From Ergotherapy to Resocialization

The Rise and Fall of the Pre-vocational Training System for Psychiatric Patients at the Central Hospital in Bucharest, c. 1966-2004

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Introduction

Work therapy has a very long history, being generally associated with the development of moral treatment in European psychiatry in the first half of the nineteenth century. This view, however, was recently challenged by Jane Freebody, following an analysis of a number of representative texts published by important authors from France, Tuscany and Britain. As Freebody convincingly showed, between 1750 and 1840 one cannot speak, at the theoretical level, of a specific recommendation of work in the treatment of the mentally ill. However, in practice, work had been used much earlier, since the second half of the eighteenth century, in institutions such as the York Retreat.[1] About this history that spans more than two and a half centuries, very little has been written. The latest, and most thorough contribution, is represented by the volume edited by Waltraud Ernst.[2] This collection of studies provides a comprehensive and critical assessment of the ways in which work and work therapy have been applied, in psychiatric institutions, in several countries, on different continents (Europe, America, Asia).

A previous review of the literature, published by Jennifer Laws[3] on the history of work therapy and other occupational therapies[4] in psychiatry, indicated at least two aspects worth mentioning here. First, according to Laws there are three major orientations in the academic research on this subject published in the last three decades.[5] The first approach has its origins in Michel Foucault's *Madness and Civilization*[6] and focuses on his governmentality thesis. The second approach comes from the historiographic writings of the specialists in the field of occupational therapy (OT). As Laws argued, these authors often ignore the Foucauldian critical approach in their attempt to highlight the relevant contributions made by major figures of the OT domain. The third approach, as presented and defended by Laws herself, offers a critique of the previous two orientations in the history of work and occupational therapy. Even if the author does not claim to offer a completely different perspective on the evolution of ideas and practices in this field, she convincingly argues for a balanced view combining the strengths of these orienta-

tions, while eliminating some of their weaknesses.[7] Second, and more important, from the perspective of the present paper, is the fact that Laws systematically explored the major cultural paradigms that influenced, for more than two centuries, the beliefs and practices in the domain of occupational therapy. These were, chronologically speaking, the following: Romanticism, the Arts & Crafts movement, biomedical reductionism, Freudian psychotherapy, industrial therapy and anti-psychiatry. A major contribution to the history of industrial therapy has been made by Vicky Long who showed a longstanding interest in the evolution of this field in postwar Britain.[8] With a more recent focus, Patrick W. Corrigan & Stanley G. McCracken have argued that two major paradigms have dominated the daily activities of the specialists in the field of professional rehabilitation, guiding their efforts to help the mentally ill in finding work, and keeping an independent way of life. The authors called these models the traditional or *"train-place" paradigm* (also called the medical or clinical model) and the alternative *"place-train" paradigm*.[9] The distinction has been also included by Stephen Bevan *et al.* in their report for the Work Foundation exploring the pathways and barriers to employment in the specific case of schizophrenia sufferers.[10]

At first glance, it is obvious that all these studies referred exclusively to what happened in capitalist societies (especially Western countries, like UK, Canada and US, but also some non-Western countries, as well). This is true even for the most recent and most thorough contribution to the field of work therapy, covering more than 250 years of history of patient work, in psychiatry, at a global scale, the aforementioned volume edited by Waltraud Ernst[11]. What is missing is an equivalent exploration and depiction of the history of ideas, beliefs and practices of occupational therapy in former socialist countries, in Europe, after World War II. It is well known that the communist bloc countries pragmatically applied both work and other occupations in the therapy of mental illness. According to Jőrn Holm-Hansen, in the USSR "The profession of work therapy (*trudoterapiia*) was developed by the well-known Soviet psychologist Solomon G. Gellerstein."[12] As Anton Yasnitsky recently showed, Gellerstein was one of the members of the first Vygotsky Circle, formed in 1924 in Moscow around Lev Vygotsky and Alexander Luria.[13] So, there is a longstanding tradition of work therapy in Russia, starting from the early 1930s.[14] At the theoretical level, a large number of articles, book chapters, and monographs have been published, in all former communist countries, discussing a variety of topics related to work therapy and rehabilitation in psychiatry.[15] A famous Soviet era textbook, by M. O. Gurevici & M. I. Sereischi, originally published in the 1930s and then translated into other languages, including Romanian,[16] examined thoroughly the field of occupational hygiene, both physical and intellectual, and the relevance of work therapy for patient recovery and social reinsertion.

Under these circumstances, a gap had to be filled, in the literature on the more recent history of European psychiatry, and especially in the narrower subdiscipline of the history of work and occupational therapy. Therefore, in the present paper, I intend to make a contribution to this field, by presenting an analysis of work therapies and other occupations, such as arts and crafts, in Romanian psychiatry. The focus of my research was the case of the Central Hospital—the most important psychiatric hospital in the coun-

try, located in Bucharest—during the late 20th and early 21st century. This mental institution was known under two different names under communism (i.e. The Gheorghe Marinescu Psychiatric Hospital and Hospital N°. 9, respectively). It is presently called, after the name of his founder, Spitalul Clinic de Psihiatrie "Al. Obregia" (The Al. Obregia Clinical Psychiatric Hospital).

It should be noted, from the beginning, that work therapy and other occupations have been employed in mental institutions in Bucharest ever since the mid-1850s, when the first workshops opened their doors to inpatients at the Mărcuţa Asylum, the first mental institution in the Romanian Principalities.[17] The first section of the newly established Central Hospital, inaugurated in October 1923, was the ergotherapy section.[18] Since then, the activity of work therapy has been continuous—with ups and downs—passing through several stages: 1) the first stage (1923-1944); 2) the intermediary stage (1945-1965); 3) the Resocialization stage (1966-2004). The pre-communist period in the history of the hospital, which ended in 1944 with the arrest of its director Dr. Petre Tomescu, by the communist regime, was characterized by the development of agricultural farms on the land attached to the Central Hospital and by the continuous practice of occupational therapy in workshops, as recommended by the founder of the institution, Professor Alexandru Obregia, in the 1920s.

During the early communist times, under heavy Soviet influence, the dominant figure in the field of occupational therapy was Dr. Ipolit Derevici, who occupied the position of director of the hospital between 1948 and 1952. He continued his activity as a physician, and head of a clinical department, until his retirement in 1969.[19] Another key figure in promoting ergotherapy for the treatment of chronically ill patients, especially schizophrenia sufferers, was Dr. Constanţa Ştefănescu-Parhon, who became Head of Department at the Faculty of Medicine in 1962. The third period, between 1966 and 2004, was dominated by Dr. Aurel Romila who became professor of Psychiatry at the Faculty of Medicine in Bucharest, in 1994, and remained a leader in this field until his retirement.

The aim of the present paper is to examine how resocialization departed from previous ergotherapeutical practices and to debate whether it represented a beneficial and progressive step forward or not. As a result, a re-evaluation of its heritage becomes possible, long after its disappearance, as a program of social psychiatry. In order to achieve that, the first step is to analyze the main theoretical ideas considered by Dr. Aurel Romila as a foundation for a synthetic medical doctrine of the therapeutic benefits of work and occupation. The second step is to briefly describe the practical implementation of Romila's ideas during the Resocialization stage (1966-2004), at the Central Hospital in Bucharest. With these goals in mind, let us have a closer look at the chronology of events.

From the dreams of a young apprentice to an old master's memories: the story of the Resocialization Centre

Psychiatrist Aurel Romila's first attempts to apply a number of simple techniques of occupational therapy in mental hospital wards date back to 1964 when he began working as a junior physician at the Central Hospital. His efforts eventually became more systematic, and gained a supplementary theoretical weight, as a result of a doctoral research, under Professor Vasile Predescu's supervision, during the years 1966-1969.[20] As a consequence of his observations and follow-ups on the evolution of his patients, Romila realized that chances of recovery were greater for patients diagnosed with acute psychoses who were offered art therapy in conjunction with psychotropic drugs, as compared to other patients, from the same clinic, who were not involved in any occupational therapies, and acted as a control group. In the early stages of what has become a lifelong research program, he asked permission from senior staff to escort some patients outside the wards and to stroll, for a few hours, on the alleys of the hospital at least once a week. He soon started to search for spaces, deemed more appropriate than wards, for new activities dedicated to this first study group of patients with psychoses. He discovered that for years a small group of chronically ill individuals had been performing manual labor in inappropriate spaces that had been active occupational therapy workshops in Obregia's time. Everything was now deserted and rundown. After the first visits to the former workshops, Romila also visited the buildings of the stables and the remains of the former agricultural farm, once a productive annex of the hospital. He made a request, addressed to the hospital manager, asking for permission to take care of those spaces and to reintroduce them into the therapeutic and economic circuit of the hospital.

In July 1975 Romila was appointed head of the Central Hospital's committee of ergotherapy.[21] From this new position, he insisted that he should be allowed the use of the former stables, the farm and a few other spaces, next to the specific area, where a football field was provided for inpatients. These pieces of property will constitute the nucleus of what would become the new clinical section for the resocialization of the mentally ill. As mentioned before, in the early stages of his career, Romila was mostly concerned with severe cases of psychosis, in particular with schizophrenia at the onset. During this period, he decided to undertake a series of studies, both alone and with his colleagues, focusing almost exclusively on patients with schizophrenia and their recovery.

With help from the Support Committee for Parents with Schizophrenic Children, founded by him in the early 1970s, Romila established an entirely different institution, affiliated to Hospital N°. 9. This was a peculiar option, as it was neither entirely dependent on the Ministry of Health, nor a typical clinic. This institution went through several stages, finally reaching a point where it was endowed with its own buildings. The plans of the new buildings were initially conceived by Romila and finally designed by an architect, the mother of a young patient diagnosed with a mental illness. Placed on the former football field, and near the former farm, the Reso remained the only clini-

cal department in Al. Obregia's hospital which was not built according to the plans of the founder. The Resocialization Centre was finally inaugurated in 1994 and "consisted of five buildings, two of which with ground floor and four floors each, with 50 wards, each limited to four beds for inpatients, an amphitheater for courses with students, a library, 16 offices for doctors, 18 workshops and a dining room of 300 m^2."[22]

Dr. Aurel Romila was inspired by the Arts & Crafts movement, which recommended a work cure instead of bed rest,[23] but also influenced by some theoretical conceptions about art therapy in Western countries (France, Germany, the USA). Dr. Romila further developed a complex non-pharmacological therapy program, in the Department of Resocialization, through handicrafts workshops, fine arts workshops, music therapy and cultural therapy (theatrical performances, poetry readings, conferences etc.). In 1982 Romila was involved in the "transcendental meditation affair," a politically framed scandal, which discredited many leading intellectuals. Along with other reputed specialists of the time, from the fields of medicine and psychology, Romila was excluded from the Communist Party, then dismissed from his leadership post, and sent to work as a low-ranking doctor at the Titan clinic, on the outskirts of the capital, until 1989. In November 1989, following a competitive application process, he returned to his previous post, temporarily occupied by Dr. Colino. Thus he resumed clinical practice at the Central Hospital and took the position of lecturer in the Department of Psychiatry, at the Institute of Medicine and Pharmacy in Bucharest. From the same year, Romila resumed his old project of rehabilitation of the mentally ill.

Art therapy was systematically utilized in the new clinic, called Reso Clinical Section N°. IX, from 1994 to 2004, when the entire section was reorganized, under the leadership of the new head of department, Professor Dan Prelipceanu. After the retirement of Professor Romila, in 1999, the resocialization concept lost its prominence, and the employees—former colleagues and collaborators of Romila's—were assigned to other wards of the hospital. The activities of the handicraft workshops were reduced to a minimum, the industrial workshops eliminated, and the huge collection of psychopathological art of the clinic was cramped in a single room, where Romila was allowed to see patients, once a week, and meet the doctoral students under his supervision. As a result of these radical transformations, neither the students nor the psychiatric resident doctors could become acquainted with art therapy, complete an internship, or obtain any other forms of training in this field, which had been considered for decades as an integral part of the resocialization program of the mentally ill.

The Theoretical Basis of Resocialization

IN A lecture dedicated to secondary doctors specialized in psychiatry, Romila stated that "by the concept of resocialization in psychiatry we understand an emphasis on the social dimension of psychiatry and of the socio-economic dimension of the remission of the sick (...) The theory of resocialization is thus aimed at a change of the social life of the mentally ill and it applies all methods that lower alienation and increase social integration of the mentally ill."[24] As the author himself pointed out, the sources

of his theory of re-socialization were grouped into three categories: foreign experience, Romanian psychiatry experience and Romila's personal, first-hand experience. When referring to the foreign experience, Romila recalled both the practical side of sheltered workshops from various Western countries—and the USSR—and the theoretical contributions of Western, post-Kraepelinian, psychiatry.[25] Cited herein were the views of Eugen Bleuler, Karl Jaspers, Harry S. Sullivan, and Kurt Lewin. To all these were added: neo-psychoanalysis, microsociology, the sociology of Talcott Parsons, the praxiology of Tadeusz Kotarbinski,[26] and Marxism. The theory of resocialization was based on four postulates, formulated by Romila as follows:

> 1. *The ontological postulate* establishes that the process of resocialization derives logically from the process of normal socialization. So, there is a correlation between the structure of re-socialization and the process of socialization; 2. *The phenomenological postulate* establishes that the essence of mental illness is a phenomenon of de-socializing, a kind of social failure, followed by a decline in productivity, a sort of "fall in the basement of the personality" where the patient is reduced to his dimension of a "consumer for the sake of consumption"; 3. *The clinical postulate* establishes that this phenomenon of de-socializing, even during the stages of the same disease, may take the mind of the patient to different levels of disorganization—mental illness itself being a reorganization of the mind on a lower level having a positive and a negative side. 4. *The etiopathology postulate* which emphasizes the value of the social dimension of etiology, even in psychopathic or endogenous diseases.[27]

Even if his name was not mentioned, one could easily see the influence of the organo-dynamic theory proposed by the French psychiatrist Henri Ey (1900-1977). Henri Ey's presence is obvious, not only in the specific manner in which Romila defines and theorizes mental health and mental illness, but also in the formulation of his theses, as postulates.[28] No wonder then that some colleagues considered the doctrine of resocialization a mere imitation and a humble application of Ey's organo-dynamism. In a personal communication, Romila rebuked this appraisal as unfair criticism, and a major mistake. Romila acknowledged that the Reso doctrine had indeed appropriated the structure of the human psyche and its de-structuration. To that, however, an entire new dimension was added, he claimed, i.e. the "social-pragmatic" dimension. This was finally conducive to a new theoretical synthesis, which Romila called, using a rather complex expression, "socio-economic and political organo-dynamism."[29]

At this point, the question is: in what respects did resocialization theory differ from earlier approaches to ergotherapy. First, the rehabilitation in this new paradigm does not address those patients who are chronically ill, disabled or deemed mentally incurable. On the contrary, Romila believed that, as soon as the immediate crisis or the acute episode was resolved, with psychotropic medication, the patient was ready to perform a variety of physical activities in occupational therapy workshops located on the hospital premises. The aim of Romila's approach was to avoid the chronic stage of the mental illness and the negative effects of long-term institutionalization.[30] Second, the workshops

built by Romila agreed with the dominant ideology of the socialist era of a rapid and irreversible industrialization, but also with a more general trend at the European level, which left agricultural work and traditional farming somewhere behind. In these circumstances, at both theoretical and practical level, the prototypical workshop was intended to become a full economic *industrial therapy unit* (ITU). Along with these *sheltered workshops*, situated right outside and near the clinic, additional handicraft workshops and workshops for art therapy (especially painting, drawing and sculpture) were placed on the first floor of the Reso building.

Third, from the perspective of the new theory, the patient was both an industrial-type socialist worker and a suffering person to be treated and cured. The ideal of resocialization was that this worker, (temporarily separated from his/her workplace—and work team—where he or she was carrying out a "social work," for the benefit of society), had to pass through an intermediary stage, as short as possible, of "work therapy" in sheltered workshops in a psychiatric hospital.[31] Afterwards outpatients were supposed to continue this work and only then would they be encouraged and supported by the Reso staff and the patient's family to resume the "social work," legally permitted to normal citizens. Of course, this return to society had to be planned and implemented carefully in order to prevent relapses and to maintain a stable remission. Towards this end, Romila developed an assessment tool, called the "remission-relapse scale," which was routinely used in assessing the work capacity of patients when discharged from the hospital.

Romila was critical of the management of the psychiatric institutions of the late '70s, based on the philosophy of "custodial" care, whereby the patient had to be hospitalized for a long time, controlled with neuroleptics, isolation, and put to rest. In my opinion, his criticism was directed at the communist psychiatric hospital as well, not just towards the "heritage" of the pre-Communist era (i. e. the 19th century asylum, or the early 20th century, capitalist, psychiatric hospital). It is interesting to consider from what vantage point Romila criticized the hospital. Was the residential mental hospital, for him, an obsolete institution? In order to answer this question, it should be remembered that, in a period dominated elsewhere in Europe by anti-psychiatry and deinstitutionalization, his theory about resocialization, among other things, looked at the hospital as not only necessary, but central to rehabilitation. He argued, however, for a new form of organization for a modern psychiatric hospital, and endowed it with a social mission and an entirely new purpose, i.e. a rapid re-socialization of workforce, and the reinstatement in society of former patients, soon enough to avoid adverse/negative/undesirable "side effects" such as institutionalism.[32] In Romila's model, the psychiatric hospital also had to play a more prominent social role, as a national *economic unit*, perfectly integrated into the larger socialist economy.

So, where did these ideas come from? As mentioned before, some of them have their origin in the organo-dynamic views of Henri Ey, together with his anti-antipsychiatric stance, based on the assumption that mental illness was not a myth but a harsh reality and no other place was better to deal with it than a residential mental institution. Deinstitutionalization, from this perspective, was a serious error.[33] Other ideas were a direct consequence of adopting a political-economic vision, whereby a psychiatric hospital would offer the State the necessary tools to recover and protect vulnerable patients,

usually with a modest socioeconomic status. A short-term goal was to reintroduce persons into the workforce as quickly as possible, in order to reduce labor shortages. This was also a strategy to reduce the costs of "custody" and related long-term care.

Romila's writings on economic topics related to resocialization explicitly considered Marxism as a philosophical foundation and as "the source" of economic concepts. These ideas have been used not only in scientific argumentation but also as a propaganda mechanism in his dialogues, and sometimes in open disputes, with various upper echelons of the society, who were involved in decisions concerning the fate of mentally ill. In this way, on the one hand, he emphasized the differences between pre-1965 conceptions of ergotherapy and resocialization, while, on the other hand, he argued for a more central position for the psychiatric hospital within the socialist economy. The reformed institution could thus play a major role in the recovery process of members of the workforce, who were temporarily impaired by mental illness.

The organization of the Reso Department

In their work, entitled "Resocializare – rezultate şi perspective" (Resocialization—results and perspectives), Predescu *et al.* (1980) presented some practical aspects of organizing a Resocialization Department in a psychiatric hospital. This department was thought of as a model institution destined to play a significant part in the healthcare system under the socialist regime to be emulated by other mental institutions throughout the country. The two pillars of this model were the "economic circuit" and the "medical circuit," which together would make up the "Resocialization Program." As the authors explained:

> Essentially, in this program, the patient plays a double role, in a medical circuit and an economic circuit, both indivisible and harmoniously designed. The medical circuit involves several stages, from hospital admission, passing through supervision, and intensive medical treatment, to maintenance treatment, in outpatient departments, with the aim for the patients to return to family and work. The economic circuit involves training in production, with the aid of psychotherapy.[34]

To financially support this system, a significant part of revenue, coming from the sale of products, was reinvested in tools and raw materials. Part of the income was distributed to patients, for their work, as recommended by the Ergotherapy Law of 1970[35] (revised in 1973 and 1974).

The approach developed by Romila, in the late 1970s, (and applied even after 1990), was actually one of "pre-vocational training" or "train then place," which was widespread in Europe in the years 1960-1970. This rehabilitation system was defined by Bevan *et al*., as "training and development to prepare an individual prior to seeking competitive employment. This includes training in general skills (such as formal and informal rules) for the working environment, and handling 'real-world' demands."[36] As mentioned before, this "medical model" of rehabilitation has been usually contrasted with "supported employ-

ment," the second vocational rehabilitation model.[37] Bevan *et al*. also reviewed the relevant literature comparing the outcomes of these two major types of vocational training approach. One important finding was that "Evidence suggests that 'train then place' models do not have a high success rate in placing people into competitive employment, despite the fairly widespread use of this model."[38] As a result of these investigations, Bevan *et al.* reached the conclusion that the models of "supported employment" were more effective in terms of increasing employment rates, in a competitive labor environment, for patients with severe mental disorders, such as schizophrenia.[39] To the same conclusion arrived some of the studies cited by Judith A. Cook & Lisa Razzano in their literature review on the same topic[40] and, more recently, similar results were achieved by a randomized controlled trial (RCT) study performed in Switzerland.[41] All these studies reflect the view that psychotic patients and, in particular, those with schizophrenia, can adapt to the demands of competitive employment and manage to maintain work quality, while building functional interpersonal relationships (e.g. interactions with supervisor and coworkers), a perspective which not all authors or health professionals endorse. Based on his observations, Romila seemed skeptical, in some of his writings, about the ability of severely mentally ill persons, particularly schizophrenia sufferers, to adapt to a very competitive work environment, even with family support and resocialization training.

Conclusions

IN ITS maturity stage, Reso was the first comprehensive program of social psychiatry in Romania aiming to reform the psychiatric institutions, and particularly mental hospitals, of the custodial/residential type, and to supplant earlier practices of ergotherapy, which were widely applied up until the 1970s to chronically ill patients. With a history spanning several decades, the program was based on a rather original theoretical synthesis developed by Dr. Aurel Romila, from a series of psychiatric doctrines formulated in France, the UK, the US and other countries, along with ideas from a number of economic and social theories. From a practical standpoint, the Resocialization program implied the building of a series of workshops for patients to work in, workshops for art-therapy, a library, and some dedicated spaces for music therapy and cultural therapy. Starting in 1994, the program had its own buildings, on the premises of the Central Hospital, thus becoming a full-fledged Resocialization Centre with the status of a university clinic, equipped with 50 beds.

Considered from the perspective of its industrial therapeutic unit (ITU) workshops, the Reso Centre was based on a philosophy of vocational rehabilitation of the prevocational type, also known as "train then place." This worked well, for several years, in a biomedical paradigm centered on the mental hospital (i.e. a "medical model" of rehabilitation). The model was later replaced, in other countries from Western Europe and the US, by a new model, deemed superior, inspired by a different paradigm arising not from medicine but from the field of social work, and fulfilling the criteria of an evidence-based practice (EBP). The new model was called the *supported employment* model, or "place

then train." As a program of social psychiatry, and as a management strategy for mental illness, in hospitals, resocialization represented a significant breakthrough, in a dual sense, in relation to the dominant philosophy of psychiatric therapy, in Romania, especially after the advent of psychotropic drugs: 1) First, in relation to treatment focused exclusively on pharmacological remedies, isolation and "bed rest cures"; 2) Second, in relation to classical occupational therapies, centered on the chronically ill, those with mental disabilities, and convalescents. From this perspective, the abolition of the Reso clinical section of the Al. Obregia Psychiatric Hospital in 2004 represented a step backwards in the management of hospitalized patients. It meant, in fact, a return to old therapeutic strategies centered not on patient needs or on human development, but on the medication, isolation, and bed rest triad. It is true that, under the impulse of international organizations, non-governmental organizations (NGOs), and the adoption of new approaches to psychiatry, the past decade has witnessed a development of community psychiatry in Romania, but at the cost of abandoning an entire direction of useful social action: i.e. the vocational rehabilitation of former inpatients.

The abolition of vocational rehabilitation services, at a national level, could prove damaging, in the long run, primarily for the sick, but also for society as a whole. Patients with acute psychotic episodes cannot currently benefit from a range of psychosocial and vocational methods, which—in addition to psychotherapy and psychotropic medication—could help them avoid the chronicity stage of their mental illness, through early detection, intervention, and better targeting. This is especially serious for those forms of acute psychosis that prove to be incipient schizophrenia and could benefit from an early intervention and tertiary prevention.

Patients with multiple admissions to mental hospitals continue to fall out of the economic system, both private and public. Due to social drift and stigma, persons with severe mental illness are forced to adopt a definitive role of second-hand citizens, permanently dependent on income provided by the state. This leads to even greater poverty and stigma. In addition, long-term hospitalization without interventions aimed at an early physical and mental mobilization, and participation in a variety of social programs, cannot but result in a loss of social and vocational skills. This hinders reintegration into the community while increasing the costs of recovery through psychosocial and behavioral interventions implemented at a later stage.[42]

I argue that a modern paradigm, of a "place then train" type, can significantly contribute not only to increase the quality of life of the mentally ill population, but also to lower unemployment rates—which have been increasing, for this category of citizens, as in other European countries.[43] Society as a whole would benefit in the long run from reduced government spending, better healthcare policies and a healthier workforce.

At the same time, considering the artistic heritage of the Reso Centre, one can see that a large collection of psychopathological art—maybe the largest of this kind at national level, with tens of thousands of works—remains completely isolated from its intended beneficiaries: on the one hand, clinical residents and junior psychiatrists, who cannot gain exposure to or training in art therapy like their colleagues in other countries, and on the other hand, the general public, who currently has no access to these artistic productions as is the case in France, Belgium, Austria, or elsewhere. In these countries

such collections are considered valuable parts of the cultural patrimony, being hosted by modern and well managed museums of psychopathological art. It is therefore incumbent upon the managers of the modern Al. Obregia Clinical Psychiatric Hospital to allocate a proper space for art-therapy for their inpatients and establish a museum of psychopathological art open to the public. These much needed institutions could make good use of Dr. Aurel Romila's extensive collection of patient art, which was started in the late 1960s and continued into the early 2000s, and could open, in the near future, new and innovative directions in therapy and clinical research.

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Notes

1. Jane Freebody, "The Role of Work in Late Eighteenth – and Early Nineteenth-century Treatises on Moral Treatment in France, Tuscany and Britain," in *Work, Psychiatry and Society, c. 1750-2015*, edited by Waltraud Ernst, 31-54. Manchester: Manchester University Press, 2016. Back in 1985, Laura Harvey-Krefting, using Thomas Kuhn's terminology, called this period "preparadigm stage." See Laura Harvey-Krefting, "The Concept of Work in Occupational Therapy: A Historical Review," *American Journal of Occupational Therapy*, 39 (1985): 302-3.
2. Waltraud Ernst, ed., *Work, Psychiatry and Society, c. 1750-2015*. (Manchester: Manchester University Press, 2016).
3. J. Laws, "Crackpots and Basket-cases: A History of Therapeutic Work and Occupation," *History of the Human Sciences* 24 no. 2 (2011): 65-81.
4. The term *occupational therapy* originated in the United States in 1914. The American Occupational Therapy Association (AOTA) was established in 1917. In a very short time, the field evolved into a distinct health profession, in the early 1920s. In 1931, John S. Coulter, M.D., and Henrietta McNary, OTR, wrote: "Occupational Therapy may be defined as any activity, mental or physical, definitely prescribed and guided for the distinct purpose of contributing to and hastening recovery from disease or injury and assisting the social and institutional adjustment of individuals requiring long and indefinite periods of hospitalization." See John S. Coulter, Henriette McNary, "Necessity of medical supervision in occupational therapy," *Occup Ther Rehab* 10 no.1, February 1931, 19.
5. Ibid., 67.
6. Michel Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason*. (London: Tavistock, 1961).
7. J. Laws, "Crackpots and Basket-cases," 67.
8. Vicky Long, *The Rise and Fall of the Healthy Factory: The Politics of Industrial Health in Britain, 1914-1960*. Basingstoke: Palgrave Macmillan, 2011; Vicky Long, "Rethinking Post-war Mental Health Care: Industrial Therapy and the Chronic Mental Patients in Britain," *Social History of Medicine* 24 no. 4 (2013):738-58; Vicky Long, "*Work is Therapy? The Function of Employment in British Psychiatric Care After 1959*," in *Work, Psychiatry and Society, c. 1750-2015*, edited by Waltraud Ernst, 334-350. Manchester: Manchester University Press, 2016.
9. P. W. Corrigan, S. G. McCracken, "Place First, Then Train: An Alternative to the Medical Model of Psychiatric Rehabilitation," *Social Work* 50, no.1 (2005): 31-9.
10. S. Bevan et al. ,*Working with Schizophrenia: Pathways to Employment, Recovery & Inclusion*. (London: The Work Foundation, February 2013).
11. Waltraud Ernst, ed., *Work, Psychiatry and Society, c. 1750-2015*.

12. Jørn Holm-Hansen, *Introducing Occupational Therapy in Russia. Swedish efforts evaluated. NIBR Report 2009-10* (Oslo: Norwegian Institute for Urban and Regional Research, 2009), 17.
13. A. Yasnitsky, "Vygotsky Circle as a Personal Network of Scholars: Restoring Connections Between People and Ideas" *Integr Psych Behav* 45 (2011): 428.
14. Arguing for continuity of work therapy as a profession, throughout the history of healthcare, in Russia, Holm-Hansen pointed out that: "Work therapy today is applied mainly within social work with psychiatric patients, among blind people, and within neurological and poststroke rehabilitation" (J. Holm-Hansen, *Introducing Occupational Therapy in Russia* 2009, 17).
15. Just a few examples to illustrate the application of work therapy—and other occupational therapies—in mental healthcare, in former socialist countries: **Russia**: V.G.Sotskov "From colonies for the mentally ill to the regional psychiatric hospital (on the 100th anniversary of the M. P. Litvinov Psychiatric Hospital)," *Zh Nevropatol Psikhiatr Im S S Korsakova* 84 no.5 (1984): 771-3. [Article in Russian]; A. M. Shereshevski- "History of the introduction of the open-door system," *Zh Nevropatol Psikhiatr Im S S Korsakova* 72 no. 3(1972): 459-62.[Article in Russian]; O. A. Balunov, B. B. Malakhov, R. P. Petrova, P. P. Ivanov, "Occupational therapy in psychiatry and neurology," *Med Sestra* 43 no.4 (1984): 24-8. [Article in Russian]; B. B. Malakhov, "Apropos of the stabilization of therapeutic remission in schizophrenic patients using combined occupational and pharmacological therapy", *Vopr Psikhiatr Nevropatol* 11 (1965): 307-15. [Article in Russian]; B. B. Malakhov, "Apropos of the Role of Associated Drug and Occupational Therapy in the Readaptation of Patients with Schizophrenia of Long Duration," *Vopr Psikhiatr Nevropatol* 10 (1964): 300-11. [Article in Russian]; A. M. Shereshevskii, "Development of services for mental patients in the USSR", Curr Psychiatr Ther. 23 (1986): 217-20; **Poland:** T. Stanczak, "Traditions of ergotherapy in Polish psychiatric hospitals," *Psychiatr Pol*. 5 no. 3 (1971): 325-30. [Article in Polish]; **Czech Republic**: V. Vondrácek , J. Hanzalová "History of the Czech Psychiatric Clinic 1886-1966." 3. *Cesk Psychiatr.* 69 no.5 (1973): 340-5. [Article in Czech]; **Yugoslavia**: D. Pavelić "25 years of the special hospital for mental rehabilitation in Jagomir," *Med Arh*. 28 no. 6 (1974): 599-601. [Article in Serbian].
16. The 3rd edition of the Soviet textbook, published in1937, has been translated into Romanian in 1949 and represented the first university manual for medical students, after the 1948 education reform imposed by the newly established communist regime: M. O. Gurevici & M. I. Sereischi *Manual de Psihiatrie*, translated and annotated from the 3rd ed. in Russian by Chivu Lichter and Polina Flexor-Manzon. Bucharest. (Editura de Stat Literatură Medicală, 1949).
17. Valentin-Veron Toma, "Work and Occupation in Romanian psychiatry, c. 1838-1945." In *Work, Psychiatry and Society, c. 1750-2015*, edited by Waltraud Ernst, 194-219 (Manchester: Manchester University Press, 2016).
18. Inspired by French psychiatrists from the nineteenth century, such as Pinel, Ferrus etc., the German psychiatrist Hermann Simon (1867-1947) developed a new form of institutional psychotherapy called *ergotherapy* (etymology: Gk, *ergon,* work, *therapeia,* treatment) in the early 1920s. In 1929 Simon published his famous monograph *Aktivere Krankenbehandlung in der Irrenanstalt,* a book that influenced a large number of specialists around the world. Even today, some European countries still use the term *ergotherapy* instead of *occupational therapy* (WFOT, 2008).
19. C. Doboş, D. Lăcătuşu, "Ipolit Derevici: O carieră profesională sub influenţa politicului" [Ipolit Derevici: a career under political influence], *Revista Medicală Română*, 61 no.2 (2014), 128, 131.
20. An initial collection of psychopathological art was established on the occasion of this research, which was carried out from October 1, 1966 until July 1, 1969 in the newly created work-

shop for art therapy, situated in the Clinical Section II of the hospital. The collection consisted of a total of 6130 works of art, of which 5777 were drawings, and 353 oil paintings (A. Romila, *PhD Thesis Summary* 1971: 17).

21. Marian Popa, Foreword to *Psihiatrie*, 2nd rev. ed. by Aurel Romila, V-VII. (Bucharest: Asociaţia Psihiatrilor Liberi din România, 2004), V.
22. Ibid.
23. See also R. E. Levine, "The Influence of the Arts-and-Crafts Movement on the Professional Status of Occupational Therapy," *The American Journal of Occupational Therapy* 41, no. 4 (1987): 248-254.
24. A. Romila, Resocializarea, Partea a III-a, 1977, 3.
25. Discussing Emil Kraepelin's major contributions to the development of a scientific psychiatry, on the occasion of the 100th anniversary of the birth of the German psychiatrist, A. Bonkalo pointed out that: "He developed a diagnostic system by longitudinal rather than cross-sectional observation of patient groups. His formula for creating nosological entities has been to define 'disease' in psychiatry through common etiology, course, outcome and pathology. (…) Much has changed since 'the epoch of Kraepelin'. The focus of interest in psychiatry has shifted away from the rigid generic principles towards the individual as part of his environment. Disease in psychiatry has become of syndrome or reaction form. Nevertheless the framework of diagnostic categories, although filled with new concepts, still shows the outline of the 'Kraepelinian' system." [A. Bonkalo "Emil Kraepelin (1856-1926)" 74 (1956): 835]. More recently, Paul Hoff concluded his study on the Kraepelinian tradition in psychiatry by saying: "As any other psychiatric concept, the Kraepelinian perspective does have its pitfalls and limitations. However, it definitely is one of the most influential approaches the field has seen. And, outspoken or implicit, his approach still shapes a lot of present day debates on psychiatry as a science and especially on psychiatric nosology" [P. Hoff "The Kraepelinian tradition." *Dialogues in Clinical Neuroscience* 17 no.1 (2015): 39].
26. The Polish philosopher and logician Tadeusz Kotarbinski (1886-1981), a representative figure of the Lviv-Warsaw School, created a philosophical theory called reism and developed a general theory of efficient action called praxiology. Praxiology was conceived as the most general of practical sciences, one that can provide the norms for the efficient performance of any action aiming at a specific goal. The word "praxiology" comes from the Greek *praxis* meaning action and it was used by Kotarbinski from 1923 [A. Zielinska "La praxéologie comme grammaire chez Tadeusz Kotarbinski," *Éthique et économique/Ethics and Economics* 6 no.1 (2008): 4]. His book *Traktat o dobrej robocie* first published in Warsaw, in 1955, has been translated into Romanian and published in 1976 under the title *Tratat despre lucrul bine făcut* (Bucharest: Editura Politică).
27. Ibid. See also, Aurel Romila, *Psihiatrie*, 2nd rev. ed. (Bucharest: Asociaţia Psihiatrilor Liberi din România, 2004), 546.
28. See Henri Ey, "Outline of an Organo-dynamic Conception of the Structure, Nosography, and Pathogenesis of Mental Diseases." In *Psychiatry and Philosophy*, edited by M. Nathanson, 111-161. (New York: Springer-Verlag, New York Inc., 1969).
29. A. Romila."Psihiatrie şi Resocializare." Personal communication, unpublished, 1992, 7.
30. A. Romila, "Asupra unei concepţii a resocializării bolnavilor cu afecţiuni psihice." *Neurologie, Psihiatrie, Neurochirurgie* 22 no.1 (1977): 35-9.
31. Ibid., 37.
32. Institutionalism, as defined by John Wing (1962) was recently mentioned by N. Rose as one of the various forms of suffering induced by long stays in psychiatric hospitals: "In Britain, Russell Barton diagnosed a condition he christened 'institutional neurosis'—a form of illness produced by the institution itself and John Wing demonstrated that institutionalism—

apathy, resignation, dependence, depersonalization, and reliance on fantasy—was common to long-stay inmates of even well-run mental hospitals" (*Historical changes in mental health practice,* Nikolas Rose 2011: 9 online edition. DOI:10.1093/med/9780199565498.003.0012).

33. A. Romila, "Asupra unei concepţii a resocializării bolnavilor cu afecţiuni psihice," *Neurologie, Psihiatrie, Neurochirurgie* 22 no.1 (1977), 36.
34. V. Predescu, A. Romila, V. Angheluţă, A. Costian, Resocializare – rezultate şi perspective [Resocialization – results and perspectives]. Comunicare la Simpozionul de la Socola, Iaşi, 1980, 11.
35. Consiliul de Miniştri al R.S.R. - Hotărârea 1210 din 28 august 1970 privind organizarea ergoterapiei in unităţile medico-sanitare şi de asistenţă socială. Publicat în Buletinul Oficial 106 din 3 septembrie 1970 (B. Of. 106/1970)
36. S. Bevan *et al*. 2013, 91.
37. As defined by the Society of Clinical Psychology: "Supported Employment (SE), also known as Individual Placement and Support, is an approach to vocational rehabilitation (VR) adapted for individuals with serious mental illness. Supported employment emphasizes the integration of employment and mental health services, rapid placement of individuals into jobs in the community, individualized job development, and ongoing job supports. Rather than segregating vocational rehabilitation and mental health services, supported employment specialists are part of the client's treatment team. The goal of supported employment is to assist the person with schizophrenia in attaining competitive, community-based employment. As compared to more traditional VR approaches for this population (e.g. clubhouse models, transitional employment), the community-based nature of SE facilitates transfer of skills into real-world work settings, directly builds relationships with employers, and provides more naturalistic opportunities to identify the client's interests and strengths." Society of Clinical Psychology, *Supported Employment for Schizophrenia*. APA, Division 12.
38. S. Bevan *et al*. 2013, 92.
39. Ibid. 93.
40. J.A. Cook, L. Razzano, "Vocational Rehabilitation for Persons with Schizophrenia: Recent Research and Implications for Practice," *Schizophrenia Bulletin* 26, no. 1 (2000): 87-103.
41. H. Hoffmann *et al*., "A randomised controlled trial of the eficacy of supported employment," *Acta Psychiatrica Scandinavica* 125 (2012): 157–167.
42. G. Harnois and P. Gabriel recently argued: "Shorter periods of hospitalization when needed and appropriate follow-up in the community prevent people from losing the social skills that are essential to adequate living in the community. The approach is also somewhat less costly to governments. However, we find that, while they are saving millions of dollars by closing psychiatric beds, at least in most developed countries, few governments have promulgated policies and developed community resources necessary to ensure the social integration of these patients. It takes greater political will and skills to put in place the conditions and programmes that will permit the meaningful return to life and society (including work) of persons with serious mental illness than it does to close a psychiatric hospital" G. Harnois and P. Gabriel (Geneva: World Health Organization, 2000), 25.
43. G.R. Bond, R.E. Drake, K.T. Meuser, and D.R. Becker, "An update on supported employment for People with severe mental illness." *Psychiatric Services* 48, no. 3 (1997): 335-346.

Abstract

From Ergotherapy to Resocialization:
The Rise and Fall of the Pre-vocational Training System for Psychiatric Patients
at the Central Hospital in Bucharest, c. 1966-2004

For decades, ergotherapy has been considered, by many Romanian psychiatrists, as a useful instrument contributing to patients' recovery but only for the chronically ill. Therefore, many hospitals developed workshops, and special programs, for their long-stay patients. A modern institution, with a social mission, endowed with sheltered workshops and offering pre-vocational training, was built on the premises of the Central Psychiatric Hospital, in Bucharest. Opened in 1994, it was based on Dr. Aurel Romila's ideas about the resocialization of psychiatric patients, developed in the '60s and '70s, under the influence of a number of prominent Western psychiatrists and social theorists. The aim of the present paper was to understand how resocialization departed from previous ergotherapeutical practices and to decide whether it represented a step forward or not. As a result, this allowed a re-evaluation of its heritage long after its disappearance as a program of social psychiatry.

Keywords

ergotherapy, resocialization, pre-vocational training, work therapy, psychopathological art, Aurel Romila, Bucharest.