Leonardo Tondo: Interviews with Pioneers

Carlo Perris

On cycloid psychoses

CONTENTS:

Biographical notes[1]

Carlo Perris (1928–2000) was born in Cosenza, in the region of Calabria, Southern Italy, during the fascist era. His family was of noble descent but of particular interest is to follow its medical tradition and professional course. His father, Francesco, was a locally highly appreciated ophthalmologist and at Carlo's age of 26 years, they published a paper on hysterical amaurosis combining his father's specialty and his own, a circumstance of some psychoanalytical interest.[2] His son Poul Perris (born in 1971) and his daughter Anna Rosa Perris (born in 1966) have both followed Carlo's professional inclination and are both psychiatrists. By contrast, one his other sons, Frans Perris (born in 1968), is a surgeon who shares the same medical specialty as Carlo's half-brother Paolo (1946–2007). Interestingly, other direct or acquired members of the family, as Francesco (Paolo's son) and Poul's wife, are also working as psychiatrists (the presence of surgery and psychiatry in the same family is rather intriguing, with the possible association that both specialties teach to look inside the individual). On a whole, Carlo's family is characterized by a tradition of indefatigable and devoted physicians.

[1] Biographical information is based on: [a] De Marco F. Carlo Perris. In: Maj M and Ferro FM (editors). *Anthology of Italian Psychiatric Texts*. Geneva, World Psychiatric Association, 2002, pp. 419–421; and [b] Herlofson J. Carlo Perris 1928–2000. Scandinavian Journal of Behaviour Therapy 2000; 29: 3–4.

[2] Perris F. Perris C. Sull'amaurosi e l'ambliopia isterica; presentazione di 4 casi [Hysterical amaurosis and amblyopia; 4 case reports]. Boll Ocul. 1954; 33: 713–720. Italian.

Carlo grew up in the tumultuous World War II period, fortunately in an upper-class cultural environment that highly valued education and intellectual pursuits. He received his MD degree in 1952 at the University of Pavia where he also specialized in Nervous and Mental Diseases in 1956. At the age of 29 he published an ambitious monograph entitled *L'elettrofisiologia clinica* (*Clinical Electrophysiology*)[3]. However, his true interest was in psychiatry and he soon embarked upon a further clinical training in the General Hospital of Cremona but he rapidly realized that the field of psychiatry in Italy was stagnant. He tried to become lecturer at the local university but failed (as it often happens in the Italian academic system for the most deserving people) and so decided to emigrate with his family to Sweden in 1959. Once there, he bravely grasped the opportunity that was provided by the opening of a short-term early career position as a psychiatrist at the Mental Hospital of Sundsvall (Sydsjöns Sjukhus) where he collaborated with Giacomo D'Elia,[4] known for his studies on electroencephalography and electroconvulsive treatment as physician in another Swedish hospital. They published several papers together from 1960 to 1977. In 1963, Carlo moved to Umeå (Sweden) where he became Professor of psychiatry in 1971.

Carlo Perris was able to effectively integrate in the clinical staff of that institution and was offered a permanent position which assured him to continue his career path in Sweden. This later condition established the ground for becoming a prominent and renown figure in psychiatry in Sweden and worldwide. His background knowledge and experience in both the Italian and Swedish medical traditions allowed him to combine the clinical approach of European psychiatry with the emerging psychological theories of that time. He also contributed to the diffusion of the Italian model of mental health, underscoring the importance of "social psychiatry." In 1966, Carlo published his seminal monograph, *A Study of Bipolar (Manic-Depressive) and Unipolar Recurrent Depressive Psychoses* [5] which contributed to the revising the classification of major affective disorders.[6] In 1974, he published *A Study on Cycloid Psychoses* [7,8] adding more clinical data to the work of Karl Kleist (1879–1960) and

[3] Perris C. *Elettrofisiologia Clinica*, Pavia, (publisher unknown), 1957
[4] No information available on Giacomo D'Elia.
[5] Perris C. A study of bipolar (manic-depressive) and unipolar recurrent depressive psychoses. Acta Psychiatr Scand. 1966; 196 (Suppl): 1–189.
[6] Perris C. Central measures of depression. In: van Praag HM, Lader MH, Rafaelsen OJ, Sachar EJ (editors). *Handbook of Biological Psychiatry*, Part II, New York, Dekker, 1980.
[7] Perris C. A study on cycloid psychoses. Acta Psychiat Scand. 1974; 253 (Suppl): 1–77
[8] In his textbook, *The Classification of Endogenous Psychoses*, Leonhard (1957) described cycloid psychoses and divided them into three different forms of psychoses: motility psychosis, confusion psychosis, and anxiety-happiness (elation) psychosis. He separated cycloid psychoses from the phasic and schizophrenic psychoses and defined them as a group of remitting bipolar disorders which resemble the phasic psychoses in their course and the nonsystematic schizophrenic

Karl Leonhard (1904–1988) on this subject. Dr. Perris showed that cycloid psychosis, with its complex mix of symptoms could be looked upon more as an affective disorder, rather than being associated with schizophrenia, and therefore could be treated effectively with antidepressant drugs and lithium. These two studies were so influential that he received the presidency of the World Federation of Societies of Biological Psychiatry. The concept of cycloid psychoses has been revisited recently by Dr. Paola Salvatore reporting some cases, and a review of the literature.[9] Dr. Perris is also known for his contributions to the clinical and etiological understanding of schizophrenia, borderline personality and mood disorders, particularly depression.

His strong interest in the application of cognitive psychotherapy was the impetus for founding in year 1980, together with his second wife Hjördis Perris, a psychologist (born in 1940), the Swedish Institute for Cognitive Psychotherapy (CBTI). Indeed, Carlo was a pioneer in introducing cognitive therapeutic approaches in European psychiatry and integrating them with biological and psychosocial perspectives. His interdisciplinary approach laid the groundwork for the modern psychiatric treatment modalities that combine psychological and biological factors contributing to mental health conditions in the so-called biopsychosocial model. His approach brought innovative views on how mood disorders, schizophrenia and other psychiatric conditions arise and can be treated and this breakthrough continues to inspire modern psychiatric research and clinical practice.

Dr. Perris' work in cognitive psychotherapy has been continued by Hjördis Perris, who has published many articles and books on the subject. Nowadays, the director of the institute is their son Poul who is devoted to psychotherapy and is a promoter of the schema therapy.[10] His sister Anna Rosa is also active at the CBTI as a child psychiatrist and psychotherapist. Carlo's first son, from his first marriage, Roberto Perris (born in 1957), was educated in Sweden but pursued a somewhat different professional path. He is currently full professor at the University of Parma, Director of an oncology centre and engaged in the field of experimental and translational oncologic biology.

Carlo's late work focused on mood disorders, especially depression, integrating cognitive approaches with traditional psychiatric practices, which were often dominated by psychoanalytic or purely

psychoses in their content (Ban Thomas, *Psychopharmacology and the Classification of Functional Psychoses*, IHNH, 1985).

[9] Salvatore P, Bhuvaneswar C, Ebert D, Maggini C, Baldessarini RJ. Cycloid psychoses revisited: case reports, literature review, and commentary. Harv Rev Psychiatry. 2008; 16: 167–80.

[10] Schema therapy was developed by the American psychologist Jeffrey E. Young (1950–) as an integrative type of psychotherapy derived mostly by the CBT combined with other psychological models.

biological models. He argued that cognitive distortions—habitual, negative thought patterns—played a significant role in the development and persistence of depression. This perspective was in line with the theories formulated by Aaron Beck (1921–2021), the founder of cognitive therapy, but Dr. Perris was instrumental in popularizing cognitive-behavioral therapy techniques in Sweden and other European countries. In fact, he promoted a shift from traditional psychodynamic therapies and the emphasis on the need for cognitive approaches within the biopsychosocial model, demonstrating that they could be effective for a range of other psychiatric conditions, including anxiety, personality disorders, and paranoia.

A significant part of Dr. Perris' research focused on the concept of vulnerability and depression. He studied how certain factors, such as early life experiences, personality traits and negative cognitive patterns, often rooted in early adverse experiences, could serve as vulnerability factors, making individuals more susceptible to depression in response to life stressors. As a consequence of this approach, he also explored the role of early attachment and its possible action in shaping cognitive vulnerabilities. He constructed a scale named *Egna Minnen Beträffande Uppfostran* [my memories of upbringing] (EMBU),[11] an inventory that highlights the patient's memories of childhood and the attitudes to upbringing by their parents.

Carlo Perris was also involved in the development of the Italian psychiatric reform after approval of Law 180 (1978) which required that psychiatric hospitals be shut down and their patients admitted to wards in general hospitals. He shared this interest with Prof. Dargut Kemali (1922–2011)[12] who was also a close friend and with whom he published some papers on the Italian psychiatric reform.[13] In

[11] Perris C, Jacobson L, Lindström H, Von Knorring L, Perris H. Development of a new inventory for assessing memories of parental rearing behavior. Acta Psychiatr Scand 1980; 61: 265–274

[12] Kemali Dargut. Italian-Turkish psychiatrist. Full professor at the university in Naples, also president of the Italian Society of Psychiatry and the Italian Society of Biological Psychiatry. Together with his wife, he established a foundation in their name, which to this day awards a research prize managed by International Brain Research Organization (IBRO). Kemali focused his research on the role of monoaminergic systems in schizophrenia.

[13] [a]. Kemali D, Perris C, Maj M, Amati A, Vacca L. Application of the Psychiatric Reform Act in the city of Naples. A survey of requests for compulsory admission to the special unit at the University Psychiatric Department I. Acta Psychiatr Scand Suppl. 1985; 316: 127–134. [b]. Perris C, Kemali D, Dencker SJ, Malm U, Rutz W, Amati A, Stancati G, Morandini G, Minnai G, Maj M, et al. Patients admitted for compulsory treatment to selected psychiatric units in Italy and in Sweden. Acta Psychiatr Scand Suppl. 1985; 316: 135–149. [c]. Perris C, Kemali D. Focus on the Italian psychiatric reform: an introduction. Acta Psychiatr Scand Suppl. 1985; 316: 9–14.

1987, he published another important textbook titled *Psichiatria sociale* (*Social Psychiatry*) [14] on community mental health and psychosocial rehabilitation.[15,16]

Moreover, Dr. Perris contributed significantly to multi-axial classification of mental disorders by developing and validating a specific instrument, the *Multi-Aspects Classification of Mental Disorders* (MACM)[17] and contributing to the construction of the *Comprehensive Psychopathological Rating Scale* (CPRS)[18,19] from which the more popular Montgomery-Åsberg Depression Rating Scale (MADRS) was derived.

Carlo Perris authored numerous books and scientific articles throughout his career, sharing his findings and therapeutic approaches with the broader psychiatric community. His writings often emphasized the need for integrated treatment models and the role of cognitive factors in psychiatric disorders. Some of his notable works include textbooks on cognitive psychotherapy and papers on the biopsychosocial model in psychiatry. He received several awards for his work and his ideas have had a lasting impact on the field and his influence extended beyond academia, as he was involved in training programs for clinicians to favor the embedding of cognitive approaches in routine psychiatric practice.

Despite his prolonged residence in Sweden, Carlo maintained Southern Italian temperament which probably benefited the cause of establishing a solid position for cognitive psychotherapy in Sweden, though not without causing some difficulties. He was outspoken and emotionally open, sometimes pleasantly and some other times maybe unpleasantly, but always with true respect based on honesty and openness.

He passed away on October 30th, 2000 of a trivial legionellosis.

Carlo Perris is remembered as a highly educated person who spoke several languages fluently, was omniscient about diverse subject matters, spanning from history to politics and from philosophy to art history. He also cultivated many hobbies, foremost cooking, reading books and collecting stamps, coins

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[14] Perris C. *Psichiatria Sociale*. Naples, Idelson Press, 1987.
[15] Perris C. *Cognitive Therapy with Schizophrenic Patients*. New York, Guilford, 1989.
[16] Perris C, McGorry PD. *Cognitive Psychotherapy of Psychotic and Personality Disorders*. Chichester, Wiley, 1998.
[17] von Knorring L, Perris C, Jacobsson L. A multi-aspects classification of mental disorders. Experiences from clinical routine work and preliminary studies of inter-rater reliability. Acta Psychiatr Scand. 1978; 58: 401–412.
[18] Perris C, Eisemann M, von Knorring L, Perris H. Presentation of a subscale for the rating of depression and some additional items to the Comprehensive Psychopathological Rating Scale. Acta Psychiatr Scand. 1984; 70: 261–274.
[19] Åsberg M, Montgomery SA, Perris C, Schalling D, Sedvall G. A comprehensive psychopathological rating scale. Acta Psychiatr Scand Suppl. 1978; (271): 5–27.

liquors and antiques decoration objects. Carlo Perris' never ending love for his native land was witnessed by the passion for the ancient local dialect that few others would remember.

About the interview

I met Professor Carlo Perris during an international congress on psychiatric epidemiology organized by the late Professor Michele Tansella (1942–2015), probably the most famous Italian psychiatric epidemiologist. We had a long chat and Perris was well disposed to be interviewed by a relatively obscure colleague. We had been introduced some time before by the late Athanasios Koukopoulos (1931–2013) with whom Perris had entertained some interesting discussions on the distinction between unipolar depressive and bipolar disorders.

Verona, November 7th, 1987

The interview

LT: Professor Perris, you have shown a great interest in affective disorders, but in relation to this subject, your name is particularly associated with the concept of cycloid psychoses. Does this topic still play a part in your research?

CP: In a certain sense, yes, even though I feel satisfied to have managed to contribute to the recognition of the concept of cycloid psychoses now included in the latest revision of the WHO's ICD-10 diagnostic scheme. The position of cycloid psychoses has always been controversial in Italy, and probably also recently in the United States, where they have often been grouped more frequently under affective forms rather than schizophrenic forms. In other European countries, before our research, which has also stimulated especially by investigators in Germany, cycloid psychoses were considered more as belonging to the group of schizophrenia-like syndromes. In my opinion, it is still necessary to identify syndromes from a clinical viewpoint, without pretending to have a consistent etiology and pathogenesis. In fact, we need to decide whether some disorders have to be considered separately or falling under larger categories. From this point of view, in my clinic, we are still interested in this topic, and especially now in the practical application of the new WHO classification that will replace ICD-9, and has just come into use here in Italy.

LT: We will discuss shortly the characteristics of cycloid psychoses, but before then, how did your interest in the topic begin?

CP: My interest in the topic developed from my interest in bipolar and unipolar psychoses, and above all, was part of a gradual reaction against the fading distinction of so-called endogenous psychoses into just two major categories, unipolar and bipolar. Leonhard opposed this dichotomy and proposed that the more ordinary and common affective disorders be divided into bipolar manic-depressive and those characterized by recurrent depressions. He then contributed to his classification by including three other groups: one made up of cycloid psychoses, another consisting of what he called non-systematic schizophrenias, and a third group of what he referred to as true schizophrenia. So, for me, it was a process of verifying a hypothesis that had been presented, finding confirmation in individual reports and articles that appeared from time to time in the international literature, with support from clinical experience. In fact, I have seen patients who did not correspond to the classical descriptions of a manic-depressive psychosis or the classical descriptions of a schizophrenic syndrome but nevertheless were placed in one of these two major categories. The result was that, by studying the medical records of patients who had been hospitalized several times due to the recurrent nature of these syndromes, the data that most easily stood out was that these patients, from one hospitalization to another, received different diagnoses: schizophrenia, manic syndrome, confusional syndrome. The finding made clear that for clinicians observing those patients that they were different from the common forms without being recognized as a distinct group. This was the beginning of the interest that dates back to the early 1960s when I was more focused on the separation of manic-depressive forms from recurrent depressive forms because even the diagnosis of manic-depressive psychosis had become enormous, covering everything. At the time, it was sufficient to have a recurring affective disorder for a diagnosis of manic-depressive psychosis.

LT: In Leonhard's classification, critics say there is an excess of categorization.

CP: One can say that there is an excess of categorization if one identifies classification with the recognition of diseases, but if one considers classification as the desire to identify syndromes that have something in common in order to determine what type of prognosis or etiology they might have, what kind of therapeutic intervention is necessary, it becomes indispensable to dismantle the existing categories and start anew, in a certain sense.

LT: And after many years of research on cycloid psychoses, is this independent classification from the schizophrenia and affective psychoses justified in terms of treatment and prognosis?

CP: Especially in terms of prognosis, because in 1987, it doesn't make sense to talk about schizophrenia as a single disorder. It is significant that any serious book on schizophrenia starts with the statement that everyone now agrees that it is a group of syndromes temporarily collected under this label, and that it is necessary to identify these heterogeneous subgroups and include them under the same umbrella. After paying this tribute, the author continues as if schizophrenia were a well-defined disease distinct from other mental disorders, which is why for eighty years we have not been able to make progress.

LT: How are cycloid psychoses placed in the current nosography?

CP: I think one must consider that the psychiatric diagnoses we use are not similar to those used in internal medicine—for example, when a diagnosis refers to both the symptoms and probably to etiopathogenetic hypotheses as well as to its subsequent course. The diagnoses we use are operational definitions we apply descriptively to the disease state we observe in patients, first of all to communicate and secondly to be able to predict the development of needs for services. If we do not know, for example, what is the risk of relapsing for patients who sometimes show a certain disease state, we would never be able to predict what kind of service we need to develop for the population for whom the service must serve. So, from this point of view, it is still necessary to use these operational definitions and not confuse them with a concept of a metaphysical disease. Ultimately, psychiatric diagnoses, as Thomas Szasz (1920–2012)[20] rightly pointed out, are myths in the sense that they do not correspond to physical entities.

LT: Since we are on the topic, briefly—because there is an extensive literature on the matter—what are the most characteristic elements of cycloid psychosis?

CP: The most characteristic elements are an acute onset that is not related to severe trauma, whether psychological or an intercurrent somatic illness, a clinical picture that could be very polymorphic or variable and does not allow for the extraction of a dominant symptomatology but remains persistent throughout the ill period, and a tendency to be self-limiting in the sense that, even if left untreated, after a certain period, it often ends with the same sudden character with which it began.

[20] Thomas Szasz was a Hungarian-American professor of psychiatry at the State University of New York, Upstate. He was best known as a critic of the moral and scientific foundations of psychiatry which he saw as a form of social control.

LT: What can you say about its average duration?

CP: It naturally varies, probably also depending on the social context in which it occurs. The average duration in relatively neutral environmental conditions is about two or three months.

LT: Why do you mention environmental conditions?

CP: Because a patient of this kind, when psychiatric hospitals were available and in countries where they still exist, could be perpetuated due to the negative influence of the environment. In other more tolerant environments, the course of mental illness is not only conditioned by the disorder but also by the environment's reaction. That's why I said a relatively neutral environment.

LT: Are you also speaking of the environment during the patients' early development?

CP: The environment of origin probably matters less for these forms compared to others, for example, both depressive forms and those still grouped under the schizophrenic label, where the environment of origin has even greater importance than for cycloid forms, in the sense that neither we nor others who have studied those syndromes under the same name or other synonyms have managed to identify consistent developmental traumatic situations in all patients, or particular personality traits that were typical or very common in patients who then presented with these acute clinical forms.

LT: Regarding therapy, is there a specific treatment?

CP: There are no specific therapies in psychiatry; we are still dealing with symptomatic therapies and this is the one reason why it is necessary to identify the symptomatology because a large part, almost the majority, of psychiatric interventions in acute cases are symptomatic rather than curative. Therefore, in theory, if one suspects an affective disorder, logically, one should resort to therapies used in affective disorders. However, in the case of cycloid psychoses, it has not been possible to conduct thorough treatment studies for a very simple reason: the number of cases that occur in a year and reach the attention of a psychiatric service is never enough to allow comparisons between different treatment methods and, consequently, determine the treatment of choice.

LT: And what about lithium?

CP: Regarding lithium, it is possible in a large number of patients with the symptomatology of cycloid psychosis to reduce the number of recurrences at least to the same extent as in affective syndromes, but there is always the uncertainty associated with the fact that we have only retrospective studies

comparing a period after the start of lithium with a corresponding period before its use, assuming that the disorder, as maintained by Leonard, continues to recur. Naturally, these studies have significant orientational value but are never decisive because prospective studies would be needed, which still require sufficiently large groups to allow treatments for some with lithium, some without, and some others with different types of therapy.

LT: You mentioned short-term prognosis, saying that these episodes resolve quickly. What about long-term prognosis?

CP: Long-term prognosis must consider two things: relapses, which, as far as we know, do not decrease over time, and the fact that there have not been enough long-term follow-ups. Leonhard reported some cases that had suffered 20 or 30 recurrences, so one must theoretically assume that there is this tendency. Thus, the long-term prognosis could be negative because those who have had an attack run a high risk of a recurrence. Another negative aspect is a relatively high suicide incidence, not only in relation to the acute episode but likely for psychosocial reasons indirectly linked to the disorder itself and this happens when the patient starts experiencing recurrent episodes, raising the suicide risk higher than in the general population.

LT: Is the suicide risk higher also compared to other affective groups?

CP: Not compared to other affective groups. There too, it is a matter of definition: if one defines all those who attempt or commit suicide as depressed, then they are all depressed. But if one sticks to the diagnoses made previously before the suicide, there is a general trend of decreasing suicide rates among patients with recurrent affective disorders. At the same time, there is a trend of increasing suicides among addicts, alcoholics, and patients with schizophrenic syndromes, especially those who improve, as improvement forces them to confront the need to live a normal life, which exceeds their capacities.

LT: Is there an evolution of these forms of cycloid psychosis toward more overtly schizophrenic forms?

CP: That is a debated question; one must also establish what is meant by schizophrenic evolution. If it is intended that some patients may become chronic, I believe this is not limited to schizophrenic syndromes. Typical manic-depressive patients can become chronic and show personality deficits after many episodes that become more frequent. The same has been discussed regarding cycloid psychoses,

with studies from Germany and Japan placing the risk of chronicity between 10% and 15%. However, it is challenging to determine the reliability of this percentage, as not all patients in these studies were consistently collected with accurate definitions of initial episodes.

LT: Is there a difference between cycloid psychoses and schizoaffective syndrome?

CP: If the diagnosis of cycloid psychosis is a somewhat unclear concept, schizoaffective syndrome is even less clear. We have particularly worked on this with an Italian colleague who came to do his PhD in Umeå, Mario Maj (1953)[21] from Naples. He dealt with defining schizoaffective syndrome, but in my opinion, it is an abuse of terminology because it assumes that specific symptoms of one disorder appear in another with its own distinct symptoms. In reality, this does not occur because the reactivity of the human psyche is relatively limited and symptoms can appear across disorders. The term "schizoaffective" was introduced by the Russian-American psychiatrist Jacob Kasanin (1897–1946) in 1933 to describe a syndrome resembling cycloid psychosis, maintaining their independence from schizophrenic forms. However, American diagnostic trends expanded use of the term.

LT: Are you satisfied with the DSM-III's lack of a specific classification for these uncertain syndromes?

CP: They tried a compromise by incorporating what used to be described as schizoaffective into affective syndromes, but the attempt seems to have failed. There will be more refinement in the DSM-IV, following ICD-10 from the WHO, likely reducing differences between the international classifications.

LT: You mentioned Professor Leonhard. What do you remember about him?

CP: I met him personally very late, during his 80th birthday in Berlin. He was still very active and enthusiastic, able to inspire those who worked with him, and showed the courage to revise his views, acknowledging the secondary importance of heredity in classic schizophrenia, with better prognoses in non-systematic forms.

LT: On a personal note, how did you end up in Sweden?

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[21] Mario Maj. Italian psychiatrist, professor of Psychiatry who has been President of the World Psychiatric Association (2008–2011) and of the European Psychiatric Association (2003–2004). He is the founder and Editor of *World Psychiatry*, the official journal of the World Psychiatric Association, one of the best established psychiatry-themed journals, with a 2022 impact factor of 73.3. He is author of more than 700 scientific papers.

CP: I came to Sweden by chance. In the late '50s, I was dissatisfied with the academic situation in Italy and wanted to gain experience abroad. I had a fellowship to study briefly in Sweden and liked the way they worked and interacted, and, having decided to leave Italy, Sweden seemed like a good option. My move was facilitated by a former classmate who had already moved there. I found it a good fit and stayed.

LT: You are here today for this conference addressing one of the most debated topics in Italian psychiatry, territoriality. How does Italian psychiatry look from outside, not just for assistance but also research and universities?

CP: The problem is that Italy is overcrowded with both citizens and universities, creating issues in coordinating and unifying approaches. In Sweden, which is larger but has only about 8 million inhabitants, there is more room to implement reforms and other activities without necessarily conflicting with others.

LT: In your opinion, has Italian psychiatry made significant progress in recent years?

CP: Oh yes, indeed. The reform carried out in Italy is one of the best in the world, but the problem has been in its implementation, which has not fully corresponded to the spirit of the law. This is likely because the focus has been placed too much on the abolition of psychiatric hospitals and not enough on the development of alternative services that should have been established simultaneously. From this point of view, the same mistake made in the USA has been repeated, where they started with the closure of hospitals. Now, discussions about reform proposals reflect the need to think beyond simply closing hospitals and consider how to provide adequate psychiatric care to those who need it through alternative services. In Sweden, this issue did not arise because it is a reformist country, so when they planned to abolish psychiatric hospitals, they did so in all counties, while also developing alternative forms of care in parallel. They prefer to keep a certain number of hospitals and wards open until they are certain that the alternative services truly work.

LT: That would seem to be the logical approach to reform in this context difficult to implement in a country like Italy. Thank you.

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