

FROM THE HOSPITAL TO THE CITY

Space in Institutional Psychotherapy

Susana Caló and Godofredo Pereira

The importance of space in clinical and psychiatric care is widely asserted. Foucault's writings have demonstrated how architecture has both mirrored and influenced conceptions of mental illness throughout history. The hospital, the asylum or the prison – as devices that spatially organize a population – are key examples of this, in manifesting the emergence of a population as an object of knowledge.¹ Following from this, research on the architecture of psychiatric hospitals has mostly focused on the influence of 19th century utilitarian typologies (such as Bentham's Panopticon) on modern architecture's design of collective equipment. From this perspective space is understood as a device for the organization and control of a population. However, we believe the role that space and the architecture of psychiatric institutions plays in therapeutic processes requires a more detailed approach. Space has played a key role in therapy that goes far beyond that of enclosing a population, or managing visibility. For that reason we will focus on the institutional psychotherapy movement in France, with the purpose of broadening the discussion of the relationship between the clinical and the spatial. This paper will explore three key moments in the history of the institutional psychotherapy movement: the reorganization of the Saint Alban hospital by the psychiatrist François Tosquelles, the procedures set up by Jean Oury and his collaborator Félix Guattari at the La Borde clinic, and lastly the research on architecture, urbanism and psychiatry developed by the research group Centre d'études, de recherches et de formation institutionnelles (CERFI).

Our argument in this piece will be twofold. First, we identify a continuity – from Saint Albans to La Borde, and to the CERFI – in considering that space is not simply a factor that should be taken into consideration, but that it is actually an *active* therapeutic agent. Secondly we will demonstrate how this understanding of space as key to treating the institution led members of the institutional psychiatry movement to propose a move from the paradigm of the isolated hospital to a paradigm of distributed activities of care, integrated within the city. Finally, we will argue that in doing so space was fundamental to the movement's development of a renewed perspective regarding the relation between the

¹ See, for example, Foucault, Michel. 1979. *Les machines à guerir: aux origines de l'hospital moderne*. Bruxelles: Pierre Mardaga.

clinical and the social, and regarding the conceptualization of health care as involving the problem of how to design cities – something that is of extreme relevance for today.



Saint Alban Hospital, Lozère. Aerial photograph.

Saint Alban and Geopsychiatry

Key to the discussion of the role of space in psychiatry is the emergence of the institutional psychotherapy movement. This appeared gradually within a broad movement of psychiatrists at the end of World War II who saw the need to think the hospital in relation to the community at large. François Tosquelles played a fundamental role in this regard. A psychiatrist, psychoanalyst, and left-wing militant, in January 1940 Tosquelles was invited by Paul Balvet to re-organize the hospital of Saint Alban in Lozère. Under his direction it became a site of resistance and militancy in both political and medical terms. At Saint Alban, Tosquelles put several procedures in place whose purpose was to break social and political barriers and to dismantle fixed roles. At the heart of this was the idea that the hospital could no longer be treated as a passive instrument or as a stable geographical site. Rather, it was important to grasp its institutional and social dynamics as part of the context of treatment. Examples of these procedures were the elimination of uniforms for doctors and nurses and the setting up of several collective events and structures. One of these was the intra-hospital Club, created to give responsibility to the patients while serving as a meeting place. Another was the creation of a journal published and edited by the patients titled *Trait D'Union*. Equally important were the theatrical activities, which typically took place in the bar. As

Camille Robcis argues, “as Tosquelles repeated throughout his work, the hospital – its architecture, its activities, its staff – constituted a *collectif soignant*, a ‘healing collective’”.² But the point was not simply to modify the spatial organization or the laws that governed the hospital. A more fundamental reassessment of psychiatric care was a stake, one that sought to move away from the idea of the hospital as a socially secluded environment – as it had been conceived up until that point.

This leads us to the essential aspect Tosquelles’ presence in Saint Alban: the breaking of the walls of the hospital: “One day, we tore down the walls of the compound. There was no longer a border between the hospital and the village of St. Alban... after the war, the liberation of the territory was also the liberation of the asylum.”³ There can be few cases where the often-repeated claim of tearing down the walls of institutions was so literally realized. There were, however, several reasons for this – some of them essentially pragmatic. The hospital of Saint Alban was isolated in the mountains, with about 600 patients. Its condition was extremely precarious, given not only the scarcity of resources during the war but also the geographic and climatic settings. However, it was also close to a small village. For that reason opening the walls to allow contact and trading with the village was of key importance for the fight against famine. It was because of this act that during the war Saint Alban was one of the few hospitals in which there was no death by starvation. To put this in perspective, it is understood that approximately 40,000 patients died during the German occupation of France, in what has been described as a process of soft extermination of the mentally ill.⁴ But this did not happen in Saint Alban, because there was the possibility of leaving, of going to the mountain to get food and the materials required to maintain life.

However, we should bear in mind how the decision to tear down the walls of the hospital was more than a response to the contingencies of the war. In fact the “breaking of the walls” at Saint Alban also occurred with regard to many of the internal partitions in the hospital, promoting a more flexible and less enclosed series of spaces. What is important to notice is how this is something that Tosquelles brought with him from his early experience with psychiatric reform in Spain, and it evidences the influence that the system of *comarcas* in Catalonia had upon him. Implemented by the regional government of Catalunya in the period from 1911 to 1924 as part of a broad process of territorial reorganization the subdivision of the territory into different *comarcas* (districts) resulted in a series of initiatives to promote the decentralization of psychiatric care (away from the main cities), allowing

² Robcis, Camille. 2016. "François Tosquelles and the Psychiatric Revolution in Postwar France". *Constellations*. 23 (2): 218.

³ Tosquelles quoted in Robcis, "François Tosquelles and the Psychiatric Revolution": 218. Original quote from Bruno Coince, “Malades, m’edecins, infirmiers . . . ‘Qui gu’erissait qui?’” *Midi Libre*, December 3, 1991. Archives Lucien Bonnaf’è, IMEC, LBF 70 St Alban 95.

⁴ Lafont, Max . *L’extermination douce. La mort de 40 000 malades mentaux dans les hôpitaux psychiatriques en France, sous le régime de Vichy*. Editions de l’AREFPPI, 1987.

patients to remain within the proximity of their families. In the words of one of the leading figures of this process, Vives I Casajoana, it was important to establish “a support network that is not centralized, one that is dispersed throughout the length and breadth of Catalonia with the intention of not removing patients from their families and their environment while at the same time satisfying the need for intermediate devices between hospital and social life, as well as the need to organize and form an effective service of nurses and social workers that would make possible that link and could follow the sick outside the hospital, to try to prevent the disease and its relapse.”⁵ Allowing patients to live close to their natural environments would prevent further trauma and make reintegration easier. This was an approach that would have a lasting influence on Tosquelles, and one that preceded what came to be known later in France as sector psychiatry.⁶ For Tosquelles and his colleagues this was a matter of replacing isolation and confinement by a more nuanced and integrated set of approaches to mental health care. They had in mind a diversification of strategies of care that included non-medical services and visiting the patients in their homes (this was a typical occurrence given the deep integration of the hospital with the village daily life). Geopsychiatry is the name that the *Société du Gévaudan* –a professional group created by Bonnafé and Tosquelles and based in Saint Alban – gave to this broad range of activities and spatial understanding of care.⁷ Space was not only the site of therapy: it became the object, and increasingly the means, of therapy.

La Borde Clinic

Tosquelles’ transformation of Saint Alban was central to the development of institutional psychotherapy and saw the involvement of important intellectual figures such as Franz Fanon, Lucien Bonnafé, Georges Canguilhem, Georges Daumézon, Marius Bonnet, Paul Éluard and Jean Oury. It was the latter who would be responsible for the creation of another important case where space was central to psychiatric experimentation, the Cour-Cheverny Clinic (La Borde).

After establishing the clinic in 1952, Jean Oury invited Félix Guattari to help develop the patient’s club (an intra-hospital committee similar to the one in Saint Alban). In their perspective, institutions were ill and it was necessary to treat them. Oury coined the term “pathoplastic” (pathoplastique) to refer to pathologies caused by the patients’ environment, such as the patients’ living conditions, their lack of friendships or respect, and the deresponsabilization of patients over their daily lives and their loss of accountability.

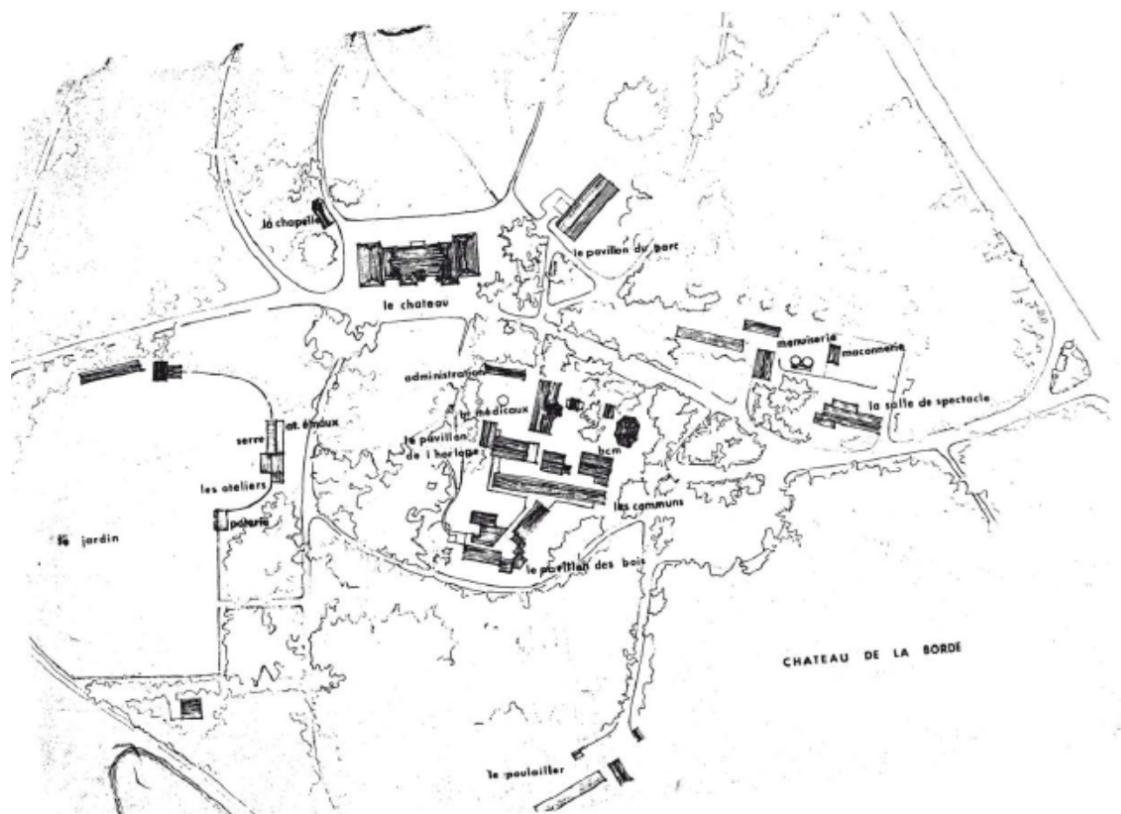
⁵ Salvador Vives I Casajoana, in Josep Ma Comelles, *La raxon y la sinrazon*. Edit. P.P.U., Barcelona, 1988:110.

⁶ See Robcis "François Tosquelles and the Psychiatric Revolution": 212-222.

⁷ The *Société du Gévaudan* included both permanent and visiting doctors, nurses, members of the resistance and their families. In Dosse, Françoise. 2011. *Gilles Deleuze and Félix Guattari: Intersecting lives* (New York; Chichester: Columbia University Press) pp. 41-42.

Hence the famous motto: “To treat the ill without treating the hospital is madness!” Very soon Guattari became involved in instigating a series of activities at the clinic, from workshops, to drawing sessions, to gardening and organizing the newspaper, etc. Such organizational protocols were set in place with the primary goal of stimulating patients’ autonomy, allowing them to regain a sense of responsibility and to “re-appropriate the meaning of their existence in an ethical and no longer technocratic perspective.”⁸

For Oury and Guattari, the fabric and dynamics of La Borde’s daily life was thought to offer analytic opportunities of diverse kinds. The scope of analysis was therefore no longer limited to the privacy of the consulting room but was extended to the whole of the institution. This implied looking at the spatial dynamics of the institution to prevent the reinforcement of power structures, as well as to identify opportunities of treatment. Like in Saint Alban, space was not seen as a mere container, but rather as an active participant. We will focus particularly on the “heterogeneity of spaces” and the “freedom of circulation”.



Site plan of La Borde Clinic.

⁸ Félix Guattari, ‘La Borde: a Clinic Unlike Any Other’, *Chaosophy*, ed. Sylène Lotringer, (Los Angeles: Semiotext(e) 1995 [orig. 1977]), p. 191.



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La Borde Clinic. Film stills from *La Borde ou le Droit a la Folie*. Igor Barrère, 1977.

Heterogeneity of Spaces

Whereas in a typical hospital medication was given in one key place (for instance the nurse's room), at La Borde the medication was administered in different spaces, and by different people. The reasons for this were twofold: firstly it makes it possible to break the hierarchical differences between nurses and doctors that were inscribed in the specific functions that each perform and the specific spaces that each inhabit. Secondly, this made it possible to extend the space of therapy to the entirety of the institution, as all its spaces were considered to be meaningful places of analysis. The series of events and workshops that Guattari organized were a key component of this in providing multiplicity of spaces and practices that allowed patients to invent new ways to inhabit the clinic. "It is a matter of working in a random field in which there can be unexpected, multireferential investments – as Tosquelles said – in a polyphonic dimension that cannot be programmed but which can indirectly manifest itself, if there are no structures that prevent this manifestation. The equipment cannot obtain this dialectical dimension. Our question is how to create a collective machine, a club – which is a part of it – that holds everyone accountable at all levels allowing for unexpected effects, interpretation effects."⁹ In this context, as Oury made clear, architecture was a non-negligible therapeutic vector: "The hospital as a set of reference spaces! What does it mean that a patient goes every day, for months, to a dark space in an unfrequented service staircase? (...) And the window, a place of opening to the beyond, a jump to death, a traditional phobic object!"¹⁰ To treat the patients involved treating the hospital and its human alienation. And in that sense both the physical structures of the hospital (the garden, the laundry, and the workshops) but also the human atmosphere (modes of communication, subjectivity) offered analytical possibilities, and thus contributed to the therapeutic impact of the institution as a whole.

It was in pursuit of this objective that Guattari and Oury set up a system called the grid.¹¹ The grid was a rotating schedule of tasks and duties, which ensured that people tried out a series of activities instead of just sticking to a repetitive routine. One of its key elements was demanding that people experiment with new activities. It also constantly exposed relations of power manifested at the institutional level, as well as emerging subjectivities connected with space. For instance, it revealed that many people wanted to do the laundry. Perhaps unsurprisingly, the kitchen was key: "The kitchen then becomes a little opera scene: in it people talk, dance and play with all kinds of instruments, with water and

⁹ Jean Oury, interview for *Percurso* (Andréa Carvalho Mendes de Almeida, Danielle Melanie Breyton, Deborah Joan de Cardoso, Silvio Hotimsky and Susan Markusszower). *Percurso* #44. *O Bom e o Mal Estar*, XXIII - June 2010, available here:

http://revistapercurso.uol.com.br/index.php?apq=artigo_view&ida=111&ori=entrev

¹⁰ Oury, Jean, "Architecture et Psychiatrie," *Recherches. 06 Programmation, architecture et psychiatrie* (Paris: June, 1967) 272. [Our translation.]

¹¹ For a detailed explanation of the grid see: Susana Caló, "The Grid", *Axiomatic Earth*, *Tecnosphere Issue*, *Anthropocene Curriculum & Campus*, House of World Cultures (HKW). Online at <http://www.anthropocene-curriculum.org/pages/root/campus-2016/axiomatic-earth/the-grid/>.

fire, dough and dustbins, relations of prestige and submission. As a place for the preparation of food, it is the centre of exchange of material and indicative fluxes and prestations of every kind.”¹²

Freedom of Circulation

For these heterogeneous spaces to work therapeutically, the ways in which patients and staff circulated through hospitals had to change: they had to be able to meet with caregivers, with other patients, and even with the outsiders who were occasionally invited to take part in the hospital’s activities. As Delion explains “the heterogeneity of spaces, groups, therapeutic activities, and interstitial times ... is of great importance in the multiplication of possibilities of the *palette*. But if the patient cannot move freely so as to be able to take part in all of these “transfers” – even partial, fragile, multiple – that heterogeneity is useless. And this is not only physical movement – rather a freedom of movement as encompassing the ‘psychic’. This is why it is essential to put in place a system in which patients can easily choose their own path.”¹³ If for Oury and Guattari the environment should include differentiated spaces this was so that the wanderings of the patients throughout the institution could provide the basis for therapeutic opportunities. As Oury explained in an interview ““A real encounter cannot be programmed. The path is done through walking, but if the path is already traced we always stay in the same place (...) It is by chance that there may be an encounter, but it is not imposed.”¹⁴ It was a matter of “programming randomness” – that is to say, of facilitating the conditions for meetings and encounters without attempting to determine their content.

In this way, at La Borde the freedom of circulation already present in Saint Alban became not only a method to promote unpredictable encounters, but also a diagram of how the daily life of the hospital was organized and how its relation to the broader social sphere was imagined. Moreover, randomness was not only conceived in relation to the internal life of the clinic. Despite being geographically isolated in the outskirts of Blois near the village of Cour-Cheverny, all sorts of socio-political connections touched La Borde. Guattari, in particular, sought to make of La Borde a similar space for militancy and intellectual activism that Saint Alban had been during the war.

CERFI

While working at La Borde, Guattari was instrumental in the creation in 1965 of the Fédération des groupes d’études et de recherches institutionnelles (FGERI). The FGERI

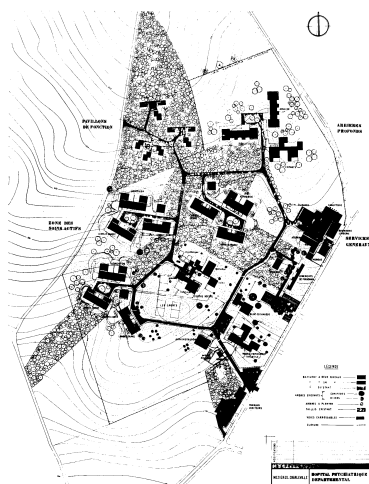
¹² Félix Guattari, *Chaosmosis: An Ethico-Aesthetic Paradigm*, trans. Paul Bains and Julian Pefanis (Bloomington: Indiana University Press [Orig. 1992]), p. 69.

¹³ Delion, Pierre, “Thérapeutiques institutionnelles” (2001), *EM-Consulte, EMC-Psychiatrie*, 37-930-G-10. Available here, <http://www.revue-institutions.com/articles/therapeutiquesinstitution.pdf>

¹⁴ Oury, interview for *Percorso*.

was composed of a network of psychiatrists, psychologists, teachers, town planners, architects, economists, academics and others, who were dedicated to the analysis of collective equipments of governance and institutional forms of oppression. This was a movement that was very much influenced by the experiences at Saint Alban. Following from the FGERI, the CERFI took form in 1967 as an institutional research center that transposed the lines of enquiry raised in institutional analysis to urbanism and to the city.¹⁵ Influenced by the experiences in Saint Alban and La Borde, the CERFI experimented with various modes of research production and with interdisciplinary research.

Of particular importance in this context was the creation by the FGERI of the interdisciplinary journal *Recherches*, edited by the CERFI. One particular issue merits our attention: Issue no. 6, “Architecture—programmation—psychiatrie”. Organized in 1967, it gathered contributions from architects of the FGERI, members of the CERFI and leading figures of the institutional psychiatry movement to discuss psychiatric hospitals and their relation to the city and to society. We shall focus on this issue in order to foreground the continuity of the focus on space that had its beginning in Saint Alban, and that now gained a properly urban dimension. The issue presents a discussion about “programs and norms” for psychiatric hospitals from the point of view of institutional psychotherapy and sector psychiatry, bringing together psychiatrist and city planners. Sector psychiatry originates in an opposition to the secluded hospital outside of town, along with thinking extra-hospital psychiatric alternatives, such as day hospitals, ambulatory treatment, community and home consultations. This evolved to become the basis of modern day community psychiatry, structured around the existing organization of the city, such as in *comarcas*, municipalities or boroughs.



Example of a Village Hospital.

¹⁵ The reason for the creation of the CERFI is due to the need for the FGERI to be able to enter into governmental contracts. François Fourquet “The History of CERFI”, interview – *SITE*. 2: 11.

Urban Hospital

One of the key texts in the special issue is a technical report titled “Programme d’un hôpital psychiatrique urbain de moins de cent lits,” (Program for an urban psychiatric hospital with less than 100 beds) by the doctors Guy Ferrand and Jean-Paul Roubier. This report develops a critique of the isolated hospital that followed 19th century types, but also of the model of “hospital villages” influenced by principles of modern urban planning and the Athens Charter. Consisting of large-scale structures for 300-600 people “hospital villages” were typically situated outside of a main town. Organized according to decentralized plans, with fluid circulations, they were subdivided into pavilions, each corresponding to a different function. In accordance to modern planning principles, they allowed for collective areas, for vast green spaces, for sun and for natural ventilation. However, as Guattari remarked in the introduction to the issue, despite being better equipped than traditional hospitals and offering better material conditions of hospitalization and care, village hospitals had “the disadvantage of having high concentrations of patients and of in general being distant from the usual *milieus* of social life”¹⁶.

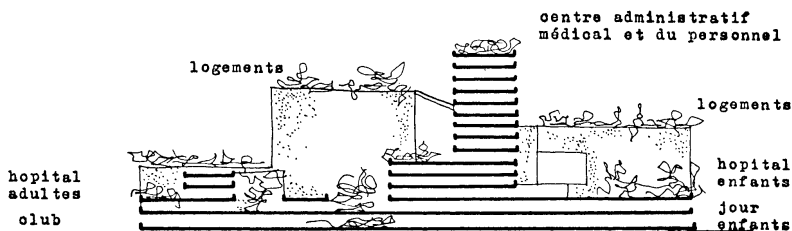
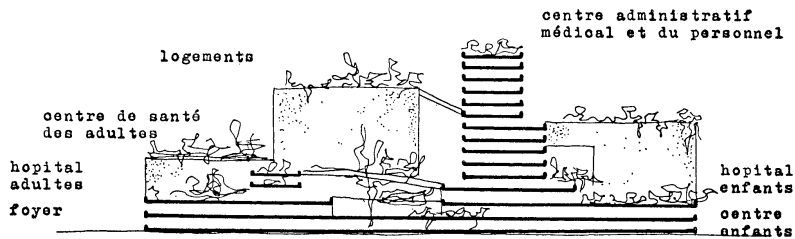
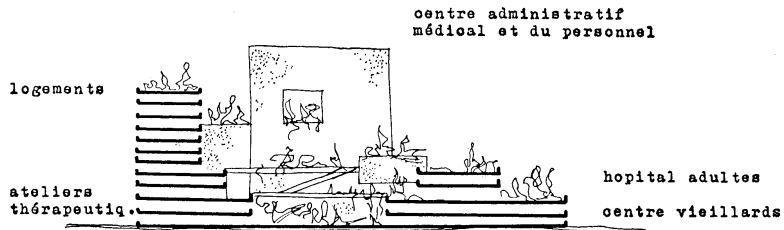
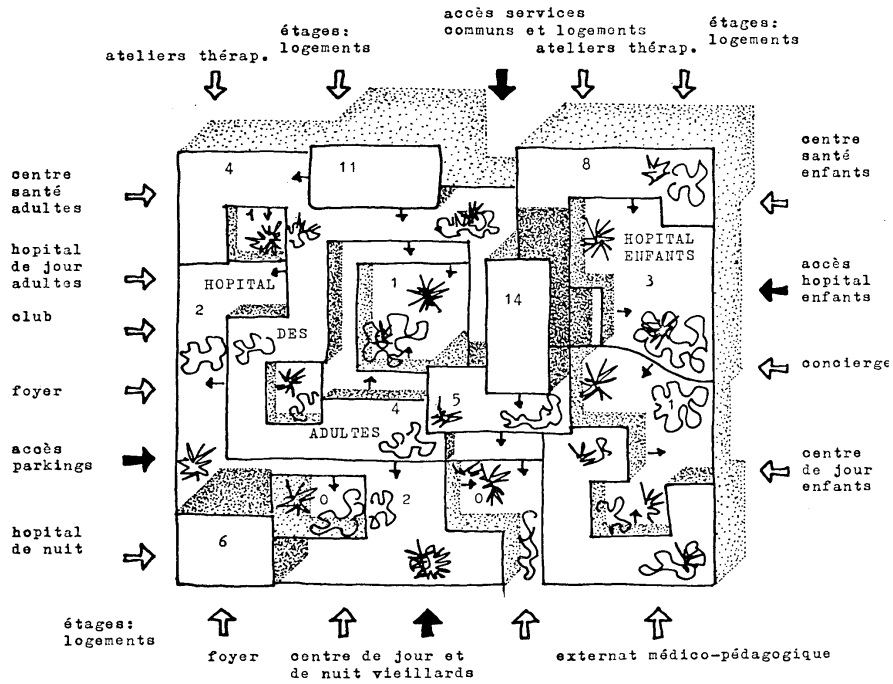
As an alternative to this, Ferrand and Roubier proposed that psychiatric hospitals should consist of units with less than 100 beds, and should be located within city areas. In a similar way to the system of *comarcas* that had been so influential for Tosquelles, they argued that these small-scale hospitalar units should be integrated with the other care activities of each specific urban “sector” (municipality). This would prevent psychiatric care from being excluded from health at large. Seen in these terms these units should be part of broader networks of part-time institutions, therapeutic workshops, day hospitals, home consultations systems, ambulatory treatment, drug rehabilitation programs, foster care units, visits to people’s homes, etc. – and of course connected with the local neighborhoods, parks, squares and other urban equipments:

“In a psychiatric hospital, and mainly in an urban psychiatric hospital, the definition of the hospital structure should fit into the idea of the participation of the realm of the hospital in the social equipment of the city. From the moment an urban institution is established, a real osmosis between its own equipment and those of the city should be implemented. The first therapeutic result is the permanent possibility of each hospitalized patient resuming contact with the real, outside of the artificial and unreal collectivity of the hospital.”¹⁷ Such principles are clear in architect Nicole Sonolet’s project “Un centre de santé mentale urbain. Proposition d’une expérience” featured in the issue.¹⁸

¹⁶ Guattari, Felix, “Presentation,” *Recherches. 06 Programmation, architecture et psychiatrie* (Paris: June, 1967): p.5. [Our translation.]

¹⁷ Ferrand, Guy and Roubier, Jean-Paul, “L’hôpital psychiatrique dans la cité : programme d’un hôpital psychiatrique urbain de moins de cent lits,” *Recherches. 06 Programmation, architecture et psychiatrie* (1967): 84. [Our translation.]

¹⁸ Sonolet, Nicole, “Un centre de santé mentale urbain: proposition d’une expérience,” *Recherches. 06 Programmation, architecture et psychiatrie* (1967): 137-155.



Nicole Sonolet. Un centre de santé mentale urbain. 1967.

The project is the result of reflections following the construction of a previous psychiatric hospital by Sonolet in the 13th *arrondissement* in Paris, and, as Sonolet wrote, following “discussions with different doctors, social assistants, staff, patients and family members of patients”. The proposal consists of a basic model for an urban hospital, identifying key technical, architectural and urban issues to be addressed. Of key relevance is how the project is designed to be one among many other medico-social facilities in the city. To this end the design refers very closely to projects that were being developed at the time, as a critique of the shortcomings of the modern architecture movement, which was replacing the functional division of the city with large complexes that integrated a diversity of services and a variety of programs.¹⁹

Two main design aspects are important to notice: firstly, the promotion of a strong relation with the city by setting up a series of services on the external perimeter of the site, and therefore encouraging encounters between those inside and outside. The reason for this is both to help the integration of patients but also to eliminate pre-conceived ideas about the psychiatric hospital among the local population. Comporting to this the complex is made accessible from all sides and the units can be independently accessed from the street level. Moreover, the use of a courtyard typology makes it possible for us to imagine how such a speculative project could provide a model that could negotiate very different urban settings. Secondly, according to the author the layout of the premises should maintain maximum flexibility in the use of spaces and the possibility of subsequent amendments, according to the needs that might emerge in the future. With this in mind Sonolet suggested that some areas (interior or exterior) could be left empty to allow the creation of new services or the expansion of local or existing ones.

In any case we should notice how this project is revealing of some of the problems and tensions faced by the sector psychiatry movement. In a closer reading we have to notice how the design does not so much involve a dispersion of health care facilities throughout the city, but rather their concentration into one single complex that is programmatically diversified – albeit smaller than the hospital village. But more importantly, the design is indicative of a problematic reduction of sector psychiatry into spatial and quantitative formulas – such as the reduction in size and the calculation of hospitals in terms of bed units per capita – that, by themselves, are unable to address mental health issues. Such a simplification of the problem of “madness” is the reason why, when they were finally

¹⁹ Important references are the project for “The Free University of Berlin”, 1963, by Candilis, Josic, Woods; the project for the “reconstruction of Frankfurt Römerberg”, 1963, by the same authors; or even Le Corbusier’s “New Venice hospital” of 1964. In any case it would be interesting to discuss the implications of presenting this unit as a single system of management, and if small or more distributed units avoiding the mega-complex would not be more adequate to the ideals of sector psychiatry.

implemented, the principles of sector psychiatry were received as reactionary by several groups in the medical community, and in particular by the members of the CERFI.²⁰

Leaving to the side a detailed discussion of a project of this kind from both clinical and architectural perspectives, what we find important here is how both institutional analysis and sector psychiatry expand the problem of the psychiatric hospital into an urban problem, instead of applying the very limited concept of the hospital as an isolated architectural object. The reasons for this are clear – as Guattari states in the introduction to the issue: “It makes it possible to consider, in very different terms, the problems of prevention, the comprehensive support of patients – not limited to the hospitalization steps – the relationships with families, social reintegration ... Merely establishing a relative proximity between the institutions of treatment and the habitat of the patients offers much more flexible possibilities. It thus makes it possible to contemplate, which is often necessary, short duration stays, in varying frequencies, trial releases, home visits, etc ...”²¹ In doing so the thinking of space was instrumental in foregrounding psychiatric care as a problem of the community – at the same time replacing a diagram in which madness implies social exclusion, by one in which it becomes a key element in the making of the city.

Concluding Remarks

In looking at these three moments of institutional psychotherapy it is evident that space and architecture are given a primary role. As we have seen, space enters not only as the background that needs to be taken into consideration, but also as a vector of health along two main lines: the heterogeneity of therapeutic spaces and the freedom of circulation. From Saint Alban to the CERFI space was central to a collective effort that sought to criticize social alienation and social relations at large, without losing track of the therapeutic needs and specificities of mental health care, in ways that differ significantly from the experiments in anti-psychiatry by Laing and Cooper, but also from the Italian *Psichiatria Democratica* led by Basaglia.²² It should be noticed, of course, that between Saint Albans, La Borde and CERFI there were key differences.

And yet, it is in the discussion of the relation between the hospital and the city that the consequences of promoting heterogeneity of spaces and freedom of circulation become more evident. The need for the integration of health care facilities in urban *millieus*

²⁰ For instance, the rule of three beds per 1,000 inhabitants proposed by Ferrand and Roubier quickly became out of date in several areas with fast population growth, such as the Parisian suburbs and satellite cities. Furthermore many forms of psychiatric control and repression continue to exist regardless, or independently, of hospitals. See Issue 17 of *Recherches* edited by the CERFI: “Histoire de la de la psychiatrie de secteur, ou le secteur impossible?” *Recherches* 17.

²¹ Guattari, “Presentation,”: 5. .[Our translation.]

²² At heart of this lies a critique of “the negation of the institution” present in both Laing and Basaglia’s work. For Guattari’s critique see “Guerrilla in Psychiatry: Franco Basaglia”; “Laing Divided” and “Mary Barnes’s Trip” in Félix Guattari, *Chaosphy: Texts and Interviews 1972-1977*. Edited by Sylvère Lotringer (Los Angeles: Semiotext(e), 2009).

progressively expands into a discussion of the role of collective equipments in the city. And in here, the proposal for mixing distinct functions and programs -in particular the promotion of a close proximity between residential and institutional areas- was not only a critique to the principles of the modern movement in architecture, but more importantly a cry against the exclusion of madness, and of minorities at large, from the collective life of the city. As pointed by Guattari, the point that discussions on space made amply clear, was that avoiding physical walls was not enough: more importantly, one had to think space in such a way as to avoid falling prey to the segmentation of the collective in identitary partitions such as the mad, the refugee, the female ...