COUNSELING IN THE PSYCHIATRIC WARD

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Sunto L'articolo è frutto di un'esperienza lavorativa di un counselor e di un educatore professionale che svolgono un'attività socio-riabilitativa all'interno di un reparto psichiatrico. È un'attività poco frequente in Italia e sta rivelando la sua efficacia, perché si integra con le altre attività terapeutiche sia del reparto sia degli altri servizi del Dipartimento della Salute Mentale diffusi sul territorio. Questo intervento si sta rivelando efficace, anche perché nel momento in cui si interviene nella fase acuta del disagio mentale in maniera organica, dunque aiutando il paziente a prendere consapevolezza di quanto gli è accaduto, si permette a questo di attivare prima il processo riabilitativo.

Abstract This article is the result of the work experience of a counselor and a professional educator that undergo a socio-rehabilitation activity in a psychiatric ward. This type of activity is not frequently found in Italy and its efficiency is being revealed, because it integrates well with the other therapeutic activities in the ward as well as in other services from the Department of Mental Health spread about in the region. This intervention has revealed itself to be efficient also due to the fact that intervening during the acute mental phase in an organic manner, helps the patient gain awareness of what has happened to him, thereby allowing him to arrive earlier to the rehabilitative process.

Key words: socio-rehabilitation, counseling, empathy, therapeutic relationship, Gestalt.

1. Preliminary remarks

The presence of an educator with counseling responsibilities in a

psyciatric ward (from now on referred to as S.P.D.C.[1]) is not common in our country. The introduction of a person outside of the health system[2] inside the S.P.D.C. can be seen as a way to invigorate, improve and go beyond the teaching of Franco Basaglia and of the subsequent law 180[3].

The idea of introducing a counselor in the S.P.D.C. in the Jesi Hospital in 2005 came from Gilberto Maiolatesi, responsible for the educators in the psyciatric section of the Jesi premises of the Coo.SS Marche[4]. He proposed to the director of the Department of Mental Health of Jesi, Massimo Mari, the introduction of a counselor with the intent of improving the atmosphere of the S.P.D.C. Dr. Mari greatly appreciated this idea, and decided together with the counselor the conditions for undergoing a socio-rehabilitative activity with the patients. This will be the focus of this article, in which the following topics will be dealt with: socio-rehabilitation, gestaltic counseling and modus operandi.

In the past years many trainees, psychologists and educators have worked together with counselors in the activities of socio-rehabilitation. It is worthwhile to mention Silvia Coltorti and Silvia Capitani, who gave an important contribution to the realization of this article, thanks to their work of transcribing what took place during various moments of group sessions.

2. Socio-rehabilitation.

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[1] Servizio Psichiatrico Diagnosi e Cura : Service of Psychiatric Diagnostic and Cure.

[2] From now an educator-counselor will be referred to as counselor.

[3] The 180/78 law, also called Basaglia Law, introduced important revisions on how to treat and manage mental health disorders, closing mental hospitals and simultaneously distributing the care of the mental health patients throughout the territory, through the Psychiatric Diagnostic and Cure Services and the creation of centers for Mental Health, Day Centers and Residential and Rehabilitation Structures, Family Homes and work Co-ops.

[4] The Coo.SS Marche is a cooperative of social services that offers, through a system of public contracts, psycho-educational personnel to the Marche and Asur Marche region.

Socio-rehabilitation, in psychiatric spheres, must be seen in terms of de-institutionalization, which has taken on the basagliano approach. This consists in working with the patient to help him along in the quest for autonomy, whereby he has to resolve practical problems in life such as looking for work, conflicts with family and friends, management of daily routines, providing for food, taking care of personal hygiene, taking care of his surroundings, etc. This type of intervention is done especially in the post acute rehabilitative process. When, on the other hand, the patient experiences the first phase of the mental problem, the most intense one, for which it is necessary to admit him into the S.P.D.C., the socio-rehabilitation applied differs from helping him re-enter society and taking care of himself. In this case the priority is to recreate, or at least approach a homeostatic equilibrium between his "self" and the context in which he interacts. For this reason it is important to provide the intervention of a specialized person, namely an educator with specific counseling expertise, who can give important and useful tools to help the patient regain a dimension of relationships. The objective of the intervention of the counselor is to constantly stimulate the patient so that he can recuperate essential psychological resources, which allow him to re-create a contact between his interior sphere and the external world, since in the acute phase of the mental illness, the "I" of the patient is completely empty, if not falling apart.

The first step in rehabilitation consists in taking action within the relationships, enabling the patient to look for the correct emotional distances, recuperating an awareness of his emotional state and his capacity to manage it. The purpose of the rehabilitation is the change in the structure of the rapport between the individual and his environment, therefore of his ability to relate to others, but also between the patient and himself .

The counselor uses the meeting and the comprehension of the psychological material produced by the patient and the content of his answers to set up and conduct the relationship, he must be able to perceive moment by moment how the patient "is" and therefore that which he is able to "become". In socio-rehabilitation the counselor must understand, through a process of identification, the emotional

impact that he has when he establishes an empathetic rapport with the patient and accompanies him in the process of overcoming difficulties, providing the basic tools to activate a journey of self-awareness and therefore of change.

In order to relate in a rational and efficient manner with the patient it is indispensable to consider that he is living in an ambiguous state in the S.P.D.C., because on one hand the patient is suffering, on the other he wishes to have left behind all the anxiety, frustration and strong, undesirable emotions. Nonwithstanding, there is a line of demarcation, inside the head of the patient, between the self that is ill and the parts that are well. It is on these that the counselor must work with, in order for the socio-rehabilitation to be efficient, allowing the patient to integrate within himself the areas that have not be touched by the illness, from regression, with the areas within himself that are still sane.

Another important aspect to keep in consideration when one relates to a psychiatric patient is that he undoubtably has good reason to justify his retreat and his rejection of the world. At this point it becomes indispensable to ask oneself about the psycosis as an active existential choice, puttting oneself in his shoes[5]. When one does this, the approach with the patient is easier, because only by working in this manner with someone who has a mental disorder is it possible to perceive that from the part of the counselor there is not an intent to impose an activity, rather, on the contrary, to propose one, trying as best as possible to share the choice. The simple fact that the patient is able and willing to take into consideration the suggestion of the counselor is an optimum starting point in order to instill an efficient therapuetic rapport. To ensure that this happens the patient must not perceive a conflict between his discomfort and the activity which has been proposed.

3. Gestalt Counseling applied in S.P.D.C..

[5] This is the most important phase of the empathetic rapport between the counselor-educator and the patient.

It is correct to consider that counseling is seen as a form of "psychotherapy" approach or re-educational"[6], to be used when treating behavioral problems, not classified as psychiatric disturbances, since these must be treated exclusively by psychiatry along with the use of pharmaseuticals. Even so, albeit with many limits, the activity of socio-rehabilitation that is done inside the S.P.D.C. in Jesi takes its activities from counseling, and in these five years there has been proof of its positive effect. For example patients feel comfortable speaking in a group with a counselor and the topics dealt within groups were then expanded upon on an individual basis with the psychiatrist or when meeting the families in the S.P.D.C.

Counseling is a technique used during healing, therefore it is applicable also in an S.P.D.C. In this case counseling with a clear gestaltic imprint is used, which has revealed itself to be congenial when working with who is going through the psychiatric disturbance, because through this one has the possiblity of working besides at the congnative-verbal level, also with the entire non verbal sphere of the patient such as sensations, body language, emotions and metaphors.

With Gestalt Counseling (from now on refered to as GC), one works to help a person become aware of his entire self, both the negative and the positive, in order to allow the individual to be able to manage himself, meaning that he is able to take care of himself and to eliminate conflicts which come from a false image that he has of himself.

Another objective of GC is to favor expression, the elaboration and the closure of incomplete situations which are deeply rooted in the patients' past. This is also the approach used by psychologists who work with patients to resolve or to help them learn to live with negative situations which are deeply rooted in the past. The patient is invited to express everything that has been repressed to date, or expressed through delirium and/or acting out. Therefore the activity of socio-rehabilitation becomes complimentary to other therapeutic interventions which are done in the ward: pharmalogical therapy,

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[6] According to the definition given by Hinsie and Campbell in their psychiatric dictionary.

individual interviews, meetings with the family, multi-family groups, etc.

One must not forget that gestaltic counselor tends to share with the group the feelings that the patient brings forth, using his emotions in the therapuetic relationship. If, in fact, all human interpersonal relationships are structured on the basis of projections, in a therapeutic counselor/patient relationship this process is surely emphasized, through the mechanism of transfer and countertransfer.

For this reason the counselor must be able to understand the awareness of the patient, to make observations limited exclusively related to the therapy, he must have a very clear understanding of the therapeutic project and of the steps the patient is able to make. He must not influence him nor impose personal viewpoints. The attitude the counselor must have, regarding his own countertransfer, is to observe him, thus to keep him under vigilance, also because the counselor has as an objective to have the patient become aware of his state, he must not himself take this route. According to Perls, the counselor must be able to manage the rhythmn between absolute closeness as well as separation from the patients' pain, he must keep one eye on the patient but keeping himself in mind as well, paying attention to his own body language, facial expressions, to his sensazioni and feelings and above all to the emotions the patient and the entire group gives him.

A patient in therapy, therefore also during socio-rehabilitation, expresses himself always through suffering and his own difficulty in facing and managing certain emotions. According to Perls, in fact, since all our lives are characterised by a constant flux of equilibrium and disequilibrium, each new need can jeapardise the pre-existing equilibrium, therefore the homeostatic process is continuously at work. The illness emerges when the homeostatic process does not come forth, leaving the body in a state of disequilibrium for a long period and creating a situation where the individual becomes fixed on a single emotion and is not able to separate himself from it. It is not commonly expressed verbally, rather the disability must be inferred and understood in the same manner as one understood the symptoms. Man forms his own identity based on his environment and the context.

Society and the individual are not always compatible and not always are able to meet their respective objectives. It is in this situation that the disturbance arises, also because society as much as the individual are systems that behave differently from the sum of its parts, and according to Perls, are both elements of a whole.

The intervention of the counselor is finalized in helping the patient to live a "significant experience" in the observation of self, with the goal of allowing him to become increasingly aware of his subjectivity, thus in his Gestalt (taking, in this case, the meaning of *whole self* from the German term).[7].

Thus in counseling, one helps the patient to come into contact with his pain, with that which hurts the most, and one tries to not allow him to escape, but rather one helps him affront the less pleasant situations, and it is in this moment that the counselor must be closest to the patient, by being empathetic and taking care of him. This is what is tried to be achieved in the S.P.D.C. in Jesi.

Observing the level of awareness of the patient is useful in order to understand which are the perceptive channels which he prefers, which does he ignore and how much attention follows physical sensations, perceptions, emotions, thoughts, immagination, memories; in practice, how much the patient is in contact with the outside world as well as with his interior self (Rossi, 1998). Gestalt, in fact, has as an ambition to restore the awareness capacity, by understanding ones past in order to be better in the here and now and uses this awareness to orientate self-observation regarding feelings of inadequacy versus people and situations. From this, the particular interest that Gesltat has for the emotional level. The incapacity to manage certain emotions is at the basis of the mental disturbance, thus the approach of the GC can efficiently contribute to affront and overcome the mental illness.

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[7] "The objective of Gestalt is the integration of all the parts; thereby allowing people to become that which they are and that which they can become. This experience of wholeness can be available for them during their entire life of during a single moment" (Clarkson, 1989).

4. Counselor-patient rapport

The counselor himself is at play during a therapuetic relationship, getting close to the pain and to what the patient has gone through. Therefore he must be very in tune to his internal barriers. The main difficulty of the rehabilitation is that both people are on common ground. The focal point of this relationship is the process, moment by moment, of the counselor-patient relationship, in which the objective is an authentic and complete meeting between the two people.

When the relationship is established, on one hand the counselor makes available to the patient something that already exists, on the other hand facilitates new experiences relative to his persona as well as to the patients'. Thefore the counselor participates first hand to the lifestyle changes of the patient, but this process does not leave him indifferent, because something changes in him, because he discovers with the patient what it means to become involved in various ways.

The counselor works within a person, trying to break down his defenses, trying to modify them and above all to soften them. In a therapuetic relationship with a patient, the rehabilitator supports the "me" functions which have been damaged and the main tool is dialogue, which for Gestalt is the central healing dimension.

The gestalt counselor tends to have a sense of the overall state of the patient. This does not mean that the patients' past is not considered interesting from a therapuetic viewpoint, but rather is seen as one of three times in the human experience and the attention is foculized on the here and now, in other words, at the moment of contact, when the patient expresses his discomfort.

The contact boundary is made up of contact functions[8], which in the counseling process are observe, listen, move, seem and touch.

The disfunction of the contact boundary is maintained from various methods of resistance and by adapting to the contact and from insufficient usage of various support systems.

The way in which the patient uses his own contact functions allows the counselor to acquire valuable information, which will allow

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[8] The contact functions are sub-motor sensory apparatus through which the boundary-contact acts.

him to intervene on that which we can define as cycles of impotence, intervening in a way that will enable the begining of a neutralization process of his failure processes.

5. Mode of operation.

The socio-rehabilitative activity is conducted twice a week, on Wednesday and Thursday, for a total of four hours, and the results of the activity are reported to the team of the department on Fridays. The modes of operation are two: the first is for leisure purposes, even if this one in the past two years has been a bit abandoned over a second which is decidedly a more therapeutic approach. The operational type to use is established only after the infirmatory personnel has given essential information regarding the climate in the S.P.D.C. and the condition of the patients. Afterwards the counselor goes to the room of the patients to invite them to participate in the activity. This is a very important moment because it often represents the first significative contact with the patients, to whom they briefly explain the socio-rehabilitative activity, which is again explained in more detail once it begins.

The leisure mode is conducted by accompanying the patients for a walk in the hospital garden or remaining in the ward to talk about different subjects, such as movies, music, literature, history. In this case the activity is purely for entertainment purposes.

The therapeutic mode is instead divided into three phases and is conducted in the dining hall or in the area where the psychiatrists conduct group therapy. The main topics discussed are: rapport with family members, the difficulty of managing emotions, the fear of stigmas and difficulties in relating with others.

The first phase is dedicated to listening to the feelings and emotions of the “here” and “now” and to the narration of the reason for being hospitalized. This is the mode through which the counselor tests the climate, asking the patients how they feel and what the main thoughts going throught their heads are. The patients are left to express themselves freely, however close attention is paid to eventual deliriums, in which case the counselor concentrates his efforts in

trying to lead the patient to a real dimension. If in the S.P.D.C. and in the group there is a sense of agitation and or nervousness, a relaxation exercise is proposed to the group, which consists in breathing techniques or in the start of self training. This last technique is only applied if there are no patients who are particularly psychotic.

In the second phase, based on the main themes which came out in the first phase, a theme which may be common to all the patients is identified.

Finally the third phase foresees the proposal of the activity to do, which will be done by the patients. The moment of the proposal and of the discussion regarding the activity to do is a crucial one, because these are done by using expressive techniques and focus exercises, the emotions and the topics dealth with in the first part of the group. The expressive techniques have as an objective to favor the awareness level of the patient and his ability to have a good contact with his environment. It is here that the function of socio-rehabilitation takes place, in that the choice of the activity and in its developement the patient re-learns to become aware of what is happening to him on an emotional level, thus within the relationships of those closest to him. During the moment of proposing the activity it is always stressed that that the final objective of the practical experience is to make the patients increasingly aware of their conditions, relying on their capacity of self-observation. In this phase it is well worth to evaluate attentively the proposal one intends to use with the patients, considering their time frames which should be respected. Furthermore it is worthwhile to agree upon a willingness to work on a specific problem or to continue with the experience, if one is at an advanced level of interaction. For obvious reasons this type of work is not feasible for those patients who are in an acute/chronic phase.

6. Execution of the socio-rehabilitative activity.

The modality which is used is dialogue and is inclusive, thus the patient is always asked if he is willing to work on a determined problem or he is asked if he is willing to continue the work done in the case of being at an advance point of the interaction and an impass is perceived. If a particular technique is considered useful, first the patient it is explained to the patient and he is asked whether or not he

is willing to participate. The reason for this is to ensure the patient, also in this occasion, activates the route of self-responsibility.

The activities of socio-rehabilitation which are proposed to patients are of various types. Since the department is a reality in flux and with an elevated turnover, therefore not compatible with an excessively rigid approach, it becomes indispensable to have a certain amount of activities available to propose to the patients, which is done after listening to what their needs are. When the situation is particularly confusing, the effort of the counselor is to attempt to find a common thread upon which to articulate an activity.

Following are some examples of the socio-rehabilitative activities undergone, among which there are substantial differences, since, as previously stated, due to the nature and to the sudden interchangeability of the user, one must have a flexible attitude, consequently is is advisable to use a vast repertoire of sources. The counselor uses both the techniques of the GC, as well as those considered strictly pedagogic-relational. In some cases, to render more efficient the description of the activity, dialogues, transcribed by apprentices are introduced. The patients are always distinguished by the first letter of their name.

The personal universe: each patient is given a sheet of paper with a large circle on it: in the center is the earth; surrounding it in a concentric fashion, are circles which are continuously more distant. The patient is asked to draw his own "universe" of relationships. Albeit simple, this exercise allows the patient to provide a summary of his network of relationships: from family to work environment, to various social relationships, etc.; and this activity allows the patient to be able to identify his own feelings, in relation to his life as a whole: they are led to consider, for example, who occupies a central position, who do they feel is distant or close, and who they imagine feels close or far away from them. When the time finishes for this activity, it is reviewed in detail and then becomes discussion points for the entire group.

The backpack: This technique takes in part the same exercise created

by Dr. Alfredo Canevaro and has as an objective to favor the process of “differentiation” between family and patient.
Keeping in consideration the main theme and the general emotional level, it is requested that the patients take their chairs and sit in a circle. Two chairs are placed in the center of the circle, one in front of the other. It is proposed to the patient who has showed the largest need to affront certain issues to sit in the middle. The other patients are asked to give to this patient one of their qualities which they believe might help him to face the difficult situation he is in. In turns the patients stand up and sit in the empty chair facing the patient in the center of the circle, they take his hand and looking into his eyes they offer him their “gift”. Below is what happened during a meeting with this activity.
D: “I would give M the ability to re-find her road, determination”.
G: “Try not to feel lost …I give you the strenght to go forward”.
L: “I feel like giving benevolance for the good of her children”.
F: “I give her the courage to leave her husband, for the good of her children”.
The counselor to M: “ Have you listened to what they have given you?”
M: “Yes”.
Counselor: “ How did you feel? Did you feel welcome?”
M: “Yes!”
M is visibly moved, so G stands up, goes close to her and holds her hand, but the other patients also hold each others hands and they all give a spontaneous hug around M. This group hug lasts a few minutes, the emotional charge is very strong. After the hug, the patients return to their seats.
Counselor to M: “How are you feeling? How did you feel in the hug?”
M: “I felt understood”.
G adds: “ I felt enveloped by the group”.
L: “I felt wellness and positive contact”.
D: “I also felt the contact, I felt warmth…”.
The counselor ends the activity by allowing time for the feelings of the patients. At the end of the session there is a general sense of relaxation among the group which the spontaneous hug inevitably

helped generate.

Here and now: it is one of the elements that make up the counselor/patient relationship and according to the GC it is the only way to live the moment. As we will see in the following example, starting from "here" and "now" can open many roads of self-awareness and/or of reflection for the person who is speaking, as well as for the other patients, who can relate with that which the others have gone through.
B starts the group discussion by saying: "I am quite happy because I get out tomorrow, and there is the prevision of an apartment."
Counselor: "When will you see your son again?"
B: "I'm not sure. I must call him first. I would like to see him when I feel stronger. During my childhood I also experienced a separation with my parents and when I think of him I'm afraid of doing to him what was done to me."
Counselor: "What is it that you fear the most?"
B: "Loneliness."
Counselor: "Who do you trust the most?"
B: "My mother and my son. I don't trust myself."
While B spoke of his experiences, of his past, of the presence of an alcoholic violent father, L left the group and returned 10 min. Later, when the counselor asked her: "Before we spoke of emotional and affectional autonomy with B, what do you think?"
L: "My stomach tightened, I had to leave the room. I also lived through the same situation as B because my father was an alcoholic. It took me back to when I was little, but different from his, my father was too present and he conditioned many choices in my life."

The empty chair: this is a technique that has as an objective to increase the awareness of ones feelings and the meaning of ones emotions. It consists in asking one to speak to a feeling or an emotion that is sitting in a chair, often to a person or to an object which is nominated or remembered, after having immagined it seated in an empty chair in front of the patient (for example to speack to ones own sadness, to ones partner or child, to an old photograph of oneself as a

child, etc.
The excercise is proposed to Mo. The counselor introduces the activity by explaining to Mo. that she should take on the role of mother, since in the first part of the group session she spoke of her difficult relationship with her son.
Counselor: “Now pretend that your son is sitting in the chair in front of you. Mo, what did you want to communicate to your son with your suicide attempt?”
Mo.: “I don't know, I feel so guilty...”
Counselor: “Tell your son, not to the group. Your son is sitting there.”
Mo. breaks down in tears and says: “He is like my ex-husband, he has such as strong personality.”
The patient is not able to communicate directly her emotions to her son and affirms that it is exactly this difficulty which she feels. She also adds that she feels stuck in this stagnant situation. The counselor invites two patients to grab Mo's hands and pull them, each to their own side. The counselor asks Mo: “How do you feel in this position?”
Mo.: “Bad” And lets go.
Counselor: “How did you feel? What were the most prevalent feelings?”
Mo. “I felt held down, incapable of acting, of going in one direction or another.”
Counselor: “Therefore between your son and the attempt to commit suicide, not one thing prevaled over the other?”
Mo: “In those moments the desire to end everything prevaled. My son gets angry when I do these things and I feel like I disappoint him. I feel like I should have a better rapport with him.”

In the group: each person is given a piece of paper with twelve caricature strips, in each one is represented the dynamics of a relationship. The patients are asked to identify which strips best represent the dynamics in their family, and to identify the man that represents themselves.
F-C: “They all turn their backs on me. I feel underestimated, especially by my cousin. He, along with his wife, imposes his wishes on me and I feel stepped on.”

Counselor: “What do you do in order to not feel stepped on?”
F-C: “I protest, that's all. The reality can be changed, but I don't know how to make them understand me. I tolerate it....”
Counselor: “Then where do you vent all this that you tolerate?”
F-C: “In tears”
P.: “Can you try to speak and explain, just like you have done with us, in a clear fashion.”
Counselor: “She has expressed herself in a clear and serene fashion, therefore this is a mode which is part of her and which she can use with her cousin.”
R: “My family and Dr. Maiolatesi[9], are deciding for the TSO[10] and for everything in my life. It is a conspiracy that torments me and makes me angry”[11].
Counselor: “One word comes to mind, RESPONSIBILITY, especially with regards to ourselves. What advantage is there in the fact that others decide for you?
R: “None... Sometimes I've asked my sisters for advice.”
Counselor: “You have two sisters, both older”?
R: “Yes, I'm the youngest and I'm the one who gets trampled on”.
M: “The group is the comunity of Monsano, I feel like a child in day care, while the others are tall and pass judgements. I feel smaller. I isolate myself from the whole town”.
Counselor: “Do you feel lonely”?
M: “Yes”.
Counselor: “And where do you feel the loneliness”?
M: “Back aches, my teeth hurt and I feel an adrenalin rush that comes out in verbal agression, I become very impolite”.

7. Conclusion.

[9] Dr. Moreno Maiolatesi is a psychiatrist in the Department of Mental Health, who at the time of this group worked at the Center of Mental Health. He currently is working in the S.P.D.C.
[10] TSO: Obligatory Health Treatment.
[11] The state of paranoia of this patient is quite evident.

The institution as a whole maintains a grade of oppression if it is conceived for someone else instead of being conceived inside a more complete project for the community, and therefore for each individual. If, on the other hand, the psychiatric department is encompassed within a community project, with the objective of socially integrating the individual who is experiencing mental trouble, then it is possible to stem the solitude of a global citizen, especially of those who have greater difficulty in relating.

The experience of those who operate in a community of health care is vast: in the daily sharing of exchange, of food, of moments including boredom, it is for everyone a constant testing of the fundaments of the existing bonds among each individual.

In this sense, the role and the importance of a councelor in the S.P.D.C. is part of this thread, or rather in being a collector between institution and society and starting and continuing the journey of "democratization" of the institution which started with the law 180. The presence of a counselor in the S.P.D.C. is one of a professional caregiver and rehabilitor, but before this, taking into consideration the history and birth of such a figure in our country, it is the expression of political and civil tension. Today, as Focault and Basaglia noted already in the '60s, the risk of segregation does not go through prohibition and reclusion, on the contrary. On one hand there is the constant attraction to participate in the enjoyment of goods, consumption, on the other hand in the planing of the assistance, according to specific programs of assisted invalidity. If the segregation at one time impeded a certain number of disadvantaged people to be complete citizens, the modern version transforms citizens in anonymous benefactors of services (of entertainment, of care, of support...) The danger today is to create pre-organized areas to manage those afflicted by madness or social contradictions in which to work with a complex system of technical-specialistic interventions where the attention for the individual gives way to an efficient culture which responds indiscriminantly to the needs (housing, employment, psycho-sociotherapy, free time) of entire spheres of users.

It is in fact in the imperfect and partial nature of a counselor that the process of "*humanization*" can be found, from a rigid institution

not to respond exclusively to needs but to ensure these are heard, individuated, and felt not only from the service / institution, but from the entire community.

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