in the possibility of passing from internment to psychiatric rehabilitation in a process

based upon four central principles:

A. Utilizing the human potential of every mentally disabled person.

B. Teaching the sick person how to develop his own capacities and his own sense of self-determination.

C. Humanizing treatment programs through a continual training and updating of health care workers.

D. Changing the life environment and changing it in a way suitable to human needs.

We have seen rehabilitation, therefore, as something involving a new vision of mental disturbance and as an expression of the "demedicalization" of the therapeutic context.

The various contemporary schools of rehabilitation should be praised for having discovered a large number of ways by which to help the so-called mad person to return to so-called normality. But an evident danger remains. As members of religious orders and as believers, we must feel called to avoid the loss or suffocation of the individuality of the mentally ill person. Following the theoretical precepts of models of rehabilitation, we must strive to avoid placing all patients in the same kinds of category. We must, rather, follow individual variations as opposed to our own scientific and professional nostrums and prejudices.

A man, even a madman, is made in the image of God and should be respected precisely because of his extreme weakness— something which constitutes his vulnerable origins. Man is always made in the image of God, and above all when he is denied those physical and spiritual traces of that sublime intelligence which has created us *ad imaginem et simulitudinem suam.*

I would even go so far as to say that if this faith in the weak and wounded God who is capable of suffering within his creatures is lacking, then the very principle of equality and solidarity among men is also absent.

If I may, I would like to make a final appeal to the men of science and to those public leaders who are interested in this subject and

this whole field. I would like to say that the mentally ill person of today's world has need first and foremost of this recognition of the wounded God who walks among us and within us.

Let us train people who are able to hear his cry and understand his movements. God is among us within those who are mad, the disinherited poor, in the suffering, just as he is present within the achievements of science and the joy of living.

Suffering reveals to men in cruel fashion the very limits of the work of God, the open wounds of a missing alliance between nature and God, the sign of a contradiction between the love of the creator and the impenetrable hardness of the creation.

Here we perceive the weakness of our God, who loves us so much as to suffer with us. God should not be the subject of our complaints and laments because He Himself suffers, and the alliance with man culminates in a partici-pation in the lowering of his son, the Christ, who makes himself suffering man.

That God is fragile because he is love is the only metaphor which protects him from the accusations of insensitivity or injustice, as indeed is pointed out by Paul Ricoeur, one of the most important of today's Christian philosophers.

Conclusion

The whole of society and, above all, ecclesial society is called upon to engage in a great qualitative advance in the exercise of the health care professions, the provision of services to people, and the construction of small residential facilities which can support the efforts and initiatives of the families of the mentally ill.

From these families, precisely at the moment when from so many directions we hear the call to close the lunatic asylums, we hear a desperate cry which in provocative fashion invokes the remedy of euthanasia rather than the abandonment of their dear ones to the streets.

All Christians, and health care workers in particular, are called upon to create points of reference and support groups for these families. We must provide room for voluntary work and initiative which can perform an educational mission greatly infused with Christian civilization and which can also constitute a major and active enterprise of social solidarity.

The mentally ill person, in whom there shines in a particular way the lamp of the Spirit of the Creator, should be protected in all possible ways against the winds of fear and wickedness if we want to be able to speak today of charity.

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Pastoral Care and the Spirituality of the Mentally Ill

Introduction

I have been asked to speak on the subject of pastoral care and the spirituality of the mentally ill. I would not like to begin this paper without thanking those who have organized this international conference, not least because this is an event which enables us to remember once again that care and concern for the mentally ill forms a part—as we can well understand from the ministry of Jesus himself—of the Good News, on the one hand, and that thought and reflection on how to improve the communication of this Good News is a pastoral necessity, on the other. I will seek to deal with this subject by answering the following question: What kind of pastoral care and what kind of spirituality must the Church bring into being today in order to provide a better service to the mentally ill, those suffering limbs of the Body of Christ? I must confess that this is a difficult undertaking, and this is especially the case because there is a general belief that at the level of local Churches real action in this sphere has yet to be taken. But even though it is difficult, this undertaking can also be very exciting because it involves—above all—the making of proposals and the sharing of ideas within the Church in order to achieve the provision of a better service to those "wounded by life" in our time.

It is perhaps a good idea to remember that I am speaking here as a priest who wants to dream when he thinks about the form and the quality of the service that the Church should provide to the suffering limbs of the body of Christ, the mentally ill. This paper, therefore, is not the work of a specialist, but of a man of experience who constantly comes up against the difference between what is actually done and what could or should be done. I would like to emphasize, above all, that my paper is "framed" by certain realities and marked by the experience of my local or regional Church. But because what takes place within this ground-level framework can help to strengthen the communion of the universal Church, I would not hesitate for a moment to seek to share our experience with others and to do this in a spirit of humility. Your questions and your observations will be most willingly accepted—so that what we have to say to each other can become enriched and so that new vitality can be given to our pastoral work.

I would like to deal with the subject of this paper by dividing it into three parts. First of all, I will dwell upon the character and nature of mentally-ill persons and illustrate the challenge that they constitute for today's Church. I will then discuss the great questions relating to pastoral care for the mentally ill and their spirituality, and the policies which should be adopted in this whole sphere—without, however, ever seeking to conceal the problems which will have to be faced up to and tackled.

1. The Mentally-Ill Person: A Challenge for Today's Church

I believe that the mentally-ill person is a challenge for today's Church. This challenge, however, only emerges when one becomes aware of the complexity of the situation, of the relationship that this situation has to the reality of social sin, and of the attitude which Jesus adopted towards illness in general.

A. The Mentally Ill Person: An Attempt at a Definition

Who is a mentally ill person and what distinguishes a mentally ill person from other kinds of sick people? On the whole, a mentally ill person is seen as someone who is afflicted by mental illness. But the term "mental illness" is very general in character and, as a result, very broad in meaning. Without seeking to offer a definition which a specialist in the field would provide, we can perhaps confine ourselves to observing that the term covers a whole range of neurological, psychiatric, or neuropsychiatric disorders which often express themselves in mental problems or a lack of structuring of the personality—something which occurs in cases of mental deficiency. These kinds of illnesses can have—depending on the case—genetic origins (trisomy 21 syndrome, autism, etc.); physiological causes (traumas caused by cerebral injuries or car accidents); psychological causes (serious neuroses); or social roots (deviant forms of behavior such as drug-addiction or alcoholism). An observation of contemporary social-medical realities demonstrates that these mental illnesses usually give rise to different approaches which range from clinical treatment to social care or which involve a combination of different approaches at the same time. Al-

though some of these forms of mental illness can be cured or alleviated through the use of medicines or rehabilitative methods involving the reawakening or stimulation of the impaired functions, it has to be recognized that some never respond to treatment.

From this it follows that a mentally ill person is, first and foremost, like every other sick individual, a person "wounded by life" and a being who suffers. He is a wounded person because he is a person whose spirit, or whose emotional, intellectual, relational, and psychological balance, have not been able to endure the impact of a number of factors over which he was not able to exercise a total control. He appears to us, in essential terms, as a handicapped person. His suffering is caused not only by this handicap but also by the feeling that he is useless, a burden, and a nuisance. He believes that without his presence everything would be more simple. This feeling can lead him to fall into a distinctive form of loneliness. But despite all this, his handicap does not deprive him of his dignity as a man created in the image of God.

In discussing the causes of mental illness, I referred to those which are social in character, such as drug-addiction and alcoholism. Certain studies have shown that there is a link between these pathologies and certain factors belonging to the social environment. If the causes of the suffering of the mentally ill can at times be traced to the social environment, it becomes possible to consider such people as victims of certain social conditions which we could well deem "structures of sin" or "social sin." There can be no doubt that sin is first and foremost a personal act, but this does not mean that we should not be held responsible for sins committed by other people or for what harms them. We and society are responsible when we cooperate in these sins "by participating directly and voluntarily in them; by ordering, advising, praising, or approving them; by not disclosing or not hindering them when we have an obligation to do so; by protecting evildoers."[1]

It should be immediately emphasized that there is always a link or a dialectic between personal sin and social sin. Indeed, "sin makes men accomplices of one another and causes concupiscence, violence, and injustice to reign among them. Sins give rise to social situations and institutions that are contrary to divine goodness. 'Structures of sin' are the expression and the effect of personal sins. They lead their victims, in turn, to do evil. In an analogous sense, they constitute a 'social sin.'"[2]

B. Jesus and the Sick: The Struggle Against Illness and the Proclamation of the Kingdom

Even a brief look at the Gospels shows us two things. We see, above all, that at the time of Jesus a specific number of illnesses and neurotic or psychic disturbances whose origins are now better known were very easily attributed to the devil. We thus see a Jesus who meets and heals sick people throughout his public ministry. Even though he rejected the traditional link between illness, suffering, and personal sin which was perceived by the Jews of that period,[3] one thing really mattered to him: to comfort those who were suffering. Jesus seemed to understand their suffering and strove to alleviate it. However, he did not judge those who were sick but always expressed compassion and tenderness towards them. But Jesus did not confine himself to being tender of heart and compassionate—he also fought against illness. For Jesus illness was something to be met and challenged.

Thus it was that "he saw in illness an evil which men suffer from..., a sign of the power of Satan over men (Lk 13:16). He feels compassion (Mt 20:34) and this compassion informs his action".[4] His actions in favor of these sick people take the form of healing. The healing which he achieves means at one and the same time triumph over Satan and the establishment *hic et nunc* of the Kingdom of God of the Scriptures (Mt 11:5). It is from this point of departure that one perceives the link within his ministry between the healing of the sick and the establishment of the Kingdom of God.

The struggle against illness cannot be separated from the announcement of the Kingdom of God—a kingdom which is also to be achieved through the healing of the sick. Every time, therefore, that Jesus heals and fights illness he proclaims the Kingdom of God.

Over recent years a large number of theologians have demonstrated in very important works on Christology that the Kingdom of God and the special love for the poor which this kingdom involves occupy a central position in the apostolic preaching of Christ. But it should also be pointed out that the proclaiming of the Good News of the Kingdom of God in Galilee (Mt 4:23; 9:35) is accompanied by a certain number of miracle-signs. These are not just demonstrations of the achievement and the presence of this kingdom—they also bring out and reveal its meaning. The apostles were informed that their mission was to proclaim the Good News of this Kingdom of God, and this communication was made when Jesus was still alive (Mt 10:7). After the death and the resurrection of Jesus and after the Pentecost the proclaiming of this kingdom was the ultimate and definitive purpose of the evangelical preaching—as is more than evident from the Acts of the Apostles (Acts 19:8; 20:25; 28:23-31).[5]

The gospels do not refer specifically to the mentally ill, but everything they say about the fight against illness also relates to this category of sick people. To fight against mental illness and everything which causes it is a way of continuing the work of Jesus—the proclaiming of the Kingdom of God.

C. The Church at the Service of the Mission of Christ

The Church does not serve if she does not proclaim. She is the servant of the mission of Christ—the mission to proclaim the Kingdom. She must be faithful to the mission which Christ entrusted to her, and she must do this in relation to illness, employing as she does so the tender and compassionate, but also real and effective, love of God.

As has already been pointed out, the acts of healing which were the

sign of the presence and expression on earth of the Kingdom of God were not linked solely to the preaching of Jesus. Indeed, Christ associated the apostles with his power to heal illness and sickness from the very outset of their mission (Mt 10:1). The promise of the constant achievement of these signs to give credibility to their proclamation of the Gospel message is made to the apostles at the moment of the bestowal of this mission (Mk 16:17ss). The life of the apostolic Church involved a large number of healings which bore witness to the presence of Christ within the community of believers (Acts 3:1ss; 8:7; 9:32ss; 14:8ss; 28:8ss).

The presbyters of the early Church were also much concerned with the health of the sick (Jm 5:14ss). Although the Church of the first centuries perceived illness as being an evil to be fought, she also taught both that illness was a difficult trial whose mystery had to be accepted by man on this earth and that it was something which united man to the suffering Christ (2 Co 4:10). From this comes that duty to exercise charity towards the sick which from the very earliest days of the Church was imposed upon Christians and that obligation to perceive Christ as being within the sick. The Christian must serve the sick and help them to bear their trials by visiting them and alleviating their suffering. To serve the sick means to serve Jesus himself in the suffering limbs of his Body (Mt 25:36).[6] This vision of things explains why the Church sees the image of her suffering and poor founder in the poor and why she strives to diminish their anguish and pain.[7]

The sick as well are the poor of our time. "The love of the Church for the poor...belongs to her constant tradition."[8] This love draws inspiration from the care and concern Jesus himself felt and expressed towards the poor (Mk 12:41-44). Mental and physical infirmities form part of that more general human misery which is itself a sign of man's need for salvation. They also create those victims among the poor with whom Jesus often identified and who were the objects of his compas-

sion. Sick people were once the objects of the special love of Jesus and today they are the "object of a preferential love on the part of the Church, who, from her very beginnings, and despite the faithlessness of many of her members, has never stopped trying to comfort, to defend, and to free. She has done this through innumerable works of charity and help which remain always and everywhere indispensable."[9]

The Church, therefore, at all times, has paid especial attention to the plight of the sick. As the Holy Father recently observed, "pastoral care in the health field continues to occupy a prominent place in the apostolic action of the Church: she is responsible for many institutions which provide help and care; and she works among the very poor with effective concern for health care through the generous commitment and involvement of many brothers in the episcopate, priests, members of male and female religious orders, and many of the lay faithful. These people have developed a marked sensitivity towards those who are in paino."[10]

In the Congo, after the first period of evangelization, the Church displayed special concern and care for the well-being of the sick. Although the Church was deprived of her health care facilities by the Marxist-Leninist regime from 1965 to 1990, she never abandoned her duty towards the suffering limbs of the Body of Christ and she always maintained a presence in the world of health policy and care. In addition to the pharmacies, the mobile, or parish-based clinics, the rehabilitation centers for all kinds of handicapped people, and the involvement of many of her members at public health facilities, the Church today completes this presence through the action of those lay people who belong to the Gospel Groups for Health.[11]

But if the Church in the Congo has, on the one hand, always cared for the sick, it is also true that, on the other, there has been almost an absence of pastoral care or a poverty of pastoral care in relation to the mentally ill. One could even speak of the nonexistence within

our country of a tradition in this most important of spheres. Indeed, although the Congo Church has rehabilitation centers for the victims of polio and training centers for the blind and the dumb, she has never been concerned directly with the plight of the mentally ill. How many of our dioceses have chaplains for the mentally ill and how many lay apostolic groups are dedicated to looking after people who suffer from mental illness?

Our pastoral activity in relation to the mentally ill is still too much concerned with providing spiritual help to the terminally ill and to giving material aid to those who are afflicted by AIDS. Hitherto, for example, our Church has neither understood the complexity of the situation we have before us nor understood the link between mental illness and social sin. This absence can be explained, on the one hand, with reference to the fears which these sick people generate—given that they have a reputation for being violent and dangerous—and, on the other, with reference to the lack of qualified pastoral workers and the absence of well-organized pastoral activity. Today, therefore, the situation of the mentally ill constitutes a challenge for our local Church because it requires the invention of an appropriate approach and the development of suitable pastoral strategies. The current pastoral gap can no longer continue and needs to be filled—at a time when everybody is talking about a new evangelization.

2. What Kind of Pastoral Care for the Mentally Ill?

The task of helping and alleviating the trials of the mentally ill and serving Christ in the suffering limbs of his body which such people represent is something which should be carried out both by each baptized Christian and by the Christian community as a whole. This is a mandatory requirement of the Christian faith and cannot be limited to a mere supportive role or to spiritual and material help and assistance. It is essential to the proclamation of the Kingdom of God and must flow over into a re-

newal of the structures of the world. In order to avoid the risks of oblivion and ineffectiveness, it must be organized in the form of a clear, global, relevant, and culturally suitable pastoral initiative. Such an initiative is necessary to evangelization,[12] and the drawing up and implementation of such a pastoral project is the principal responsibility of the bishops, who must bring it into being with the help of those among their advisers, priests, members of religious orders, and lay people who are involved every day in the field of service to the mentally ill.

The pastoral gap which I referred to above can be filled only by a deep-rooted commitment to pastoral action. And by pastoral action we mean "organized action by the Church which is promoted by the clergy or by the lay faithful."[13] Such action has no other purpose but that of responding to the mission Christ has entrusted to his Church. The question which forms the title of this paper links two concepts which involve a dilemma—should we aim for assistance or pastoral care? Are we dealing here with an assistance which must be pastoral or pastoral activity which takes the form of assistance? It is my view that we are referring here to assistance which becomes pastoral action. But I also know that in relation to the mentally ill our pastoral activity does indeed often take the form of assistance. Furthermore, why should we not speak directly about pastoral care for the mentally ill and commit ourselves to speaking about assistance which has a pastoral dimension?

It is clear that not all these questions and problems can be faced up to and tackled if one seeks to discuss the action of the Church in relation to the mentally ill only in terms of pastoral assistance. To answer the question posed by this paper in a more or less relevant way—a question which I express in the following manner: What kind of pastoral care is of use for the mentally ill of today's world?—we must first of all answer two other questions: what do we mean by pastoral care and what is its purpose?

A. Pastoral Care and Evangelization

It is clear that "the mission entrusted by Christ to his Church is that of preparing for the eschatological reign through the promotion of the growth of the Body of Christ within humanity during the course of history. Considered in these terms, this mission takes only one form. But in every believer the Body of Christ only forms progressively. For this reason the Church—in order to perform her unique mission—must be involved in different kinds of mediation which conform to this organic future."[14] The Church performs this mission through evangelization because "the first task of [her] mission..., without which her other tasks would be in vain and would not really build up the Body of Christ, is evangelization. The Church must carry out this missionary task wherever the Gospel has not yet been preached whether in a geographical or a sociological sense."[15] The mentally ill are not a geographical element but a sociological reality in relation to whom the Church must carry out her missionary task. The proclamation of the Gospel message is at the center of the mission of the Church and "in essential terms involves seeing the event of Jesus Christ as a present-day mystery. Not a mere statement about God nor a simple fact belonging to the past, but the contemporary coming of God into history in order to christify history."[16]

The work of evangelization which the Church carries out in the world is the principal means by which the Word of God—who is Jesus Christ—enters into human lives. Indeed, it is through the Word that the Good News—which the Word brings in the Holy Spirit—comes to be expressed for the benefit of those who receive it. Each act of evangelization presupposes the presence of the spoken word, the normal channel by which the Word of God is propagated. This follows the example and the mission of Christ himself. But the history of salvation also shows us that God has always spoken through facts which render visible, and attest to the veracity

of, what is said or spoken. This means that "every evangelization requires signs which are connected to the spoken word."[17] Such signs are necessary because "for believers the sign is within the new life of faith. For non-believers the sign must be external and should emphasize the realism of the proclamation by showing the fruits of the Gospel in the world of empirical demonstration. One goes here from the more sensitive to the more spiritual, from the sign of the Gospel to the very heart of the Gospel, which gives meaning to the sign. And at the same time it is through the spoken word and through the sign that the power of the Gospel in the Holy Spirit touches welcoming hearts. The signs also bear witness".[18] The evangelizing mission of the Church has a collective goal: the building up of the Body of Christ. This objective means that the Church should also employ collective signs.

B. In Search of a New Pastoral Initiative

From these reflections on the mission of the Church in the world and the means by which it can be carried out in order to achieve pastoral care for the mentally ill, we can draw the following conclusions. Pastoral care for the mentally ill must take two directions: that of the proclamation of the spoken word and that of its proclamation through individual and collective signs.

The proclamation of the word is directed towards ensuring the welcoming of Jesus Christ into the life of every person. This welcoming usually occurs through conversion and then entrance into the Christian community. The proclamation of the word must be carried out within the framework of small groups or through a one-to-one relationship. It should seek to wake men from their torpor and slumber—without, however, ever violating their liberty of conscience. It must be suitable to the condition of those to whom it is addressed, people to whom the mercy of God must also be shown.[19] It must take the form of *a catechesis which is culturally suited to the real situa-*

tion and condition of mentally ill people. The question of a culturally suitable catechesis brings us to the problem of "inculturation." By this term is meant "the embodiment of the Christian life and message in a specific cultural area so that not only is this experience expressed through the elements of the culture in question (if things were left merely at this level one would be dealing with an eminently superficial adaptation), but it also becomes a source of inspiration which is at one and the same time both a guideline and a unifying force which transforms and creates anew this culture, indeed promoting thereby a new 'creation.'"[20]

The deep insertion of the Christian faith and life into a specific culture is the fundamental principle of inculturation. A successful process of inculturation can give rise to three essential features. First of all, there is the *presentation* of the message and the values of the Gospel in the forms and terms specific to a given culture. Then there is the *new cultural development* which springs from the sowing of the Gospel within a culture. Finally, there is the *new expression* which the members of a specific culture who have received Christian faith proceed to give to the Gospel.[21] A culturally adapted catechesis must be the product of this process, and this process must be within the reach of a Church such as ours, which has been engaged in evangelization for over a century. Such a catechesis is required, above all, in a situation where most mentally ill people experience socialization only in their families or their villages—realities where the weight of local culture is still very important.

When we refer to a *catechesis suitable to the real situation of the mentally ill* we mean simply that we should be fully aware of the seriousness of the handicaps and the ability to be independent of these mentally ill people. The word of God cannot be offered in the same way and with the same approach to a person suffering from a trisomy syndrome, a person suffering from Alzheimer's disease, a psychotic (schizophrenic or autistic person), to an individual suffering from aphasia, to a psychas-

thenic, to a neurotic, or to a depressive—to list only the more obvious. The clinical and medical-social treatment of these very different situations and conditions requires methods and techniques which are varied and different. A proclamation of the word of God which is to reach the victims of mental illness should also be suitable and appropriate to the special characteristics of each individual situation. But pastoral workers often do not have the training and the grounding to achieve this end. For this reason the Church should often take advantage of the help of people who are qualified in this field.

The *proclamation of the word of God through individual and collective signs* bears witness to the power of Jesus Christ's being welcomed by every baptized person and every community of believers. It further attests to the fruitfulness of the Gospel within the Christian community. These signs are at the service of evangelization because they can lead lives which are lost in drowsiness to listen to the spoken word of God. The welcoming of Jesus Christ should not close Christians within themselves but—on the contrary—open them to others and in particular to the poorest and most afflicted in whom indeed they recognize the presence of Christ. Such signs can take the form of *practical works of faith and charity* in relation to people who suffer. Practical works of charity, for example, may take the form of *individual or organized visits* of the faithful to sick people in order to express their fraternity or their solidarity. There can also be *material help* to reduce the suffering or the burdens of those who suffer or *spiritual help through the sacraments* at very difficult moments in the lives of sick people.

All this is already done in our local Church so as to provide help to the mentally ill even though—and this is something which has to be recognized—few of the lay faithful or lay apostolic groups are really involved in such activity. We have to ensure that Christians perceive this duty as being an impelling part of their faith. This means that our catechumenate

should lay great stress both upon the need for orthodoxy (sound doctrine) and upon the need for orthopraxis (Christian practice which conforms to the message of Jesus). It may be observed that up to the present time our pastoral assistance to the mentally ill has involved the development, above all, of the dual dimension of charitable assistance (material help and visits) and sacramental help at the moment of death. This is the pastoral work exemplified by the behavior of the Good Samaritan, a proclamation of the word of God through signs of fraternal help and care. Such pastoral activity along these lines is necessary not only because it is required by Christian faith but also because it imparts credibility to the proclamation of the word of God.

Pastoral action which takes the form of charitable help towards mentally ill people who are very poor and spiritual assistance (of a sacramental character) to those who are about to meet death is necessary, but it is also markedly limited. It is limited because those who practice it confine themselves to *assistance*. They do not pay sufficient attention to all the aspects of the individual condition and situation of the mentally ill person. For example, what is his social and family environment and what is the real level of his independence? The giving of help to a mentally ill person often means helping him deal with something he lacks; it means fighting against everything which injures his condition. In certain cases, the assistance supplied by the Church cannot go beyond material help and support. This is what the Church already does in relation to those who have no autonomy of action and suffer from intense levels of poverty. In other cases the Church could help those people whose health could improve as a result of treatment or suitable rehabilitative aid. In this way, such people could be helped to regain their dignity by enabling them to support themselves from a material point of view, or at least in part. Medical-social centers engaged in such activity have still to be brought into being in our country. Although our Church may lack the means by

which to create such centers, it remains true that public authorities could be encouraged by the Church to establish such centers and to support their day-to-day running and administration.

In yet other cases the Church could pave the way in the fight against certain traditional ways of treating and understanding mental illness. Our pastoral activity in relation to the mentally ill would gain from an integration of the dimension of *liberation*—that is, a campaign against social sin which in the Congo takes the form of families abandoning their mentally ill members, on the one hand, and through a rejection of inhuman living conditionsw which are often imposed upon the mentally ill by traditional forms of treatment which pay little attention to the dignity of the individual, on the other. All this should be done, however, without forgetting the social causes of mental illness, where these really exist. We are referring here to a collective struggle to achieve a transformation of social structures—this fight against social sin forms an integral part of evangelization. Such an initiative would also help to open the human contexts where it operates to the proclamation of the word of God. We should therefore go beyond the logic of assistance. *Aliis verbis:* what is needed is a pastoral initiative in relation to the mentally ill fully suited to the new evangelization which, to be complete and fully appropriate, must not be confined to mere assistance.

This pastoral action *must be at the same time both assistance and liberation*. We must therefore find new ways by which to deal with the problems involved in the individual condition of mental illness. Such pastoral activity would clearly rise above the efforts of the apostolic workers who are currently involved in helping the mentally ill. In order to achieve the Church's goals of evangelization, those who are responsible for pastoral care in the field of health must accept the idea of acting in cooperation with other ecclesiastical elements and with the public authorities. How can the Church address herself to the social and

ethical problems which surround and/or accompany mental illness caused by the use of drugs or connected with the condition of trisomy 21—to give just two examples—if she does not cooperate with the public authorities, with legislators, and with the various medical and associated bodies? This kind of cooperation could help and foster the search for solutions on a very broad front. What we need, therefore, is pastoral activity based upon *openness and cooperation*. It is most important, however, that such an initiative is not programmed and put into practice outside communion with the Holy Father and the bishops—with those, that is, who are responsible for the evangelizing mission of the Church.

Pastoral care for the mentally ill has not yet become a challenge involving a *proclamation of the evangelical word which is both culturally suitable*, on the one hand, and a *proclamation of the same word through individual and collective signs which at the same time integrate the dimension of assistance and liberation*, on the other, within the range of activities of our local Church in the Congo. We have for long been dedicated to care and help, and this is something which must never be lost from view because it involves expressing the face of the Good Samaritan to many of those who are "wounded by life"—something, it may be pointed out, which is an imperative of our faith. But today we should also strive to be concerned with how we can transmit the Gospel message and fight against the different forms of social sin in order to ensure that our pastoral activity in relation to the mentally ill involves a complete and integral evangelization.

However, "pastoral care can only be a reality which is in perpetual evolution. It should always redefine itself in line with the ways in which the advance of history reveals new aspects of the divine work which itself is to be followed. It must express itself in the form of a functioning human project, but it must never cease to take place because it is rooted in a divine mission which rises above it and whose breadth and size al-

ways escapes us. It lives by the tension between this project and this mission and it is, by nature, open."[22] It is for this reason that pastoral care can be born only within the contours of a debate which is continually in progress.

3. The Search for a Suitable Spirituality

As I have already pointed out in this paper, it is my opinion that this international conference constitutes a helpful framework by which to improve the quality of our commitment and approach to the sick. When we address ourselves to the question of the spiritual lives of the mentally ill, we necessarily set in motion a search for a spirituality which is suitable and appropriate to their condition. But can we look for such a spirituality without first of all establishing what we actually mean by this concept?

In a general fashion—and without getting lost in technical details—we can define "spirituality" as a set of ideas, principles, methods, and techniques which enable man to draw near to God. Spirituality is concerned first and foremost with the personal relationship between man and God—that is, man's attempt to reach God in order to be transformed by Him and to live in communion with Him. Where this is achieved we can speak about a spiritual life. But this term can also refer to an organized body which has its own nature and its own special spiritual tradition. This is because "spirituality is like efflorescence, the spontaneous and personal expression of spiritual life—that is, its invitation to share in it."[23] Thus it is that we talk about an Ignatian, Franciscan, or Benedictine form of spirituality. Spirituality, therefore, can take the form of elements which give rise to an authentic spiritual life or to communicable factors which reflect a specific spiritual tradition designed to promote and sustain spirituality. These two dimensions to spirituality will now be discussed in the last part of this paper. In the light of these considerations we must now reformulate our question in

the following way: in being near to the mentally ill person what kind of spirituality should we choose for him and upon which aspect of Christian mystery should we place emphasis?

A. The Spiritual Life of the Mentally Ill Person

Spiritual life can only be that life engendered by the Spirit given by Christ. Nourished by faith, it becomes defined through a relationship with God made possible by his Spirit and flourishes in the presence of God. It is the relationship with God which is of preeminent importance in spiritual life, and this life is the reply of the Christian to the call for communion which God makes to him. Like every other Christian—and despite the handicap which afflicts his rational faculties—the mentally ill person is called to take part in this communion. When the "spoken word" is proclaimed in such a way as to enable him to receive it, he also experiences the need to fight the spiritual fight and to open himself to the grace of God through faith. Those who have experienced the growth and development of faith in the mentally ill know all about this process. But to ensure that the response of these mentally ill people to the call of God becomes ever more authentic it must be sustained and supported by a *life of personal and community prayer* and by a suitable *approach and attitude to the sacraments*.

Although, obviously enough, it should be adapted to their real condition and situation, the spiritual life of the mentally ill which the pastoral work of the Church is called upon to promote should first of all be *Christian and Catholic*. These characteristics will be displayed in proportion to the establishment within that life of an experience of a personal relationship with God. This means that the spiritual life of the mentally ill should be based upon the Word of God and upon faith—the Word by which God calls man to Him and the faith by which man recognizes and accepts this call.[24] In the Catholic Church there cannot be a spiritual life which is "authentic

without the achievement of a co-presence of other believers, with Christ and us, in the Church. And this is necessary not only because it is an essential means but also because it involves the very purpose itself of spiritual life."[25] For this reason we should be fully aware that the spiritual life of a mentally ill person will become more Catholic the more he develops his personal relationship with God within the Church. This is "because the Word of God is spoken to us within the Church and it is inseparable from the Church to such an extent that we can only really accept it in the way that it is communicated to us by the Church."[26]

The poverty of the mentally ill person leads him to pray—that is, to turn towards the Other, towards God. His prayer, therefore, must be nourished by biblical faith and by the tradition of the Church. Like every other Christian, he should look for and find the principal source of his life of prayer in the Old and New Testaments. But the Bible should be presented to him in a way which takes his limits fully into account. Since he is handicapped in relation to his rational faculties, it will be almost impossible for him to engage in such forms of prayer as meditation and contemplation, both of which require a major employment of the mind. However, it will be relatively easy for him to *pray personally with his own body and his rosary*—to give just two examples. These two forms of prayer can be easily used by mentally ill people at an individual level but they can be even more easily practiced within a group context. *Prayer groups based upon charismatic renewal*, where great importance is given to the word and the body can be of very great help in developing the prayer life of the mentally ill person. *Praying the rosary* can involve its mysteries being explained by gestures and images. These are two forms of prayer which should be encouraged. In becoming familiar with them mentally ill people can see their relationship with God grow deeper and flower in the context of the practical expressions of faith.

In addition to these forms of prayer, which can be experienced

both personally and with others, great emphasis should be placed upon *taking part in liturgical assemblies*. "The liturgical assembly of the Church is the assembly of the people of God, summoned by God himself principally to hear his word."[27] Suffering members of the Church, but members of the Church in the full sense of the term, mentally ill people should take part in her prayer and be the subjects of her prayer. They will feel accepted and welcomed as brothers and sisters whose presence completes the body of Christ. They will remind other limbs of the Body of Christ of the duty to pray for them.

The culminating point in shared liturgical celebrations must be the *celebration of the Eucharist*. Christ's work of salvation centers around the celebration of the last supper. The Eucharist is the prototype of every shared prayer in the Church and reminds us of the cross of Christ. It invites us to contemplate the cross within the suffering limbs of his body—that is, in this case, the mentally ill. The liturgical assemblies are certainly the places where the word of God is proclaimed, but they should also be the place where there is a *sacramental manifestation of salvation*. "The word of God which is illuminated by the ecclesiastical tradition is captured to the utmost in a mystery—Christ and his cross. But in the Church the mystery is not merely proclaimed. With the authority itself of God, it is proclaimed as being present. It is therefore represented and made present for us in us. The sacraments have the role of supplying us with this presence and communicating to us the permanent actual reality of this mystery. This explains the close links between the divine Word proclaimed by the Church and the sacraments which the Church celebrates and administers to us."[28] The sacraments express the redemptive love of God. Through the sacraments the Church represents the salvation brought by Jesus and promotes the spiritual lives of mentally ill people. The sacraments are important because they render such people more holy and help them to live out their communion with the

mystery of the cross of Christ. In order to benefit to the full from all the graces of the sacraments, mentally ill people must be helped to welcome and receive them in faith.

B. Certain Key Features of a Spirituality for the Mentally Ill

Spirituality is also a kind of doctrinal corpus which has been drawn up to support and accompany the efforts Christians make in their search for authentic communion with God.

Because it has this characteristic, it can be transmitted and communicated. In order to facilitate its transmission or communication, it must be presented in the form of certain key aspects. Mentally ill people, in one way or another, are handicapped in relation to their rational faculties. This kind of handicap often makes them incapable of intellectual activity and elaboration. The key aspects of the kind of spirituality which are being proposed in this paper are not directed principally to the mentally ill, but to pastoral workers—whether members of the clergy or the lay faithful—who should discover the best means by which to transmit this spirituality and ensure that it is marked by vitality. A perception of these key aspects which is highly systematic in character forms a part of helping the mentally ill to live out their spiritual lives in a positive fashion. It is therefore a necessary feature of pastoral work and activity.

But these key elements cannot be offered without reference to the condition and lives of the individuals who are called upon to receive them. Pastoral workers must pay especial attention to each individual mentally ill person whom they help and support and should base their action upon these vital aspects. These key elements are rooted in the Word of God and ecclesiastical tradition. They are human dignity, the special love which God feels for the weak, spiritual childhood, sharing in the cross of Christ, and hope in the resurrection. Why these elements in particular and in what ways can they help the spiritual lives of mentally ill people?

Human Dignity

Despite their handicaps, mentally ill people retain their whole dignity—something which is received not only from the fact that they are created "in the image and likeness" of God (Gen 1:26) but also from their vocation to live in communion with Him. This is what Vatican II made clear when it declared "the highest reason for the dignity of man lies in his vocation to communion with God. From the moment of his birth man is invited to a dialogue with God. Indeed, he exists only because he is created by the love of God and he is always protected by God's love. In the same way man does not live fully in conformity to truth if he does not recognize God freely and he does not place himself in the hands of his Creator."[29] Indeed, man is the only creature on earth whom God wanted for his own sake. If emphasis is placed upon this dignity of the mentally ill in helping and supporting them, this can help them to accept their handicap and to see their handicap not as a divine punishment but as a feature of beings who are unique in the eyes of God and have their own place in the creation. They can thus also be opened to the mystery of the love of God.

The Special Love of God for the Weak

The teaching of the prophets and of Jesus shows that the weak and the poor are the object of a special love on the part of God and that they are the privileged heirs to his kingdom. For them this love is the expression of God's intention to honor his promises. An awareness of this love on the part of mentally ill people—something which is in contrast to the attitude of a society which often finds no better solution to their condition than that of excluding them—can help them to rediscover faith in their own lives. The feeling of being loved, notwithstanding everything and above everything else, can in turn be of help in the promotion and development of their spiritual childhood.

Spiritual Childhood

Jesus engages in the same behavior towards children as that of God. He beatifies them (Mk 10:16) and thereby reveals their predisposition to enter into his kingdom. Each and every Christian is invited to welcome the Kingdom of God like a child (Mk 10:15) and to agree to become a child once again (Mt 18:3) in order to enter the Kingdom of God. To be or to become a child means to become humble. This spiritual childhood leads to total trust in God. Taught by the Gospel and constantly inspired by St. Thérèse of the Child Jesus, for mentally ill people this childhood can constitute a path to finding peace of heart.

Sharing in the Cross of Christ

The Cross of Christ evokes the sufferings of Christ. St. Paul often observes that the Christian is called upon to make Christ live within him. Suffering is a path of communion with the mystery of the Cross of Christ. "The Christian lives in a state where 'it is no longer he who lives, but Christ who lives in him' (Ga 2:20), and as a result the sufferings of the Christian are the 'sufferings of Christ' (2 Co 1:5). The Christian belongs to Christ through his own body and suffering makes him like Christ (Phil 3:10)."[30] If emphasis is placed upon this reality, mentally ill people can be helped to bear their suffering more easily and to bestow upon it a mystical significance.

Hope in the Resurrection

The reality of hope demonstrates the future of happiness to which all men are called in their lives as Christians. Trust in God and in his intention to honor his promises nourish this hope. The resurrection of Christ bears witness to God's honoring of his promises and is thus at the center of the hope of the Christian. The dead and risen Jesus Christ is the future of man. He calls upon his disciples to follow him and thus to accept suffering and death to take part in his glory (Mt 16:24ss). Each and every Christian who is in communion with Christ's suffering can hope to achieve communion with his glory. Reference to this aspect of the Christian experience—an aspect upon which a

large number of spiritual teachers (Ignatius of Loyola, St. John of the Cross) have laid great emphasis—can also be useful in helping and supporting people who are mentally ill. In particular, it can help them to keep their hope alive when they are engaged in treading their path of the cross.

Real and authentic pastoral care for the mentally ill cannot omit these key elements which should be communicated within the framework of catechesis, liturgical celebrations, and the individual spiritual support and advice which are promoted. Spiritual help to the mentally ill based upon these simple, clear, and profoundly evangelical ideas can help our brothers and sisters to accept their condition. It can also help them to transform it into a means by which to engage in real praise of God and to achieve a real encounter with Him. These are all insights which, if judged to be of worth by specialists in the field of spiritual theology, could be subjected to a more rigorous process of elaboration and development.

Conclusion

If we recognize the complexity of his situation and condition and the problems which they involve, the mentally ill person clearly constitutes at the present time a real challenge for the pastoral work of the Church—a challenge at the level of the training of pastoral workers, the work of our theologians, and our global pastoral initiative. Today the Church should involve herself with courage in new experiences but at the same time she should not turn her back on her past experience. This is our most deepest feeling.

Indeed, through what I have just said we can already see that the pastoral activity and the spirituality that we are all seeking to achieve with full respect for the special local conditions of our Churches—which we hope will help such Churches to carry out their evangelizing mission towards the mentally ill—must oblige us to reflect upon the question of the training and formation of future pastoral workers and to

modernize the knowledge of those who are already working in this field. Our local Churches must take advantage of the modern methods and techniques which are employed to help and advise mentally ill people and to establish communication with them. These pastoral workers must cooperate with the structures of their local Churches or within the broader framework of the wider Church. In addition, the special character of the condition of mentally ill people opens up new fields of research and study for our theologians.

In order to achieve greater effectiveness and fruitfulness in her evangelizing mission, the Church's pastoral role in relation to the mentally ill must not become separate from her overall pastoral purpose. Priests must become used to bearing in mind and perceiving the social and individual dimension to sin, to the spiritual struggle, and to the building of the Kingdom. Such a path can increasingly lead every baptized Christian to honor the implications of his duty to charity towards those "wounded by life" and the suffering limbs of the Body of Christ—that is, our brothers and sisters.

May these simple words which spring from the experience and the dream of a priest who shares a commitment with the many people who help him—whether priests, members of religious orders, or lay people—to an ecclesial presence in the world of health policy and care and contribute to a common search for pastoral care which meets to the full the requirements and aspirations of the new evangelization.

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Notes

[1] *Catechism of the Catholic Church*, no. 1868.

[2] *Ibid.*, no. 1869.

[3] See the healing of the man born blind in Jn 9:1ss.

[4] XAVIER LEON-DUFOUR, *Vocabulaire de Théologie Biblique* (Paris, Cerf, 1981), p. 700.

[5] *Ibid.* p. 1146.

[6] *Ibid.*, p. 702.

[7] See the address of John Paul II to mark the Fourth World Day of the Sick, 11 February 1996.

[8] See the Encyclical by John Paul II, *Centesimus Annus*, no. 57.

[9] See the instruction issued by the Congregation for the Doctrine of the Faith: *Libertatis Conscientia*, no. 68.

[10] See note 7.

[11] The reference here is to movements of lay apostolate of which Christian health care workers form a part.

[12] Indeed, as the Holy Father often observes, pastoral care in the health field which is perfectly organized is rooted in evangelizationo.

[13] See "Pastorale" in *Catholicisme*, X, p. 766, col. 2.

[14] See "Evangélisation" in *Catholicisme*, IV, p. 755, col. 2.

[15] *Ibid.*, p. 757.

[16] *Ibid.*, p. 758.

[17] *Ibidem.*

[18] *Ibid.*, p. 760.

[19] *Ibid.*, pp. 759-760.

[20] P.ARRUPEE, "Lettera sull'Inculturazione", *Acta Romana* XVII, 1978, p. 283. 21. Théoneste Nkeramihigo, "Préalables pour une Conception Inculturée de la Formation Jésuite en Afrique et Madagscar," unpublished text, p. 3.

[21] THÉONESTE NKERAMIHIGO, *Préalables pour une conception inculturée de la formation jésuite en Afrique et Madagacar,* Inédit, p 3.

[22] *Ibid.*, p. 768, col. 1-2.

[23] See the contribution by MICHEL DUPUIS to the article on spirituality in the *Dictionary of Spirituality*, p. 1164.

[24] L.BOUYER, *Introduction à la Vie Spirituelle: Précis de Théologie Ascétique et Mystique* (Paris/Tournai, Desclée & Cie, 1960), p. 27.
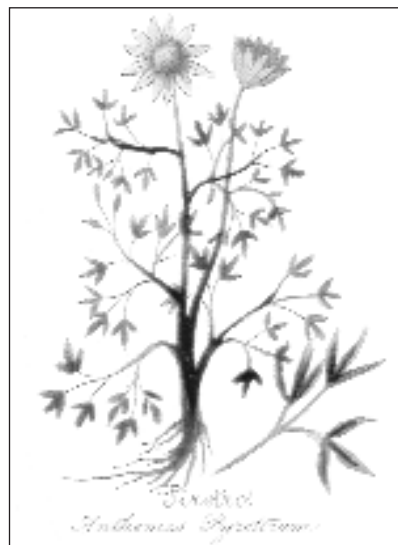
[25] *Ibid.*, p. 13.

[26] *Ibid.*, p. 27.

[27] *Ibid.*, p. 30.

[28] *Ibid.*, p. 107.

[29] *Gaudium et Spes*, no. 19, 1.

[30] See the article on suffering in X. LEON-DUFOUR, *op. cit.*, p. 1524.

Anthemis Pyrethrum

Round
Table

Legislation on
Mental Illness

PHILIPP JENNINGER

Legislation on the Mentally Handicapped in Germany

1. Introduction

The Constitution of the Federal Republic of Germany guarantees all citizens respect for their human dignity, the right to life and the right to physical integrity, the free development of their personalities, treatment on an equal footing by government authorities, and the upholding of the fundamental principles of the welfare state.

These rights and all the other fundamental rights are also bestowed in Germany upon the mentally handicapped, whatever the cause, the character or the seriousness of their handicap. All other juridical laws and regulations apply in the same way to handicapped people whatever the level of their disability, and for this reason acts of discrimination in relation to the disabled in Germany are not allowed according to our national law. This expresses an interpretation of basic principles laid down by the state.

However, a mutual readiness on the part of the sick and the healthy to accept each other—a mutual process which should be implemented as such—remains of fundamental importance if the mentally disabled are to play a full part in the social life of our country. The concept of the human being expressed in our national Constitution requires integration, cooperation, and participation. Everybody must cooperate in the achievement of this goal, whether ordinary citizens, members of the Church hierarchy, or professional or voluntary health care workers. Unfortunately, in our country solidarity towards disabled people and respect for their human dignity in daily life cannot as yet be considered real features of the way we live. In the same way, real equality of opportunity between disabled people and nondisabled people has not yet been reached in all sections and fields of our national life.

They thus remain a task and a permanent challenge in a country which wishes to consider itself civilized and to create a climate in which the disabled do not feel discriminated against in the way they live their lives, in which, wherever possible, equality of opportunity is ensured, and where the disadvantages which still remain are greatly reduced.

2. The Juridical Position of the Mentally Disabled Person

1. Juridical Capacity

The first part of our civil code lays down that every individual acquires juridical capacity from the moment of his birth, regardless of his sex or his physical or mental condition. This juridical capacity is inalienable and irremovable. Each individual thus has a large number of rights such as the right to welfare support and the right to be the owner of goods or to inherit them.

The second article of the Constitution guarantees to the mentally disabled person, as to others, the right to the free development of his or her personality as long as this does not come into conflict with the rights of other people or with the provisions of the Constitution. The mentally disabled person, like other people, has the right to life and physical integrity. The freedom of his person is inviolable. The same may be said in relation to liberty of thought and of religious faith and practice.

Article 20 of the Constitution guarantees the individual the right to enjoy the security offered by the welfare state.

Article 103 guarantees everybody the right to be heard by a judge.

2. The Capacity to Act of the Mentally Disabled Person

Not all people who have a juridical capacity can achieve the upholding of their rights or the performance of their duties. We should therefore distinguish between general juridical capacity and the capacity to act. The capacity to act is the capacity to generate juridical effects through one's own behavior and to be able to engage in the independent exercise of one's rights—for example, to sign contracts, take part in a trial, and so forth. But it also means being able to undertake an obligation such as being held responsible for damages.

The capacity to act includes legal responsibility relating to agreements and criminal acts. Such a capacity is in part determined by the age of the person but in part also by his mental state. According to German law, the "person who has reached the age of eighteen is held to be completely responsible for what he does except in the case of the person who is in a pathological state of mental infirmity at such a level as to exclude the free exercise of personal will, except where this state is of a transitory nature" (section 104 of the civil code). Pathological disturbance of mental activity takes place when an individual is incapable of the rational and independent management of his will. This is always the case when an individual does not have the neces-

sary faculties of criticism or judgment, when he is not able to reflect upon his own decisions in a reasonable way, and when he is unable to form a suitable idea of what the possible consequences of his actions might be. In other words, when the individual is incapable of acting. In such cases the will of the person has no juridical relevance at all and any acts of will are null and void. A person of adult age who is in reality unable to consent cannot sign a contract. This form of effective incapacity is very important in the daily work of the mentally disabled because it is in a certain sense a corrective by which contracts are annulled which have been signed by a person who is not capable of judgment and who is not aware of their significance and implications.

It is not, however, true that this rule defines or establishes the incapacity to consent in matters of civil agreement of an adult person with a mental handicap in overall terms. The invalidity of a juridical act of consent involving a mentally handicapped person is only established when the disabled person himself, or the other party, asserts or even demonstrates that at the moment of the conclusion of the contract there was an incapacity to consent. The circumstances of each individual case are then examined in a judicial context. The person who claims that there is juridical incapacity to consent must prove that this is so because for those of adult age the law presumes the presence of a capacity to consent.

3. The Civil Responsibility of Mentally Disabled People

The questions of responsibility which can arise in relation to care for the mentally disabled for the most part concern the payment of damages in a civil court or tribunal and are largely a matter of the repayment of debts.

In our civil law offenses are illicit acts carried out against certain juridical goods such as health, freedom, and property. The performance of an illicit act in the civil law sphere produces the right to compensation for the damage to the person who has been wronged.

Anybody can commit an illicit act, including children and the mentally disabled. But, on the whole, illicit acts require the payment of damages only when the author of those acts is culpably aware of what he is doing. The person who causes damage in a malicious or culpable fashion is said to have acted with culpability.

It is believed that acts are carried out with culpability only when the author of the violation of the juridical good does so with wrongfully-intentioned will. It is assumed that the author could have avoided that act of will which gave rise to the damage. The question of whether culpability is involved therefore depends first of all on the assumption of the presence of the freedom to make decisions and autonomy of will on the part of the person who carries out the act. Section 827 of the civil code lays down that a person in a condition of pathological disturbance of mental activity which rules out the free formation of will or brings about a condition of unawareness is not responsible for damage caused to a third party. The presence of such forms of disturbance is assumed to be operative in cases of serious mental handicap. But the presence of less serious mental disability does not necessarily lead to the supposition that there is an incapacity to commit illicit works. Here, also, each case must be examined on its merits.

In general terms, therefore, people with mental handicaps can also be required to pay damages. The person who invokes an incapacity to commit illicit acts is called upon to demonstrate the validity of his assertion. Only a medical examination can establish in each case whether the mental disability is such as to justify the exclusion of responsibility. The mentally disabled person is held to be responsible where it is not possible to prove his incapacity to commit illicit acts.

4. The Law on Social Security

The law on social security which came into effect on January 1, 1996 has greatly improved the juridical status of adult mentally disabled persons. In Germany this law has eliminated the discriminatory practice of interdiction and has replaced the obsolete juridical norms for the defence of adults and the custody of the mentally or physically infirm with a new and flexible legislative instrument which envisages different kinds of personal care and assistance which are to be established by the judge according to the case in hand. By this instrument it is possible to achieve suitable solutions to the problems and difficulties presented by different kinds and degrees of illness or handicap. To help disabled people in their daily lives assistance can be provided only where there is a real need because of mental illness or mental and physical handicap. Such help is not allowed when other forms of action are deemed to be possible.

The aim of this law is to improve the care and assistance provided to individuals—that is, this law seeks to increase the personal rights of the subject and to take into account—where this is possible—the well-being of those receiving care, and their wishes and needs. Help and assistance in rehabilitation should be directed towards regaining autonomy and freedom of action.

According to these principles:

– the provision of care and assistance to individuals does not have any bearing on their capacity to act;

– the search for well-being, like an attempt to meet the wishes of the assisted person, are the main guiding principles in helping those who receive care;

– with regard to their own responsibilities, those who receive help must themselves act to exploit all the opportunities available to eliminate the illness and reduce their handicap or mitigate their consequences;

– major measures regarding juridical goods can only be applied with very severe conditions attached to them, and their sole purpose must be to act in the interests of the person receiving assistance;

– the selection of properly trained assistants and health care workers is of particular importance;

– all judicial decisions must be reconsidered every five years.

This new law greatly improves the juridical status of mentally sick and disabled people.

3. Help Envisaged by the Law for the Social Integration of Mentally Disabled Persons

For those people who are mental-

ly disabled from birth, the so-called "assistance for integration" envisaged by the Law on Social Security must be seen as the most important instrument for rehabilitation. Section ten of this law declares that, regardless of the causes of his or her handicap, each mentally or physically disabled person and every person who is likely to undergo such a handicap has the social right to those forms of help and assistance which are needed to:

– prevent, eliminate, mitigate, or impede the worsening of a disturbance or to reduce the consequences of handicap;

– and to ensure a place in the community for that person, and in particular in the world of work, which corresponds to his or her interests and capacities.

This "social right" is not only recognized in a general sense as a juridical principle in the interpretation and application of German social law, but it is also seen as the primary guideline in the policy of rehabilitation and of help to the disabled. I would like to draw attention to, and emphasize, the following principles which arise from this right. They are as follows:

– the principle that the objective is the integration of disabled people into society;

– the principle of ultimate purpose—this lays down that the forms of help and assistance which are provided must be given to all those with a handicap or who risk a handicap without reference to the cause of the handicap;

– the principle of rapid action which is directed towards containing to the greatest extent the seriousness or the consequences of disability;

– the principle that individual help and care must be supplied with reference to the practical needs of each individual handicapped person and that this must be supplied in suitable form and with appropriate methods.

4. The Chief Forms of Assistance Directed at Social Integration

1. Help for Children and Adolescents

With regard to so-called early assistance, all the measures of treatment and help for children which have still not reached school age are seen as instruments of rehabilitation. The risk of illness is a sufficient cause for such action in an individual case. On the whole, pediatricians diagnose those forms of handicap when they carry out their preventive medical examinations. After the birth of a child, doctors sign a certificate which lays down which measures of early assistance can be given to that young person. Care supplied within the family by professional practitioners forms the most important part of early assistance.

Each child with a mental handicap has the right to a place in nursery school and where possible with children who are not handicapped. Disabled and nondisabled children should be able to have the opportunity to do tasks and act and behave in a way which is natural to their age. The Law on Social Security also provides for a right to a suitable school education. This right includes, among other things, access to all those therapeutic measures designed to help disabled children and adolescents. These provisions have had a decisive role in expanding the system of "differential schools" (*Sonderschulen*) in Germany. They have also facilitated the creation of experimental schools which are state-aided. These schools have shown that it is possible to provide an education to children with a mental handicap. As a result, the local Landers in recent years have created an elaborate network of special "differential schools."

2. Help in Transport

As a rule, free transport to the centers for disabled people has formed a part of the policy of rehabilitation.

3. Housing Assistance

Help in finding and maintaining a residence suitable to the needs of a disabled person also forms part of the policy of promoting social integration. It includes both modifying a flat to meet the needs of handicapped people and in placing the disabled in special residential centers or family homes for which a state grant is available.

4. The Provisions of the Law in Relation to Residential Centers for the Mentally Disabled

The person who lives in a residential center depends in a special way upon those who organize and manage that center. The law upon residential centers seeks to defend the rights, the interests and the needs of those who live within them and of those who would like to enter them. The definition of the contract in relation to these residential centers is the central concern of these provisions. The signing of a contract between those who finance the residences and those who live in them is *obligatory*. The following principles must be respected when the contract is signed by the two parties:

a) The obligation to describe each service. Those provided by the organizers must be listed clearly and precisely in the contract and a distinction must be made between normal services and special services.

b) The centers must provide adequate space for long-term residence.

c) In the contract the constraints on freedom of action must be reduced to an absolute minimum and intrusions into the private sphere of the tenants must be treated in the same way (in full respect for the rights of the liberty of each individual as laid down by the Constitution).

d) The inhabitants must have the greatest degree of freedom possible with regard to the decorating and furnishing of their rooms with their own furniture and personal objects.

e) There must be no constraints on the right to choose their own medical doctor.

f) As a general rule, the contract must be open-ended.

g) The conventional right to terminate the contract is exclusively in the hands of the person who lives in the residential center.

h) Wherever this is possible, the financing authority must take into account the improvement or worsening of the condition of health of the tenant and adapt its services accordingly.

The above-mentioned provisions relating to the signing of the contract are an implicit right in that

they constitute rules by which to protect the tenant.

All residential centers for disabled people are under the control and supervision of suitable government agencies which have the duty to make sure that the law is correctly and well applied. Where there are instances of transgression they can intervene and take suitable measures, and may even, where necessary, close the residence.

5. Workshops for Disabled People

Those mentally disabled people who because of the nature or seriousness of their handicap are not able to take advantage of those provisions of the law designed to ensure their participation in the general labor market must be given the opportunity to work in a way which is suited to their kind of disability. This is envisaged in the so-called "workshops for the disabled" clause. The workshop for the handicapped is an institution which seeks to insert the handicapped person into the world of work. It offers a job or the opportunity to engage in work which is suitable to them when the kind or seriousness of disability from which they suffer is such as to prevent them from being inserted or re-inserted into the general labor market. The workshop must allow the disabled people to develop, increase, and reacquire their capacities and give them the opportunity to receive a suitable wage. The workshop should also be able to offer a wide range of jobs and work activity and be equipped with an in-depth and far-ranging system by which to provide assistance and support.

The system by which the disabled are paid in these workshops is still totally inadequate. In the Federal Republic of Germany the people who work in a workshop earn on average 220 marks a month. There is thus an urgent need for new forms of labor law in this area.

6. The Special Defense of Disabled People who Work within the Normal Labor Market

In the free market all workers and office workers with a mental handicap are considered as providers of labor. They thus enjoy the same rights and the same duties as those laid down by general labor law. The serious invalids who have worked for at least six months for a company or other kind of employer also enjoy the protection of the special law on serious invalids. This means that every termination of a relationship of work involving a serious invalid by the employer can only take place with the consent of a government social security office.

The period of notice can not be less than four weeks.

In relation to the actual validity of the dismissal the invalid worker has the same—indeed, more—rights than other workers to present the dismissal to a labor tribunal for judgement.

In all those companies where more than five serious invalids are employed—that is, people with an invalidity higher than 70%—a special representative committee for such invalids must be established in addition to the normal system of workers' committees. This committee must ensure that within the place of work all the laws, regulations and contracts relating to the disabled must be enforced and upheld.

7. Assistance for the Elderly and Seriously Mentally Disabled

The Law on Social Assistance lays down that the defence of the disabled person is to last for the whole of his or her life. For example, there should be no age limit applied to the provision of social care and support. Elderly mentally disabled people should be able to decide whether the assistance given to them in the workshops is still of help to them. For this reason they can decide upon how long they want to remain as workers within these workshops for the disabled. The law for the provision of assistance of 1994 lays down that an elderly mentally disabled person who is need of constant help can avail himself of free assistance supplied by specially qualified staff. Here what is of great importance is that in addition to grants for daily assistance the positive help in ensuring insertion into the world of work is not suspended—indeed, it should continue to be provided.

Concluding Observations

It is our opinion that the task of ensuring that the mentally disabled take part in the "most normal way possible in social life" is not only an obligation on the part of the state but also a responsibility of society as a whole. It has always been natural for the family, for friends and for neighbors to be especially caring towards the mentally disabled, to try to integrate them into family life and to guarantee them to the best of their ability the daily support and necessary assistance that they need. Today this task is accepted by public institutions and it is performed ever increasingly in the various sectors of private, social and public life—for example, in the spheres of education, transport, work, or free time. This takes place with the full recognition that disabled people are important in the construction of society as a whole because they show us that the completely healthy and perfect person does not exist. They allow the "normal" individual to understand that from certain points of view he himself is fragile or handicapped and this promotes a socially positive form of behavior which expresses Christian charity.

Juridical laws and orders, institutions and services of social assistance cannot but represent means and opportunities by which to achieve social integration. But such goals and aims can be achieved only if the disabled person is himself motivated. For this reason consultation and help to promote such integration must be linked to the practical motivations of those concerned, developing them to the full and understanding and appreciating all the opportunities for rehabilitation which exist in each individual case. The adoption of measures of rehabilitation can only take place with the consent of the disabled person. And because from many points of view it is difficult to develop the personality of mentally handicapped people, we must strengthen and promote—wherever this is possible—their personal initiative and self-determination, that is to say, their ability to help themselves.

Dr.Philipp JENNINGER
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RAYMOND R.M. TAI

Mental Health Law and Mental Health Services in the Republic of China

Foreword

The transformation of the Republic of China on Taiwan from a sleepy, impoverished, war-torn backwater to become one of the most vibrant industrial economies in a short forty years has earned the Chinese island dynamo world renown. But with this success came some of the common ills of modern societies—including maladjustment caused by rapid change, drastic upheavals in the social structure, erosion of the family as the basic building block of society, and more, all of which have led to a rise in mental illness.

In the nineties, issues of mental health have gained increasing importance as governments and community organizations at all levels strive to get mental illness under control. So as to meet head on the growing problems associated with mental illness, the Central Government's Department of Health (DOH) has placed higher priority on mental health policies.

This represents a major change, and an important recognition of this modern-day problem.

Much of the impetus for the greater priority of mental health comes from the basic ideals of the president of the Republic of China, Dr. Lee Tenghui. Since taking the reins of office in 1988, President Lee has emphasized the need for greater respect for human dignity, regardless of the economic, physical and mental status of the individual.

His pursuit of equality and opportunity for all has helped place the calamity of mentally ill persons at the forefront of public policy concerns. In his election campaign earlier this year, President Lee stressed long and hard the need for a kinder, more caring society, and a return to the past Chinese virtues of community self-reliance and family-based welfare.

Under the stewardship of Lee's Administration, the DOH has taken steps to integrate policies of improvement of mental health into the National Health Insurance (NHI) programs.*

Mental Health Legislation

The first Mental Health Law commission in the Republic of China on Taiwan was established in December 1981. A first draft of the Law was written by the Mental Health Association under the auspices of DOH in July 1983. But controversy over its potential implementation arose over issues such as a shortage of psychiatric professionals, and serious lack of an infrastructure in existing hospitals to handle the expected influx of patients with "new rights". Thus, the Law was postponed.

Following this failure, DOH set out to prepare for the eventual implementation of a Mental Health Law by setting up Regional Psychiatric Care Networks round the island, as well as related support programs for improving mental health care. With the joint efforts of psyichiatrists, psychologists, lawyers, social workers, consumers and families of patients, DOH has organized numerous forums to help promulgation of the Law.

These efforts led to the creation of a special task force on Mental Health Law in August 1987. A new version of the Mental Health Law was drafted in collaboration with various government agencies related to mental health. That draft was passed in 1990 by the Legislative Yuan, the central government's law-making body. It was promulgated into law by President Lee on December 7, 1990. The Law provides the legal basis for the prevention and treatment of mental illness. For President Lee, it was a watershed event in his pursuit of ensuring the rights and dignity of all citizens.

Not unlike the laws regarding mental health in other mature democracies, the Mental Health Law of the Republic of China on Taiwan is comprehensive, including fifty-two articles in six chapters. The Law provides comprehensive provisions for a wide range of mental health system facilities, treatment of patients, and the rights of patients. Its real purpose is to promote, protect and otherwise guarantee the rights and welfare of patients, and to enhance the overall mental health of the country, specially in these trying times of great social and economic adjustment to rapid and epochal change on Taiwan.

Content of the Mental Health Law

1. Definition of Mental Illness

Mental illness is defined as one involving abnormalities of mental state with respect to thinking, or of an emotional, sensory or cognitive nature, which, giving rise to hindrances in the capacity to

adjust to daily life activities, require medical treatment and care. The term includes psychosis and neurosis, as well as alcohol and drug addiction. (Article 3)

2. Mentacl Health System and Facilities
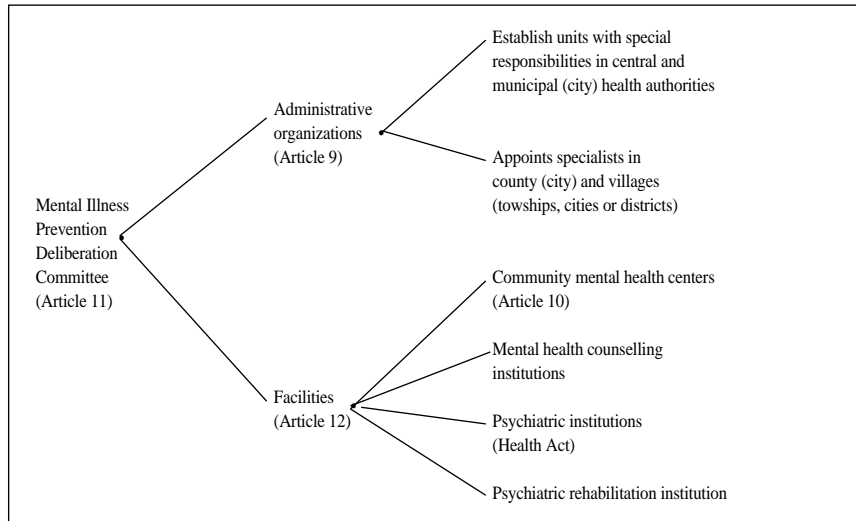
3. Protection of Mentally Ill Persons

1) "Severe mentally ill persons should be diagnosed by a specialist physician. (Article 5 [2])

2) For a severe mentally ill person, a "Caretaker" shall be assigned. (Article 14 and 15)

3) A Caretaker shall assist the mentally ill person to receive medical treatment. (Article 18)

Otherwise, the Caretaker shall bear, together with the mentally ill person, the responsibility of compensation for the harm. (Article 19 [1])

4) The institutions or settings having the purpose of detention, correction, or social welfare shall assist ill persons who have been detained for long periods to receive medical attention. When a mentally ill person has left an institution or setting, the institution or setting concerned shall immediately inform the local health authorities to provide follow-up protection. (Article 20)

4. Compulsory Hospitalization

The Law expressly deals only with one form of hospital admission, compulsory hospitalization.

Such hospitalization is to be effected when, upon initial and conforming diagnoses by two specialist physicians respectively, a severely ill person is "clearly likely to injure" others or self, or who has already acted injuriously, is deemed to require full-time hospitalization. Compulsory hospitalization for purposes of evaluation may not exceed seven days. Determinations as to the necessity for continued compusory hospitalization is to be effected through reexamination by two specialist physicians using the same criteria, after the first thirty days and at six-month intervals thereafter. (Article 21 & 23)

5. Scope of Psychiatric Care

1) Psychiatric institutions shall provide mentally ill persons with affirmative and appropriate medical treatment without unreasonable delay or detainment. (Article 26)

2) A psychiatric institution shall explain the nature of the illness, the plan of treatment, the prognosis, the reason for hospitalization, as well as the rights of the patient to the mentally ill person and his Caretaker or family members. (Article 27)

3) Psychiatric institutions may not confine the ill person, impose bodily restraint, or restrict a mentally ill person's freedom of movement. (Article 29)

4) When a special treatment is needed to be carried out by a

teaching hospital or psychiatric institution, written consent of the mentally ill person shall first be obtained. (Article 31 & 32)

6. Medical expenditures

1) Governments of each level shall subsidize impoverished mentally ill persons. (Article 33)

2) The expenses of sending a severe mentally ill person for compulsory evaluation and impatient treatment shall be borne by the central government. (Article 34)

7. Rights of Mentally Ill Persons

1) The personal dignity and legal rights and interests of mentally ill persons shall be respected and protected. (Article 36)

2) There shall be no audio recording, filming or photographing of a mentally ill person without the prior consent of the mentally ill person and his Caretaker or the mentally ill person and his family members. (Article 37)

3) Mentally ill persons who are hospitalized shall enjoy personal privacy, the right to freely communicate, and to meet visitors. (Article 38)

4) When rights and interests set forth in the law of the mentally ill person are violated, he or his Caretaker or family members may appeal to the health authorities concerned. (Article 39)

5) Mentally ill persons who have recovered may receive occupational training and guidance. (Article 40)

6) In accordance with the law, an appropriate reduction or waiver of taxes may be granted to the mentally ill person or one who provides for him. (Article 41)

Actions for the Mental Health Programs

Since the promulgation of the Mental Health Law, the Department of Health has taken the following actions:

1. Establishing a mental health administration system:

According to the Mental Health

Law, DOH at the central level should establish a direct route of administration from local health departments to the central health authority. Thus, one unit each is created in the national, provincial and municipal health authorities; and at the country (city) level, there are specifically assigned personnel for the administration of mental health programs; (Article 9)

2. Strengthening mental health services and reinforcing manpower:

Psychiatric care requires team work involving physicians, nurses, clinical psychologists, social workers and occupational therapists. Psychiatric educational programs were initiated in 1986 to provide continuos and systematic training for all levels of mental care workers. Mental health personnel has increased considerably from 1985 to 1996 (Table 1).

TABLE 2 PSYCHIATRIC CARE FACILITIES IN TAIWAN						
Means	No. of Means	Beds	No. of Patients in Day Hospital	No. of Provincial and Municipal Hospitals with Services	No. of Patients in Community Psychiatric Rehabilitation Centers	No. of Family Residence Beds
1985	79	11,066	179	5	0	18
1991	112	11,935	559	22	461	71
1996	160	14,045	1895	28	945	359
Percent increased	103%	27%	958%	460%	945%	1900%

4. Promoting the Rehabilitation of Psychiatric Patients in the Community:

Beginning 1989, action has also been taken to promote the rehabilitation of patients in communities by sponsoring public and private hospitals to set up community rehabilitation centers, shelter workshops and half-way houses to assist discharged patients in adjusting to the realities of social life and to promote

6. Prevention and Treatment of Drug Addiction:

With the increase in drug abuse in recent years, DOH is taking various preventive measures and medical care measures for addicts and to prevent drug abuse problems from becoming worse. To enable drug addicts to receive adequate medical care, DOH has designated 132 hospitals and clinics to provide adequate medical care to help drug addicts quit. In addition, DOH has also established a drug-cessation system in the psychiatric care network.

TABLE 1 PROFESSIONAL PSYCHIATRIC MANPOWER IN TAIWAN, R.O.C.					
Professional Manpower	Physicians	Nurses	Clinical Psychologists	Social Workers	Occupational Therapists
1985	202	832	48	35	79
1991	454	1292	103	112	111
1996	629	1832	170	187	204
Percent increased	211%	119%	245%	434%	158%

3. Integrating and increasing mental care facilities:

In the Republic of China on Taiwan, there are roughly 14,000 psychiatric care beds. The goal for the next five years is to increase the number of beds to 20,000. Several concrete measures are being implemented, namely:

1) Add a total of 1,000 beds to public general hospitals.

2) Encourage private organizations to invest in psychiatric care units that will add 4,000 more beds.

3) Build a new psychiatric center in the southern area that will accommodate 500 beds.

4) Use the 1,500 beds that are currently not in use in some psychiatric care institutions (Table 2).

home care in order to avoid recurrence.

5. Assisting local governments to establish community mental health centers.

Health authorities in national cities and in counties may establish community mental health centers responsible for activities related to the promotion of public mental health. Kaohsiung City - a special municipality under the central government, together with Taipei Country, Taichung County and Chiayi County of the Taiwan province, each has been assisted to set up a community mental health centre to provide mental health services to the people and to promote mental health education in the community.

7. Reinforcing public education of mental health at all levels to ascertain the correct knowledge of mental health and understanding of mental illness

To summarize, the Mental Health Law reflects our basic mental health policies, which are:

1) Emphasizing both psychiatric care and mental health;

2) Promoting positive cure and rehabilitation, reducing negative confinement and segregation;

3) Combining psychiatry with social welfare; and

4) Emphasizing both patients' rights and social security.

Based upon those basic policies, DOH has taken some positive steps in the work of prevention and treatment of mental illness. In the future, our mental health work should be based on the Mental Health Law and the conception of community psychiatry to reduce confinement and segregation of patients, to provide more efficient and accessible mental health services and to improve the state of mental health.

Conclusion

The emphasis placed on preserving human dignity for all citizens by President Lee Teng-hui, a devoted Christian, will figure prominently in the mental health policies pursued by DOH. Dignity for al regardless of one's economic, physical or mental status is one of the cornerstones of President Lee's drive to bring full democracy to Taiwan, Pescadores, Quemoy, Matsu and other islets under the sovereign control of the Republic of China.

President Lee's course and ideals mirror closely the tenets of human equality and world unity espoused by Confucius (551 - 479 B.C.). That sage left no human being unaccounted for when outlining his famous relationships between people and among nations.

Those tenets, which still carry much weight in the modern Chinese society in the Republic of China on Taiwan, coupled with President Lee's respect for human dignity for all, signal the importance attached to issues of mental health.

His Excellency RAYMOND
R.M. TAI
Chinese Ambassador to the Holy See

FRANCISCO EDUARDO TRUSSO

Legislation and Mental Health in Argentina

In Argentinean law, and I believe this is the case in most countries, a specific set of legislation relating to mental illness does not exist. The legislature has dealt with mental illness through the instruments of the civil code where that code addresses itself to the legal capacity and responsibility of individuals and the legal validity or otherwise of their actions. In the penal code, on the other hand, the mentally ill are covered by the legislation relating to impunity or mitigating and attenuating circumstances.

Mental infirmity is dealt with in this way by the Argentinean civil code to protect those who suffer from it, the society in which they live, and the third parties with whom they come into contact.

The civil code lays down that the legal responsibility of an individual is a pre-requisite for the acts of that person to be considered real and valid.

This responsibility is always assumed to be present because incapacity must be expressly declared (art. 52 of the Argentinean civil code). The "demented" are the most conspicuous members of the category of those who are defined as being not legally responsible. The Argentinean civil code follows other precedents and stresses with very great emphasis that it "protects the incapable" and seeks to "remove the impediments to their responsibility." It therefore gives them special "representatives" who act on their behalf and whose task it is to protect them and their interests. These representatives can either be private individuals (in this case they are called guardians) or the public ministry responsible for

such people can perform this role.

Who are the people that the law defines as being "incapable because of a state of dementia"? The answer is straightforward: "Those people who because of mental illness are not able to govern themselves or to manage their own property" (art. 141 C.C.A). In such a context the law has to step in and take suitable measures.

Such people are not allowed to operate in a legal sense on their own and wherever it is feared that they could cause injury to themselves or to other people they are deprived of their liberty and admitted to a special institution for the mentally ill.

Chronic alcoholics and drug-addicts are included within this category of people who are to be placed within special institutions.

The penal code declares that no prosecution can be made in relation to those people who at the moment of the crime suffered:

1) "from an inadequacy of their faculties"; 2) "from illness-induced alterations in such faculties"; and 3) "from mental alienation." In the case of the third condition the judge can order the individual to be placed within a lunatic asylum. In the other two circumstances he can order the person to be admitted to a "suitable institution."

The aim of these clauses is to *protect* those who suffer from dementia or from alterations in their faculties, and to protect third parties to whom they are linked in a juridical sense. At the same time, naturally enough, the intention of these provisions is to protect society as whole.

Argentinean legislation consid-

ers a "state of violent emotion" as a mitigating circumstance in deciding what the punishment for a criminal act should be. This state of violence is placed on a par with alterations in mental faculties. For this reason this subject requires special consideration and analysis in this paper.

The Italian penal code does not see this condition as a mitigating circumstance. Article 90 of that code declares that "states of emotion or passion neither exclude nor reduce imputability."

At the same time in increasing or reducing the punishment attention must be paid to the various circumstances which led the individual to commit his criminal act. Thus "the poverty or the difficulties of obtaining a living for himself or his family" acts as an attenuating factor, and in cases of "violence or rape" or "the abandonment of people" where the victim of the criminal act "lacks his or her rational faculties" the punishment must be increased.

Marriage Law

The Argentinean civil code lays down that the "permanent or transitory loss of reason, irrespective of the causes," is an impediment to contracting marriage and, when present at the moment of marriage, leads to the annulment of the validity of that marriage.

The Code of Canon Law, which operates on a broader front than its civil counterpart in this area of contracting marriage, lays down in canon 1095: "The following are incapable of contracting marriage: 1) those who have an inadequate lev-

el of reason; 2) those who are seriously lacking in their capacity to judge in relation to the essential rights and duties of marriage, involving, as they do, mutual giving and receiving; and 3) those who cannot assume the essential obligations of marriage because of psychic factors."

The marriage partner who at the moment of marriage is not of sound mind or does not possess the powers of judgement which enable him or her to perceive, understand or accept the essential rights and duties of the mutual giving and receiving of marriage, or is impeded from assuming the essential obligations of marriage, does not have the capacity which is necessary to engage in that special act of will which is pivotal to the consent to marriage.

Lack of a Sufficient Use of Reason

Lack of a sufficient use of reason is deemed to exist in those people who suffer from a mental illness and at the moment of consent are deprived of the use of their own faculties of understanding and volition—elements which are considered essential to the validity of a human act. This definition also applies to those people who, at the moment of expressing their consent to marriage, suffer from a mental disturbance (such as states of disorder, drug-addiction, alcoholism, drunkenness, sleep-walking, hypnosis, etc.) which—whether or not they constitute an actual mental illness from a medical point of view—cause a lack of self-government and of the use of their faculties of understanding and volition. In law, such a state is placed on the same level as the lack of a sufficient use of reason and means that the acts which are carried out while this state is operative and present cannot be considered as being full and responsible human acts.

A Serious Lack of Powers of Judgment

The expression "powers of judgment" does not so much refer to the cognitive ability of the individual or his powers of intellectual perception as to the level of personal maturity he has reached. Such maturity enables the individual to understand and perceive the essential rights and duties of marriage. The expression "serious lack" is connected to the notion of "powers of judgment," which is a legal concept. As a result, it is not the seriousness of the psychic anomaly, but the seriousness of the lack of powers of judgment which gives rise to the inability to consent and to the invalidity of the act. What is decisive is not so much the illness or the mental disorder which has created the serious lack but the fact that this lack is really produced and that it deprives the individual of his powers of judgment. The seriousness of the defect is seen in the light of an *objective* criterion which the same code of canon law itself supplies—that is, "the essential rights and duties of marriage which must be mutually assumed and accepted."

This is a factor which is distinct and separate from the question of the insufficient use of reason. From the first decades of this century canon law, when approaching the subject of mental illness, has asserted that the only incapacitating criterion is that of a reduced level in the use of reason. In cases of marriage between people under the age of puberty, St Thomas (IV Sent. d. 34q. 1 to 4; d.27 q.2 to 2 and Suppl.q.43 ad.2; q.58 a.5 ad.1) and Sánchez (*De Sancto Matrimonii Sacramento*, I disp. 8 n.5; disp.16 n.16; VII disp. 104 nos. 5,21,22, and 27), like all the following authorities and the system of jurisprudence itself, always required (in addition to the use of reason and the suitability of the marriage partners) a sufficient level of powers of judgment to allow "the assumption of obligations or the understanding of the nature of consent to marriage."

The jurisprudence practiced by the Sacra Rota (Sent C.Sabbatani 24/2/1961) involves reducing the importance of the very static criteria of the use of reason and the deliberative capacity, which have to be present for a mortal sin to be committed, in favor of a more dynamic criterion—the presence of that power of judgement which is a prerequisite for marriage. This is seen as the only proof of the validity of consent to marriage in the case of every individual, including those suffering from mental illness. Debate among legal experts as to the specific and precise limits to this power of judgment has led to a reliable conclusion: "Reference to similar criteria which are applied to penal responsibility in the context of those of the same age engaged in marriage" (cf Sent. C. Felici, 3.12.1957).

At the present time the concept of powers of judgment is very distinct from the concept of the use of reason and involves a speculative-practical—and at the same time very profound—concept of marriage. The concept of "powers of judgment" adds another faculty to that of the (abstract) faculty of cognition—the faculty of criticism—that is, the ability to perceive, think about, assess, and weigh the implications of the marriage to which one gives one's consent, the obligations which that marriage involves, and the personal motives behind the choice of such a life condition. Modern psychology holds that this critical way of perceiving matters, or this critical faculty, appears later than the faculty of cognition and is by no means the same thing. This last faculty is held to emerge at the age of about seven, whereas the faculty of criticism appears at about the age of twelve.

The need to recognize the presence of both forms of faculty—that is, the one involving speculation, which is abstract in character, and the one involving the power to assess, which implies an ability to weigh matters up and apply the conclusions of such reflection at a practical level—appears in the deliberations of the Sacred Rota for the first time in the Wynen sentence of 25.2.1941.

In order to render a person incapable of consent and thus to define a person as having a "serious lack of powers of judgment," both jurisprudence and the law do not refer to a total lack or an absolute lack of such powers. Equally, they do not refer to any kind or nature of lack. Instead, for such a lack a very serious cause is required. In the case of forms of mental illness

which are evident and manifest such causes are those belonging to the following list:

a) Psychosis. A mental disorder where the decline of the mental functions has reached such a level as to interfere in marked fashion with the individual's processes of introspection and the ability to decide or to deal with certain ordinary questions of his life or to maintain suitable forms of contact with reality.

b) Neurosis or neurotic forms of disturbance. Although the patient may have marked capacities for introspection and an assessment or appraisal of reality which has not undergone alteration, and despite the fact that he is not confused in his perception of his individual personal experiences and does not mix his fantasies with external reality, his behavior nonetheless is influenced by his neurosis or neurotic condition in extreme fashion. However, this disturbance remains within socially acceptable limits and his personality is not directly affected. This condition finds expression in excessive anxiety, symptoms of hysteria, phobias, and frequent obsessive-coercive or depressive symptoms.

c) Borderline state or limit state. This condition exists between neurosis and psychosis and involves disturbance of the patient's emotional life, pan-anxiety and pan-neurosis, and easily provoked reactions of anger and aggression which are often caused by stress, the use of drugs, and acute psychotic episodes of a paranoid character. We may also note as belonging to this condition such phenomena as hypochondria and ideas connected with the experience of depersonalization.

In his commentary on canon 1095, Luis Vela, S.J. includes personality disorders which manifest themselves in the stage of the emergence of the abstract faculty. They are to be approached and analyzed with reference to the practical responsibility of the individual as regards the fulfillment of the purpose of consent and are not to be placed solely within the framework of mental illnesses.

One is dealing here with a category of abnormalities of the personality and of the character in-

volving symptoms which affect behavior, even though they cannot be placed within the category of mental illness. When they influence the personality or character, they are termed "characterpathic," and when they affect behavior, they are called "sociopathic."

Here we encounter three principal groups with their own internally mixed sub-groups:

—Sexual pathologies: homosexuality, erotomania, perversions, and immaturity;

—Emotional pathologies: the schizoid personality, the cycloid personality, the paranoid personality, and emotional instability.

—Asocial-amoral pathologies: anti-social personalities, vagabonds, morally deficient individuals, misanthropes, and mythomaniacs.

In terms of symptoms all these forms of disturbance are characterized by interference with the emotional and volitional cohesion and balance of the individual. They give rise to unsuitable behavior and to maladjusted behavior which differ markedly in character, however, from the symptoms of psychosis or of neurosis. They are permanent and appear during youth or even during adolescence or childhood. Here one is dealing with a failure of integration of the emotional life, anachronistic forms of behavior which are regressive—all of which are elements connected to infantile ways and methods of living and experiencing the world.

The judge must not dedicate

Salep
Orchis maseur
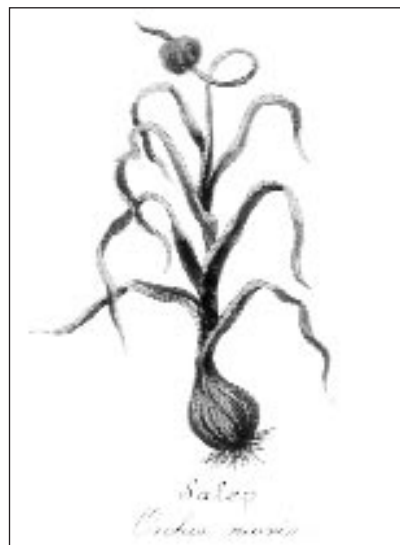
himself so much to understanding the illness as to determining the level of incapacity and of maturity. In doing this he must investigate and explore all aspects of the individual's personality (cf. L. Vela, Marriage Law, class notes 1985/1986, P U Comillas).

From a detailed and extensive jurisprudence of the Sacred Rota on psychological immaturity we may cite as illustrative examples: C. Mattioli 6.11.1956: SSRD 48, p. 873; C. Ferraro 6.2.1973: SSRD 65 p. 56; C. De Jorio 11.3.1973: SSRD 65 p. 656, and in more moderate terms: "matrimonii nullitas tuno tantun declarari potest, si invicte probetur *immaturitatem psychologicam* alterutius vel utrius que contrahensteis causam fuisse gravis defectus descretionis judicii corca jura et officia matrimonialis essentialia, quia non quaelibet psychica inmaturitas matrimonii nullitatem gignit, sed la tantummodo in qua difectus descretionis judicci verificetur" (C. Pinto 14/12/1984, no.3).

The Impossibility of Assuming the Essential Obligations of Marriage for a Psychic Reason

The psychic cause lays down that individuals cannot *assume* they lack the self-government or self-dominion which are necessary to them to take on and discharge the essential obligations of marriage.

As one authority has well expressed it, "it is supposed here that the individual has a sufficient use of his reason and a sufficient power of judgment. But, beyond these factors, it can happen that an individual who embraces marriage through a consent which is expressed conscientiously, by his own free will, and with maturity, may have problems in relation to the question of his obligations."

The incapacity to which the canon refers must come not from a somatic or purely psychological cause, but from a cause of a psychic nature (psychosis, neurosis, a characterpathic condition, and so forth).

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MICHEL MBOUSSOU

Mental Health Law in the Gabon

French legislation relating to mental illness was based for a long time upon a law more than a hundred years old—that of 30 June 1838. After the general approval provoked by its enactment, this legislation—which was imitated in many countries—came to receive intense criticism, especially as regards the whole question of arbitrary arrest and the lack or ineffectiveness of guarantees by which to protect individual freedom. After 1860, and for these reasons, the reform of this law was constantly on the public agenda.

In this paper I will dwell in overall and brief terms upon the general legislation concerning the mentally ill in so much as it concerns imposed confinement and civil and penal responsibilities.

As a citizen of a developing country I would like to draw attention to the limits to a real and proper legislation on mental illness caused by the fact that psychiatry is not possible without institutions—in general, in black French-speaking Africa, the institutions are themselves sick.

1. The Confinement of the Mentally Ill

The placing of people in psychiatric hospitals can take place in two ways:

—in line with the provisions of the law of 27 June 1990 where such confinement takes place without the consent of the patient.

—without reference to this law—a process which involves the patient going to hospital of his own free will. This kind of hospi-

tal treatment tends to be that most widely practiced and as result the law of January 1968 provided for the protection of the goods and property of the mentally ill person which are left outside the institution.

A. The Hospital Structures and Procedures Governed by the Law of 27 June 1990

In order to hospitalize a patient without his consent three conditions must prevail (art. L333):

—the mental disorder of the patient makes his consent impossible to obtain;

—the state of the patient requires immediate care and treatment;

—one of the following procedures is adopted after a constant monitoring of the patient in a hospital environment and in line with his requirements:

A.1. Hospitalization on the Request of a Third Person (HDT)

This procedure has taken the place of the old voluntary admission (PV).

1. For this admission into hospital to take place the following documents are required:

a) A handwritten request for admission drawn up by:

—a member of the patient's family;

—a person acting in the interest of the patient. This person can be the patient's doctor, as long, that is, as he does not practice within the institution to which the patient is to be admitted.

b) Two medical certificates, drawn up within the previous fif-

teen days, which both declare that the above-mentioned conditions are present.

2. Before admitting the patient the director of the institution must verify that the documents are in order, check the identity of the person who requests the admission and of the patient, and must then send these documents as soon as possible to the local prefect and the departmental commission for psychiatric hospitalization.

3. In cases where the health of the patient is in danger, an exceptional procedure can allow the sick person to be admitted when there is only one certificate.

4. A psychiatrist of the institution to which the patient is admitted (but not the person who has drawn up the second certificate) must draw up a new certificate within twenty-four hours which admits the necessity or otherwise of admission to the hospital as requested by a third party.

5. After a period of time which goes from twelve to fifteen days a psychiatrist of the institution which has admitted the patient (in principle the same person as that stipulated in paragraph 4) must draw up a new certificate (the so-called "fifteen-day certificate") which lays down that the conditions still exist for the hospitalization of the patient and makes clear as to whether there is a need to prolong the so-called HDT.

In such a situation the hospitalization of the patient can be continued for periods of a month which are renewed every month in the same way.

6. The hospitalization of the patient finishes:

a) if the certificates are not drawn up and signed;

b) when the HDT conditions no longer prevail, that is to say:

—if a psychiatrist who works in the institution produces a certificate which states that this is the case;

—if a prefect gives an order to this effect;

—on the request of the medical doctor who treats the patient, or of a member of the patient's family, by grandparents and parents or by children and grandchildren, or by the departmental commission.

A.2 Official Hospitalization (HO)

When the mental disorder of the patient threatens public order or the security of other people, the prefect can order an official hospitalization which at one time was called official admission (PO). He does this when he has a medical certificate available and acts through a precise and justified order. In the case of imminent dangers he can also use special emergency procedures.

The director of the psychiatric institution has the same obligations and duties as those laid down in the case of HDT. The medical certificates must be drawn up in line with the same conditions as those involved in HDT (twenty-four hours, fifteen days, a month).

B. Hospital Structures and Procedures not Governed by the Law of June 27, 1990

In this instance the mentally ill people are treated on their own request or by the family but always with their agreement and co-operation. Here one is dealing with open services.

B.1. The free services offered by psychiatric hospitals

On the whole these are small-scale facilities which have twenty to forty beds. They are located in the surroundings of a psychiatric hospital, but do not have the administrative regime of forced confinement. They usually receive seriously ill people who cooperate in their treatment and do not require close supervision.

B.2. Psychiatric Hospitalization in General Hospitals

At the present time most of the general hospitals—both CHU and CHR—offer specialized service in psychiatry where patients are sent from other wards and sections of the hospital when they display symptoms of psychological or mental disturbance. But these hospitals also receive patients from outside for a period of hospitalization which usually lasts for short or medium terms.

B.3. Private Psychiatric Clinics

These private institutions are officially recognized by the Ministry of Health as being psychiatric clinics and at the level of treatment their worth is commensurate with that of the skill and expertise of the medical staff. These specialized clinics are numerous and usually crowded. The waiting time for admission lasts from a day or two to a week or two.

2. Civil Responsibility

Civil responsibility is defined as being the "legal role of an individual in the enjoyment and exercise of his rights."

Here measures are employed which involve the protection of the property and goods of the individual where his mental faculties are damaged by illness, infirmity, or by old-age, or when a simple "alteration of the physical faculties" prevent the expression of his will.

This new system has separated the actions of hospitalization from civil protection. In this way an officially hospitalized patient can manage his own property and goods. In the same way patients in a free service, or even when they are not hospitalized, can enjoy a measure of such protection. Furthermore, the law of 1968 softened and simplified the procedures involved and sought to confer greater responsibilities upon the individual's medical doctor. Indeed, the judge responsible for the case is required to ask for a medical opinion on the patient.

Finally, the diversification of the forms of protection is one of the principle intentions of this new law. Three different kinds of mea-

sures—the safeguarding of justice, the tutorship of the patient, and his guardianship—each involve different kinds of possible application.

A. The Safeguarding of Justice

The safeguarding of justice is the simplest and least intrusive of these measures. In principle it assumes that the civil capacity of the patient remains. It allows the annulment or modification of acts or undertakings only when these have been carried out in an ill-judged fashion during the period of protection. This measure is put into practice on the recommendation of the judge or when a medical declaration is presented to an attorney of the Republic (here one is dealing with the declaration of a general medical practitioner accompanied by a similar judgement by a specialist or the declaration of a specialist on its own).

The system of safeguarding is provisional. It lasts for two months after the entry in the register of the state attorney's office and can be renewed on the application of the medical doctor for a period of six months.

B. The Tutorship of the Patient

Such tutorship is the system of protection which is the most important. In principle the individual concerned is freed from his legal capacity and is represented over a constant period of time by a "legal representative" in the various acts of his civil life.

The tutorship judge is informed by a request accompanied by a certificate signed by a specialist. The request can be made by the patient's doctor who is asked only to give his opinion on the question without having to provide a diagnosis. The certificate must be drawn up by a specialist chosen from a list drawn up by the state attorney. One is dealing here with cases where there is an alteration in the mental or physical faculties of the patient and not of a psychiatric diagnosis or assessment. The judge decides on such an assessment only when there are doubts about what kind of alteration in the patient's mental faculties are involved.

The tutorship depends upon a judgement. An adult who is under such defense is represented by the following.

—A tutor. This is the usual form that such tutorship takes. The mentally ill person who is not defended cannot make a will. He loses his right to vote and cannot be elected. When he is married his wife becomes the tutor except in cases where the judge believes that this choice is not in the interests of the sick person. The judge also appoints a substitute tutor and a family council. If the patient is unmarried the family council appoints the tutor. The patient's doctor can participate in a consultative capacity in this council but he cannot become the patient's tutor or the substitute-tutor;

—A legal administrator. Appointed by the judge, the administrator (a near relative or relative-in-law) acts as a tutor under judicial control (in this case there is neither a substitute tutor nor a family council);

—A defense guardian. This takes place only in the case of adults without a family or who are very poor. The defense guardian's powers are relatively limited and he may be appointed from within the psychiatric institution or may be a special administrator.

These different approaches enable the patient's incapacity to be dealt with and managed. At any moment the judge, after consulting the doctor in charge of the case, can give—or restore—to the patient a partial responsibility, listing as he does so the various acts which the patient can carry out on his own or with his tutor.

The acts carried out under this defense regime are rendered "null and void" at the request of the tutor, the patient himself, or his heirs. Marriage is authorized only with the consent of the family council except where the parents give their consent (in such a case the opinion of the doctor in charge of the case is also taken into consideration).

This defense finishes when the causes which have brought it about also finish. The procedures for ending it are the same as those for bringing it into being.

C. Guardianship

This system of protection, which is less complete and intense than tutorship, is applied to those people who need to be advised or controlled in the acts of their civil lives. But such guardianship does not involve the possibility of imposing certain acts. The procedure here is similar to that to be found in the regime of tutorship. The capacity is decided upon and determined by the judge after he has consulted the medical doctor in charge of the case. In this way certain acts can be performed without the guardian. Others, however, need his presence (on the whole those acts which require the authorization of the family council in the system of tutorship). The right to make a will and testament, however, is maintained. The presence of the guardian is required in the case of marriage. In situations of divorce the presence and role of the guardian is usual.

3. Penal Capacity

Like normal individuals, the mentally ill commit criminal or illegal acts. For this reason they come up against judicial systems which try them for their actions at a penal level. In such situations there is the question of the penal sanctions that they might encounter and the matter of their responsibility for such actions. Capacity is understood as the ability an individual has to exercise penal responsibility when a wrongful act has been committed. Penal sanction implies two preliminary requirements: the ability to exercise responsibility and the imputability involved in a crime which has been really committed and then proved to have been committed.

In French penal law the perception of a criminal fact implies a moral element which in turn involves notions of guilt, being guilty, responsibility, and the application of a penal sanction. In order for a person to be accused and tried for an action he has committed, his actual responsibility has to be demonstrated, and of course this is not the case when an

individual is in a state of madness.

The French penal code declares: "A crime or illegal action does not take place when the accused was in a state of dementia at the moment of the action." The idea of dementia is interpreted in the widest sense possible and includes mental illness belonging to every nosological category without any etiological or clinical distinction. The shared feature of all these forms of mental illness, however, is that they damage the responsibility of the individual concerned. This damage must be total and must have existed at the exact time of the action. This of course excludes mental illnesses prior to the illegal act and those which emerge after it. Also excluded are partial alterations in responsibility caused by the interference of mental illness or by a personality disorder subsequently revealed by a crime or an illegal act.

The identification and ascertainment of this state of dementia lies exclusively in the hands of the investigating judge, who must engage in a highly private decision. In this procedure he makes special use of an examination of the accused by a specialist, in this case a psychiatrist. But the opinion and judgment of this figure is by no means decisive as regards the judge's decreeing whether or not the illegal or criminal act was carried out during a state of dementia.

A. The Role of the Expert

The judicial authorities who consult a psychiatrist in order to ascertain the presence of a state of dementia set out what his tasks are. The questions he is asked are the following.

—Does the psychiatric examination of the individual reveal mental or psychic anomalies?

—Is the transgression of which is accused linked in some way to such anomalies?

—Is the individual in a dangerous state?

—Can penal sanctions be applied to the individual?

—Can the individual be treated or rehabilitated?

B. Conclusions

If at the end of the psychiatric examination it is ascertained that at the moment of the action a complete state of dementia which deprived the individual of evaluating the meaning and consequences of his actions was present, then no case for imputability in relation to the act exists, on the grounds of the presence of dementia.

If the case is only at the preliminary stage of investigation, the investigating judge can immediately issue an order of "no trial" which thereby puts an end to the judicial process.

If the case is at the trial stage, the individual is absolved if he is being tried by a county court. He is ordered to be released from prison if a correctional court is involved.

If at the end of the psychiatric examination it is observed that the elements do not exist for the declaration of a state of dementia, then:

—the individual is deemed free from any form of mental illness and the judicial process is allowed to carry on its path;

—or the individual is deemed to have mental anomalies, an intellectual handicap, or a mental illness with no bearing, however, on the acts of which he is accused, or are of such a character as not to remove the responsibility of the individual in relation to the act which has been committed. The same occurs if the illness is deemed to have been merely a concomitant factor, a facilitating factor, or a modifying factor in relation to the transgression without having been of determining importance in the illegal or criminal act. The investigating judge inquires into the case, and the individual is then placed within custody.

4. Legislation in Relation to Mental Illness and African Realities

The countries of French-speaking Africa, which are former colonies of France, have for the most part adopted the penal code of the colonizing country.

Despite certain adaptations and changes, the governing principles remain the same. The application of the legislation in relation to mental illness involves two very great problems: the experience of the mentally ill person and the psychiatric institution.

A. The Experience of Mental Illness

Black people have never sought to deny illness, but have known how to employ the best and most subtle instruments and means by which to defeat it; they have never accepted it as a natural phenomenon. It is nearly always seen as a supernatural force which disturbs the peace and serenity of the living.

When faced with mental illness, the community (and this is especially true of the rural areas) applies the traditional methods of healing (sacrifices, rites, initiations, and so forth). The increasing ineffectiveness of traditional forms of treatment in "reconciling" the patient with society is now commonly observed, and this is especially the case in the urban environment. There are many reasons for this failure, but they are probably linked to a progressive lack of commitment to traditional methods of social control.

Even today, more than a half of those suffering from mental illness are first subjected to traditional forms of treatment.

B. Psychiatric Institutions

All over French-speaking Africa on the eve of independence institutions were created which were largely run by general doctors and only rarely by psychiatrists. These institutions were conceived along lines of the model of confinement and involved exclusion or entrance rather than treatment. The example of the psychiatric hospital of Thiaroye (in Senegal), which was created in 1960, brings out the delicate mission of the psychiatric institutions in Africa. Reserved for the chronically ill, the dangerous, and the marginalized, Thiaroye was much more interested in their confinement and their concentration in

one place than in seeking to cure them. Law no. 75-1093 of October 23, 1975, which created a specialized closed institution at Thiaroye after a specific judicial decision, reinforced this role of being a place of confinement or prison, a place where the mentally ill or the homeless were dumped. After more than thirty years of independence the situation is Africa has become worse: various health care systems have collapsed and psychiatric hospitals are reverting to what they were at the outset—places of confinement.

5. Conclusion

Real psychiatry cannot exist without institutions. Legislation relating to the mentally ill cannot be applied without competent and skilled psychiatric institutions whose fundamental role is to treat and to cure those who suffer from mental illness.

Although it is certainly true that such legislation in the industrialized countries has been supported by suitable facilities and institutions, in developing countries—and especially in Africa—legislation dealing with mental illness is still not implemented in the right way.

The authorities in African countries must look again at the concept of psychiatric institutions and bring them into being with reference to our realities so that a truly human application of legislation relating to mental suffering can be achieved.

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