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A Spin in the Toyota

In 1986 I spent a summer in Argentina as a guest of Dr. Angel Fiasché[1]. Together with a colleague he had purchased a run-down hotel in the countryside and was working to renovate it for use as a treatment centre. Behind this project lay quite a special and simple idea. The patients came primarily from Buenos Aires and the idea was that the move from an urban environment to a small rural community would involve a re-adjustment that would challenge stereotypical patterns, "shake up" the person and thereby open the way to new opportunities for learning.

The first goal of the project was the restoration of the hotel itself. The carpenters and the "patients" did the work together. Every day we gathered by the swimming pool to drink argentinian maté generally accompanied by lively discussion over day-to-day situations. However, it was not only manual labour that stood on the day's agenda. With help from professional artists, musicians, and journalists working in the project, creative activities such as music, painting and writing gave the patients an opportunity to express their inner dramas, develop, and cultivate their gifts. One important principle was that the local community assimilates the institution for the purposes of mutual ecosystemic enrichment. The surrounding society's resources were relied upon and in exchange the locals were provided with concerts and other forms of help. A cafe was opened, along with a movie theatre, which had previously been non-existent in the town. These meeting places gave the townspeople a chance to revise their prejudices concerning psychosis and the "patients" an opportunity to contribute to the life and culture of the society from a position other than that of dependency; they were no longer passive consumers of health care, inferiors, but participants in the social contract - equals. A. Fiasché´s interest in institutions and institutional forms of working with the psychoses connects him with the Italian psychiatrist F. Basaglia as well as R. D. Laing, with whom he worked during the 1960s.

[1] The Gothenburg Institute of Psychotherapy was founded in 1974 by the Pichon-Rivière disciple Dr. Angel Fiasché and his wife, the Kleinian child analyst Dora Fiasché, together with a Swedish group

The work at Varpen and Gyllenkroken, in Gothenburg, Sweden, facilities that provide services for people in psychotic states, builds partly on experiences from Los Cocos. On the basis of our social contact with our guests,
and with an in-depth knowledge of their often disorganised lives, we try together to establish organised habits. The co-operative restaurant, Gyllenkroken's heart and meeting place, is run by the staff and the tenants together and offers nutritious, inexpensive dishes. This generous, basic provision for the body, together with the hospitality it implies, is a way for us to show our often suspicious visitors that the world isn't always so heartless. In addition, the restaurant has become popular among the residents and workers in the neighbourhood.

My intention in this essay is to introduce the reader to the organising ideas behind the work being done at Varpen and Gyllenkroken and to place them within the wider context of psychosocial, and other views on psychosis. I have participated from their inception as a supervisor with my theoretical and experiential knowledge during their formation and development as well as in their day-to-day clinical work. Both institutes were established with the aim of providing an alternative to the traditional**,** authoritarian**,** psychiatrically based drug treatment and its tendency to understand human nature in terms of a biological paradigm. In this context, these facilities share the ethos of the Arbours Crisis Centre; a mental health facility in London, England set up in 1973 with similar aims in mind.

- What do you do if a patient becomes psychotic? asks a representative of traditional Swedish psychiatry, a staff member at Varpen in a question-and-answer session that has begun to resemble a steely cross-examination.
- Oh, we take a spin in the Toyota, replies a staff member.
- Don't you give them any medication?
- No, we sit outside their rooms or read to them if they are suffering from anxiety attacks. We don't believe in medication; we believe in relationships.

Varpen Psychosis Treatment Centre lies an hour's drive from Gothenburg in a beautiful, rural setting. The Centre is situated in a newly-built, aesthetically pleasing house. The emotional atmosphere within is broad and generous. The staff is currently 12 strong and the patients are there voluntarily.

The goal of treatment at Varpen is to be with the patient in his attempt to find himself and his place in life and help reconstruct and work through the patients' experiences. Thus, we do not consider the patient as sick; rather, we see

him as someone who suffers, but does not always understand why. Varpen's job is to try to break the emotional isolation that has led the person to insanity; to transform the neurotic/psychotic suffering to everyday suffering that allows for an existential choice with the only curative tool we can trust - the human relationship.

Of the first six patients, all in their twenties with different varieties of psychotic conditions, five no longer live at the Centre. The sixth, who had been severely mistreated under traditional psychiatric care, killed herself very dramatically after a stay of about six months. For the others, it took five to six years of treatment at Varpen to begin to establish a wavering, though medicine-free life. Today they consume no psychiatric services other than the follow-up therapeutic contact that is regularly included as a part of Varpens´s leaving process. Instead, they spend their time at vocational training, university studies, or work, and develop their social lives.

We are kindred spirits with the Arbours Crisis Centre, in London. This link has helped us maintain and further develop a tradition of psychosocial interventions with psychotic patients. Dr. Joseph Berke has given several seminars at Varpen since the first contact was made with him at a public seminar at Gothenburg Psychotherapy Institute 1992. Almost all the staff at Varpen has, during these years, visited Arbours on separate occasions. Similarly, people from Arbours have visited Varpen. A member of staff from Varpen is currently in psychoanalytic psychotherapy training at Arbours and works at their Crisis Centre as resident therapist.

Gyllenkroken is not a treatment centre; rather, it is a meeting place, an activities house and a residence organised by the staff, the tenants, and the visitors together. A former psychiatric nurse and the parents of two adult seriously iatrogenically[2] damaged children founded Gyllenkroken in the 1980s. Our guiding principle is that insanity is the result of both inner and outer solitude. Man is a social being and becomes human only in relation to others.
The institution has grown quickly and today employs approximately 20 full-time staff members organising 50-60 visitors a day. Around 25 persons live in the residential services.
Gyllenkroken offers a number of activities from woodworking to tango. Music occupies a particularly important place and has come to provide a sense of identity for both the centre and the musicians. Recently a CD of original music was released.

[2] Iatrogenic: caused or created through treatment; from the Greek “yatros ”, meaning “doctor.”

From its inception Gyllenkroken has received financial support through a public fund, but it wasn't until the project demonstrated its viability that it began to receive regular support from the local authorities. Today Gyllenkroken is recognised nation-wide, enjoys the support of the Swedish Board of National Health and receives over 2000 study visitors annually.

The Ideological Infrastructure

The activities at Varpen and Gyllenkroken proceed from a few underlying principles, an ideological infrastructure of traditions and theories that enable us to "see" the person within the insanity and organise our institutional and clinical work accordingly. These principles can be briefly summarised in few key concepts: historical consciousness, that is, an awareness that our current understanding of what constitutes "health" and "sickness", "normal" and "abnormal", is a historically and culturally determined construct; humanism, in the sense of a belief that human beings can learn from experience, differentiate between good and evil, give respect to each other and work for mutual improvement; psychoanalysis, especially the socially conscious psychosocial philosophy developed in Argentina by Enrique Pichon-Rivière and his disciples; and an absolute existential-phenomenological respect for the experiences, integrity, and life-choices of the other.

Images of insanity have been part of human history and its cultural expression from the first written mystic and religious tracts to today's current cultural gestalt as expressed in literature, theatre, art, religion, film, law and science.

Concurrently with Shakespeare's dramatic meditations on the nature of human passion and the rise of the capitalist system, the modern conceptualisation of insanity began to take form. The unemployed, the vagabonds and the madmen were confined together in camps and hospitals that had at one time housed lepers; perceived as the carriers of pestilence and decay, they were isolated and demonised. Confinement reduced social problems to the level of the individual, where they could become observable and classifiable, the very prerequisite necessary for the establishment of a medical/psychological conceptualisation of madness.

Humanist protests against confinement began to make themselves heard during the French Revolution. Reform movements in France and England strove to transform the asylum from a prison to a medical institution. The goal of these new

institutions was the cure of the mentally ill by allowing them to admit their "guilt" and gradually re-integrating them as useful members of society; the institutionalisation of power's discipline.

Towards the end of the 19th century, Darwin's theory of evolution was combined with Morel's theories on degeneration and heredity into a new paradigm of abnormality. A promiscuous, immoral lifestyle was believed to lead to the degeneration of the nervous system; from depression to spinal disintegration. At the same time, Freud developed a revolutionary alternative thesis that symptoms resulted from a conflict between the drives, desire, and the disciplinary demands of culture: an expression of humankind's eternal battle between Desire and Necessity (Ananke).

The "subject that speaks" emerged as a central figure from within psychoanalytic discourse, and with it a new understanding of psychological suffering. But mainstream psychiatry in general was not influenced, with a few isolated exceptions such the Swiss hospital Burghülzi, where E. Bleuler, J. Piaget, L. Binswanger, K. Abraham and C. G. Jung, around 1910, constructed the concept of "schizophrenia" and other models for understanding psychosis. In the traditional asylums, human beings were consistently dehumanised and correctional methods developed and employed: cold water baths, strap-down chairs, ECT and, during the 1940s, lobotomies and forced sterilisations. The height of this medical-psychiatric tradition was finally reached, we may hope, with the Nazi doctors' extermination of "degenerate elements" in the mental hospitals.
It is probably this historically determined, deeply rooted picture of psychosis as a disease that presents the largest obstacle to our attempts to listen to and respect the life and existential choices of the other.

The Treatment of Psychosis in Scandinavia

Swedish psychiatric practices were until the 1960s completely dominated by the biological paradigm.The psychiatrist Herman Lundborg, founder of the world's first state-run institute for "racial hygiene" in 1921, had great influence on the psychiatric community. Like many other countries, beginning in 1935 Sweden passed laws for the forced sterilisation of the "mentally ill", i.e.

people not living according to the narrow definition of normality, a practice that continued until the mid-1970s.[3]

3 62,888 supposedly "mentally ill" people were sterilised in Sweden between 1935 and 1975.

During the 1940s and 50s, the academic world in Sweden was totally dominated by Uppsalian analytic philosophy (i.e., logical positivism) which meant that areas of knowledge from existentialism, phenomenology, psychoanalysis and marxism were looked upon as metaphysical.

Mainstream psychiatry had its detractors, however, throughout the 1900s, in part those who believed that it essentially pathologised and then locked up otherwise healthy (albeit outspoken) people, and in part doctors from other fields who felt that it was unscientific and authoritarian. Inspired primarily by the Anglo-Saxon "anti-psychiatry" movement, this criticism culminated in the 1960s when psychologists, counsellors, social workers, psychiatric nurses, and many others began to challenge the psychiatrist's exclusive right to understanding and treating the mentally ill. This in turn led to bitter conflicts during the 1960s and 70s, which found psychiatrists pitted against even the smallest reforms in their attempts to maintain their professional dominance. Even to this day, many Swedish psychiatrists do not accept therapy as a form of treatment in its own right, but see it rather as a compliment to the use of antipsychotic medication.

One of the earliest experiments in an the alternative treatment of the psychoses in Scandinavia began in 1950s, with the implementation of milieu therapy at Ullevals hospital in Norway. A tradition developed further by the influential Norwegian psychiatrist Svein Haugsgjerd. In Finland, Prof. of Psychiatry Dr. Y. Alanen has also been influential in non-biological psychiatric circles, especially during the 1990s. The central idea behind "Aabo-model" is that the way the person in crisis is met the very fist time he seeks help determines the outcome. With a combination of individual and family therapeutic interventions, and if necessary a small dose of benzodiazepines around 60% of the clients turn around at the door and never require further psychiatric treatment. In Finland out of five current professors in psychiatry, three are psychoanalytically trained and have taught philosophy in the humanistic tradition of Georg Henrik von Wright[4].

In Sweden Barbro Sandin's psychotherapeutic work with schizophrenics at Saeter's Hospital during the 1970s broke new ground in the treatment of psychotic states. There have also been attempts to copy the "Aabo model." Despite this enthusiasm and involvement, a number of therapists drowned

4. Prof Y. Alanen, personal communication

in the context of the drug oriented psychiatry. In the 1980s an overhaul of the entire system, known as the "psychiatric reform", begun, and the old. delete system of huge, monolithic mental hospitals were dismantled. While therefore, there are today quite many treatment centres in Sweden (but far too few in relation to the need) most of them are still dominated by the traditional psychiatric view. Even today, to claim that human relationships are of themselves the curative element is very controversial.

Psychosis as a survival strategy

In his analysis of Schreber's autobiography, Freud revolutionised our understanding of the psychoses by demonstrating that it was an attempt to solve an impossible relationship to reality. On the other hand, Freud expressed little interest in psychotic persons, claiming that the narcissistic basis of their pathology hindered them from developing transference, the basis for psychoanalytic treatment. However, during the 1940s, many of Freud's conceptualisations were placed in new contexts and redefined, especially concerning the psychoses. The Argentine psychoanalyst Heinrich Racker created new possibilities for the analysis of psychotic conditions through his extensive work on the concept of transference.

In the1960's, the work of R. D. Laing gave new perspectives on "psychotic states". According to the existential-phenomenological perspective, a person's existence in the world is formed out of the essence of his experiences. The psychosis is a subjective "rational" survival strategy in an impossible reality, not an illness in the medical sense of the term. For example at Varpen most of our patients have been sexually abused.
The overwhelming violence inherent in the psychiatric interpretation of these underlying motivations as expressions of an illness can be emotionally devastating, and the instant when meaninglessness is transformed into meaning irrevocably lost**.** The result: hopelessness and chronicity. In our work the most important task is to create and sustain hope in the search for meaning.
The essence of the existential-phenomenological perspective in the meeting between people, can be summarised in a few lines from Laing's *The Divided Self: 1*) I recognise that the other is who he believes himself to be; 2) He recognises that I am who I believe myself to be. It is this mutually reinforcing confirmation of the other´s existential being that establishes the basis for a transformative learning relationship, sometimes via deep regression if necessary which Laing's co-worker Joseph Berke´s demonstrated in his work since the 1960s. Arbours is the bearer of the traditions from Kingsley Hall, and the bridge to us.

Among the influences on our clinical practice are the ideas from the Argentinean psychiatrist and psychoanalyst Dr. Enrique Pichon-Rivière (1907-1978). The following vignette expresses the essence of his attitude:

"Enrique Pichon-Rivière spent his entire life investigating the mystery of human depression and helping to open the cages of non-communication. He found an effective ally in the game of soccrre. During the 1940s, Pichon-Rivière organised a soccer team together with his mental patients. The Crazies proved impossible to defeat on the soccer fields of eastern Argentina and at the same time applied with their game the best social therapy imaginable."The soccer team's strategy is my most important task", the psychiatrist would explain, who was also the team's trainer and one of its best forwards."[5]

The marxist Pichon-Rivière felt driven to make psychoanalytic treatment available for broader social groups. His goal was to transcend the traditional boundaries for psychoanalysis and develop new forms of therapy for the psychoses: group and milieu therapy, the therapeutic society and other such projects. Some of his theoretical contributions can be summarised as follows:

The Human Bond[5]: He expanded the concept of object-relations and referred to it as a bond. He emphased the mutually dialectic relationship to the other and his theory encompasses both behaviour and affect. The human bond describes the context in which the human being emerges.

The Psychosocial Group: The inner psychosocial group is formed from early experiences. It constitutes the prototype for understanding and acting within the various sociodynamic groups in the external world. This conceptual distinction can be used to help the clinician/patient differentiate between the world as it is and the world as we interpret and experience it.

At Varpen, we combine collective coexistence with individual therapy. Imaginary people from the patient's historically established inner drama find or create roles that impose themselves within the social life of the group.

The Drive for Knowledge: Klein's concept of epistemophilia - the drive to knowledge reveals itself in the communications between the patient and the staff. One of the aims of the treatment is that the patient discovers the distinction between inner world and external reality. Problematic areas, cliffs and distortions reveal themselves and stereotyped frozen tranquillity is set in motion.

5 Galeano.E

The Operative Group: Pichon-Rivière worked as a psychiatrist at a big hospital. At one point, due to his participation in a political protest, he was relieved of his entire staff. To resolve the resulting crisis Pichon-Rivière created the operative group. He trained those patients who were in the best condition to take care of their fellow patients. This solution, of course, expressed a rather inopportune and radical belief in the capacities of mental patients - after all, they were supposed to be incurable!
The operative group's ability to think in the goal oriented learning-process are of central importance as well as its ability to contain the fear which accompanies change when the Uncanny is mobilised.

ECRO[6]: Beyond the neurotic attitude in which most of us live drifts an incomprehensible, chaotic, magical, concrete, and occasionally terrifying psychotic world. In Pichon-Rivière's theories, this dialectic is conceptualised in terms of the psychotic nucleus and the neurotic superstructure. In a crisis, when the superstructure fails to fully contain anxieties, the underlying, latent nucleus becomes manifest. The various expressions of psychotic symptoms reveal the seriousness and desperation in the patient's inner drama. With Pichon-Rivière's models it becomes possible to "read" it´s expression psychically, bodily and socially. ECRO - is your own basic theoretical assumptions for personal operational clinical work.

"….every confused behaviour comes from an inability to learn; a blocking of the ability to learn from reality"[7].

In the psychotic state you live in your own inner world and do not doubt your interpretations of it in relation to reality. The images generated in this internal world superimpose themselves on reality and dominate it. Panic, the fear of annihilation threatens the ability to feel and think; the tools for solving of conflicts. Will the outcome be creativity or madness?

Madness refers to the condition of non-learning. Only with emotional involvement in the other you can discover, through experience, that your picture of the other doesn't really correspond with the "real" other. Transferential mistakes are welcomed

6 The term "bond" ("vínculo") has a central and very specific meaning in the theories of Pichon-Rivière that unfortunately lacks a precise English equivalent. For Pichon-Rivière, the "bond" describes a specific type of object relation -- a kind of "emotional linkage" possessing a distinct quality. The quality of the bond forms the basis of Pichon-Riviére's diagnostic system (see below).
7 Escema Conceptual Referential y Operativo.

As we understand the individual as an expression of society, of social- and class membership, of family and surroundings the "psychotic" is the speaker who reveals that something in this context is wrong. Our scepticism regarding psychopharmacological treatment results from the fact that the speaker is robbed of his voice as well as his emotional presence with affect and thought, the very material necessary for transforming a dilemma to a conflict and an existential choice. Treatment of symptoms provides us with nothing to learn and no need for restructuring of the inner world. "Don't expect anything of me; I'm schizophrenic". With medical treatment something alien is introduced which strengthens the feeling of Uncanny and the image that we fear him. There is nothing to listen to with meaning. In the authoritarian relationship the person is turned into a diagnosis and forms himself accordingly. Hope is doused and panic intensified

The Psychosocial Intervention

"Institutions" are representational spaces wherein individual and society dialectically intersect. They are collectively founded organisations that maintain, develop and create traditions, ideologies and dialectically influence culture and society.

Our work proceeds from the hypothesis that the decisive force in becoming human is the human relationship of love, and that several generations influence the creation of an adult identity. The family is the most important "institution" to introduce the human being to the culture. Sometimes it fails to fulfil its task to guide the child from absolute dependence to the adult position of independence.

One patient at Varpen, who had been violently provocative, unpleasant, and antagonistic, was once again admited to the psychiatric ward. The manic state protected her from her own destructive impulses. In her individual therapy she began to reflect over what was happening to her. It was discovered that she unconsciously followed her female historical tradition with precision. Both her grandmother and her mother had lost their husbands while their children were very young. Both had been remitted to psychiatric care. As the patient became conscious of her dread of this "inescapable" destiny, her terrifying inchantment vanished. After this abrupt event her relations took a different turn, exhibiting a new-found sincerity and openness. Her attitude changed; she sought out support from the staff and her previous arrogance disappeared. However, all was not completely resolved. On numerous occasions, in contact with her therapist, "something" came closer to consciousness, despite desperate, frightened attempts to hold it at bay. At last the

explanation for her earlier, inexplicably violent irritation – which had something to do with the curtains at Varpen – was revealed. When the patient was five or six years old, she had been used as a kind of "mannequin" by a neighbour who sewed clothes. However, when the curtains were drawn, the patient was not only used as a model; she was also severely sexually abused. The discovery of these memories led to new qualities – depression and repairing. She now possesses the ability to live alone and deal with the existential dilemmas in life and relationships that are our lot.

Time and Spaces

The Psychosocial approach provides time and space. It takes time to learn the "semiotic" of the other; to discover the hidden story.

From one of Varpen's vacation trips: A male patient develops severe stomach pains during a ski trip. The patient is terribly anxious. His therapist, who is also on the trip, suggests jokingly: "Let's travel to another country." They get into the car and drive off. On the way back from Norway into Sweden the therapist says, "We ought to bring something home from our travels abroad," whereupon he stops the car in the middle of nowhere to jump out and cut off the branch of a tree with his knife. At this, the patient's panic becomes total; he behaves as if he had been physically attacked.

Out of this apparently situational and inexplicable event the contours of sexual abuse appear to the therapist and his patient. The patient's father raped him in the shower during a ski-trip many years ago.

The term "space" refers to a special place with specific rules and a contract that organise the work. The task of the staff is to participate in the creation of different spaces: the intimate, for interpersonal trust; the social, for the interchange of everyday thoughts and experiences; and the practical, wherein one learns "know-how". The patient chooses the person in whom he has faith, and with whom he will be. In particular, we must be able to reside in those inner spaces where no one else has wanted or been able to be. New praxis, emotional and intellectual, requires time and space to develop. When the patient leaves the external "institution", he will be able to use the internalised "institution" in situations that formerly led him to suffer psychotic panic. When reflection, symbolisation, and feeling of depression replace inexplicable acts of irritation, the end of the work begins to approach.

The Supervisory Space

In the beginning we started with careful reconstruction, through Kleinian concepts of the patient's inner drama from his biography. With the information available to us I attempted to demonstrate that those behaviours the staff experienced as bizarre represented the only alternatives the patient had in his battle against his terrifying phantasies. Today, the focus is not on how to handle the objective person, but on how to understand the way we experience him within ourselves. The work with transference and countertransference is central. Moments of transformation require that we follow the process without understanding it; our attitude towards and ability to contain the unknown is important. Sometimes the we must bear the craziness, even to the extent of becoming crazy, in order to successfully digest the introjected parts of the patient, create meaning, and return that to the patient. This in turn highlights the extent to which we see our patients through our own constructs; values, prejudices, feelings and personal experiences. We learn who we are in relation to others. We discover time after time the difficulties inherent in *listening*, and the ways in which we try to avoid unpleasant insights.

The social space

The mundane social routines of day-to-day living, on the chair beside the bed or in the car, are the main therapeutic tools in the battle against madness, together with the individual therapy. The social space conveys and maintains the elemental structures of social life as well as a given culture's social codes. The psychosocial approach´s strength lies in its capacity to provide for the patient a dual perspective: to been seen both as a social being and as an individual. The interaction among the social collective's activities, the individual therapist's room, create possibilities for the person to learn to know himself and the other.

The staff must respect the patients as capable of making their own choices, and be willing to engage in confrontations. "Technique" and "treatment" are concepts we must reconsider because we believe that an unreflective relationship can lead to a non-affirmative, distanced emotional absence. This is probably a repetition of the person's childhood experience and the reason he has come to us in the first place. The ideal is that we do not treat people; rather, that we treat each other. It is preferable to be honest, spontaneous and wrong rather than cold and right. This attitude helps create the necessary mutual presence in the "bond".

Our institutions must be more tolerant than the surrounding society and minimise the consequences of "not knowing" the rules. Many of those acts that in normal social life lead to ostracisation are a good starting point for reflection.

Psychoanalytic interpretations do not belong to the social space. This rule prevents the development of a subculture of "interpretative terrorism" in daily life. Holding the function and rules of the social space separate from those of the individual's therapy is central in the work. The staff is forced to find innovative ways to communicate our basic values and to create a climate in which no participant has reason to fear another. The staff had to intervene when it saw the destructive behaviour of a specific individual. His attacks were treacherous and concealed in such a manner that we could not fall back on our traditions of "folkvett."[8] Nevertheless, we could see the way he would unerringly locate certain guests and cunningly deduce the sphere in which their fears resided. He implemented his fears via projective identification. His victims would "become psychotic" and let out terrifying screams. We learned to see the subtle pattern and finally we were forced to intervene. Horse-tied by the restrictions, the staff had to find a creative solution. We decided that the staff member who had the best relationship to him would be on his guard, until an occasion for action arrived. This opportunity arose in the form of shriek and a defensive flurry of hand gestures emanating from a corner of the cafe. The scene was unmistakable. There he stood with his victim. The staff member slided by the scene and commented, "Good job man. You really scared him," in such a manner that the attacker could not help but realise that he had been found out.

The psychosocial approach places the person in a social, moral context with new possibilities; an environment that cultivates and promotes internalisation, not by virtue of the staff's reformative attitude but by virtue of their companionship.

8. Elementary rules for social life

To express unequivocally the essence of our work I provide a shard from Freud.
He writes: "We cannot avoid also taking for treatment patients who are so helpless and incapable of ordinary life that for them one has to combine analytic with educative influence; and even with the majority now and then occasions arise in which the physician is bound to take up the position of teacher and mentor. But it must always be done with great caution, and the patient should be educated *to liberate and fulfil his own nature, and not to resemble ourselves*."(p.399)[9]

The outlook on humankind is the key to understanding Varpen´s outstanding result in the tradition of psychosocial treatment of psychosis in Sweden[10]. We are capable of doing this work when we have exchange with and inspiration from other institutions like Arbours, which respect people as human beings. Facilities which shelter and improve important traditions of treatment, while the spirit of neo-liberalism is characterised by the desire for quick gains and short-term profit, even when caring for others. In Sweden today most of the research and teaching in psychiatry is done by the medical-pharmaceutical industrial complex.

The network of institutions is society and culture. As a part of this framework our activities in our interventions acquire a meaning beyond ourselves. They create a climate of relations and a way of understanding the human being in the society we all inhabit. In a deeper sense our work is political.

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9 Freud. S
10 Prof. Bengt-Åke Armelius Umeå University, personal communication.

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