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Crossroads and Dilemmas in the Intervention for the Process of Social Inclusion of Patients with Schizophrenia within the Framework of the Therapeutic Community- Casa De Medio Camino Querétaro

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Abstract

This article focuses on describing some of therapeutic crossroads that have been identified in daily work with patients with schizophrenia indoors the device of a therapeutic community, in Querétaro-Mexico. Considering a series of paradigms that the patient, their family and mental health professionals face in relation to the interactions and dynamics that are generated from and in the therapeutic device. The complexity faced by those of us who work daily with patients with schizophrenia is problematized based on the discrepancies between theory and practice that generate a gap whose difficulty lies mainly in the psychosocial dynamics to maintain the social bond.

Finally, some problems are described that involve the network that is woven between: patient, mental illness, family and community when stigma still continues to be one of the most frequent variables in work and treatment to provide comprehensive follow-up to the patient with schizophrenia to maintain its functionality and autonomy.

Keywords: Therapeutic community, Schizophrenia, Device, Social bond, Functionality and autonomy

Introduction

The history of psychiatry invites to be a subject to be debated and to be thought not only from its historical vein but also from its social implications: law, institutionalism, human rights, medicine, therapeutics, psychology, anthropology, among others, this leads to rethink the discourse from which it builds its ideological and action skeleton. At the dawn of the birth of psychiatry, a scar that does not disappear is that of the social stigma of the so-called "mentally ill", this is still linked to its very particular relationship with medicine, being its configuration specifically in Mexico still entrenched with

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its socio-cultural roots.[1] Hence, a series of contradictions and conflicts arise at present to think, propose and promote mental health programs which are grounded and realistic; focused, adequate to the characteristics and needs of a specific population. Public policies on mental health in Mexico have had hospitalization as their epicenter. Debates continue on its usefulness, capacity, validity, attention, importance, quality and effectiveness for the treatment of psychiatric patients. Although some perspectives are in favor and others against, the social reality is what determines to a great extent the importance and justification of its existence. However, discussions beyond focusing on the hospital-centric device should reformulate a series of important premises on the diversity of devices that have a specific function and objectives for the situations and stages of follow-up to psychiatric treatment. Each device has a function at specific times and needs for the family and the patient. However, we have continued to look at the problem from the duality: benefits vs. negative effects. The blindness we face promotes the wide gap for clinical-therapeutic work that involves improving the patient's quality of life. The existence of a hospital-centric model, became the way to solve and give care to patients with schizophrenia, however, this model focused mainly on attending agitated and chronic patients. The stigma about "confinement" and therefore, the loss of freedom to lead a functional life has been encrypted in the relationship: illness-schizophrenia- confinement. Historically, at a cultural level, and despite the efforts of physicians, psychiatrists, psychologists and social workers through psychoeducation and prevention[2] on mental health, the differences between concepts such as: rehabilitation, reinsertion and social inclusion are not very clear. Currently, these terms are used indiscriminately by different social areas, disciplines and public policies. Generating confusion and therefore, disorienting the lines of clinical-therapeutic work, as well as the ethical and subjective position of the subject who requires psychiatric and psychological care together. The confusion lies mainly in the fact that the core from which cultural stigmas about mental illness arise is historical. While at another time in Mexico, mental illness sought to become invisible, hidden from the social gaze and, in others, to be considered a social discomfort, today the search for institutional control of public care by the quantifiable - number of patients treated, medicated and "treated"[3] - is one of the main lines of approach and practices established in the field of public health care, forgetting its implications and social impact and to a lesser extent focusing on providing solutions to improve the quality of life of the patient, his family and environment. Likewise, a clear concern for questioning and thinking about the present, what are the perspectives, scopes and limitations that we have with this population when mental health programs continue to consider them from the social stigma and intellectual disability?[4] As part of the measurement strategies implemented by the so-called neoliberal model at the health level, the treatment of mental illness is usually conditioned to the disability-adjusted life years (DALY) and its direct correlation to the years of life lost due to disability (DALY).[5] The above has been a relevant issue that has left its historical mark on the health system, talking about mental illness has slipped and oscillated in the "between" border that draws the: intellectual disability and psychosocial disability, this as an effect of the diagnoses, lines of research and practices that guided the discourse of psychiatry in conjunction with the needs of

[1]In Mexico, the history of psychiatry begins with an ambitious and promising project, that of the General Madhouse of la Castañeda. At the time, one of the icons of the new scientific production, seeking to emulate and improve French technique and also as one of the main lines of progress in Mexico. The research carried out by Cristina Rivera Garza in this regard suggests that this project took more than 20 years to set up and between the dawn of this consolidation they went through various complex situations. "(...) Analysis of the confinement techniques and the role of state-funded psychiatric hospitals began in 1883 in Mexico, seven years before psychiatry classes were taught at the School of Medicine in Mexico City and only six years after Porfirio Díaz took power. " Cristina, Rivera Garza. La Castañeda (Mexico: 2010, Tusquets): 37.

[2]The preventive campaigns will be the axis of which the medicine will be exercising in the field of social action, especially for the epidemics that are beginning to register, starting with the constitution of the Institute of Tropical Diseases (IET) in the year 1934. The political-governmental activity sought to develop models for the prevention of diseases that for medicine at the time were considered contagious. The health and medical landscape will be strongly tied to the social needs that would have left their deep mark behind the revolutionary movement. The rearrangement, reorganization and constant destabilizations in the political and economic framework would have forced the doctors also to carry out their practice from the processes that were steered by the government order. The psychiatrists' interest in treating diseases that had long been considered contagious, such as epilepsy, alcoholi, homosexuality, would have been centralized, in History of public health in Mexico 19th and 20th centuries.

[3]Document AC. For necessary reason. (Mexico: Open Society Foundations, 2020).

[4]In the legal framework today the mentally ill person is considered a psychosocial disabled person. It is the term that is emphasized at the level of legal medicine. In Mexico, the term is used to define both government health and social development programs. The concept has varied, having been initially employed by surgery in which the subject is invalidated or physically "useless" by the loss of an extremity or sense. However, the term is conceived by Kreaplin who mentions: "There are explanations, common in melancholy patients, that they nurse because of this or that failure, or because of a change, or because they are concerned with a question of economic order, or that they barely got sick for missing their loved ones from those who were separated (...) After the cure we have the opportunity to accompany the correction of those erroneous conceptions. But who can tell how many misleading conclusions we are exposed to, if we take as true the information of the sick whose truthfulness it is not possible to verify?" In The forms of manifestation of insanity. vol. 11., nº.3 (Sao Pablo: Revista Latinoamericana de Psicopatología Fundamental, 2013): 133.

[5]The need to unify terminologies and from the field of science and to seek criteria that organize information and describe it, they have resulted in different decrees within countries and in 1980 already at the international level from the functioning of disability to substantive the adjective "deficient" declaring that disability is above the person. Manuela Crespo, "History of the international classification of disability and health (CIF): a long journey." Spanish magazine on intellectual disparity 34., nº, 205, (Spain: 2003): 20-26, point out the historical process of how it has been transforming since the thirties to date. However, the term remains a problem for those working in the field of physical or mental disability, because on the one hand, the hinges: classification and treatment used at the beginning of the twentieth century, today have adhered to a series of more complex factors and variables that are no longer necessarily operable from the conceptual framework in which they were conceived.

each government. From its beginnings until the eighties, there have been many efforts and research works by historians, sociologists and anthropologists on the subject, however, it is considered that there are still unexplored traces "between" the Castañeda and the intermediate period in which the doctors of that time contributed to build a discourse where psychiatry in Mexico is linked from its construction: science-subjection-homogenization-exclusion. Several authors have written texts where the need to return "the patient's voice to those factors that lead to illness"[6] is evident. Psychiatry, due to its historical background, has become, in the social view, a control link for the population; however, there is a gap where the traces that have drawn the current landscape at the level of psychiatry discourse have also been stigmatized from a categorization and description of this discipline, largely due to the directions and practices it has exercised.[7]

Questions such as what are the frontiers "between" normalization, functionality and homogenization of people with schizophrenia? are most of the time adhered to a specific line of intervention, hence psychiatry is parcelled as a discourse and has also become a discipline that remains as a mouthpiece of stigma in search of the exercise of power and control,[8] hence, its actions directed to the patient, the disease, medicine and other epistemic fields that have questioned it. It is important to begin to clear the equation: on medical practices and the variable that culture has crystallized on the subject, therefore, the ethical positioning against the socio-cultural context that has established a stigma on mental illness, in addition to the claim and demand that members of a society would have to fit into the functioning of social ideals of productivity, normality and usefulness. Rafel Huertas[9] identifies cultural history as the main core of the psychiatric discourse and, therefore, a way to analyze its different vertexes, approaches and motivations, making differences in its understanding and application from the cultural vector on the one hand in Europe, Latin America and the United States.

Inter weavings and Fragilities: Family, Stigma and Society

The symptoms of schizophrenia are a challenge to common sense and therefore to the unified belief of a reality shared by all. The threshold[10] that implies for mental health professionals the clinical-ethical work when faced with the position that the patient is suffering and experiencing changes that he/she does not know how to verbalize or point out exactly, when there is a sense of disconnection from the body, added to the fact that thoughts seem to acquire a dimension of interference, a singular form of transformation in the fundamental way of seeing the world becoming latent "the subject-object polarity vanishes and the self-consciousness suffers a transformation in the mental processes",[11] However, the work of accompaniment, follow-up and subjective-emotional-familial stabilization required for the construction of links with the world, as well as the particularities centered on the context and environment in which the patient finds himself, leave him outside the correlation between variables that are necessary to build in order to provide support to the patient. The real limitations in the three spheres of his life: biological, environmental and family, are dimensions that enable or obstruct the ways of working and therapeutic follow-up of the patient so that he can be socially included and not be left out of the social framework[12].

The configuration of mental illness linked to schizophrenia has impacted the social imaginary in such a way that stigma continues to be a recurrent spectrum[13] that is presented with the cultural intensity with which it has left its historical mark.[14] To date, the WHO[15] proposes modifications in language to consider and begin to reduce stigma by substituting words that reverse the

[6]Lilia Esther Vargas et al, El sujeto de la salud mental a fin de siglo. (México: Universidad Autónoma Metropolitana, 1996), 7-11.
[7]José de León. "Is psychiatry scientific? Letter to a resident of psychiatry". The Servier of Biological Psychiatry, 21 (2014).
[8]Michel Foucault. Watch and punish. The Birth of Prison (Mexico: XXI Century, 1976). Where he mainly specifies the practices of institutions in charge of the State for the subjection and moral reading of bodies at their service.
[9]Rafael Huertas. Cultural history of psychiatry. Re (think) madness. (Spain: Cataract, 2019).
[10]Reference is made to the concept made by Jacques Derridá. "between" as a division whose implication is the difference with a limit. The "between" the author poses, is the dividing threshold, a boundary that divides and marks the difference of two concepts that are separated and in turn united.
[11]Louis, Sass. "Solipsism and schizoprheinc delusions", Phil Psych Psycholgie 8, no. 2 (EUA: 2002),101.
[12]According to Waxler, highly technologized and competitive countries mark people with a mental condition as unsuccessful for the social environment that they impose as ideals of success and productivity. The relationship of stigmatization with the course of the disease could be seen in the fact that the latter has a better prognosis in developing countries than in developed countries., in "Is outcome for schizophrenia better in non-industrial societies?" Journal of Nervous and Mental Disorders (1979).
[13]Concept worked by J. Derridá. It refers to the difference between ghost and spectrum, where the first operates in relation to duality: presence/absence - effectiveness/ineffectiveness - life/death. The ghost is in the middle, playing "between > one and the other: between life and death, between effectiveness and ineffectiveness, between the present and the absent, between the present and the in -actual. Derridá shows that the effect of spectrality disrupts this whole game of oppositions and allows us to think in other terms: to think what is not, to think about what exists but in its own way. The spectrum will always be an 'other' (either you or I) to come., in Marx's Wraith. The state of debt, the work of grief and the new international. (Spain: Trotta, 2001).
[14]In Michel de Certeau the concept of footprint raises the way in which the foreigner links with his object of study. Implying this a particular way of speaking and inhabiting the language, creating a historical distance in the "between" as is said and described to the other., in The Place of the Other (Mexico: Katz, 2007).
[15]The World Health Organization, founded in 1946 by 61 States, entered into force on 7 April 1948 under the Mental Health Policy Project. Policy and Services Guidance Package (2001):28.

nomenclature, for example, modifying "mental illness" with "mental health condition",[16] although this allows to qualify the impact at the level of language on the stigma that has been culturally solidified, this action is not enough to consider an adequate treatment and follow-up for the so-called psychiatric patient who has been trapped and correlated to ideas of dangerousness, risk, lack of control, unpredictability, as well as a latent denial and silence of the family nucleus that one of its members suffers from it. Stigma is usually related to the type of diagnosis, its duration, treatment and functionality of the individual. This stigma as "mentally ill" reduces opportunities for personal development, creating a significant gap between the limitations of the disorder and the occupational and functional difficulties it represents.

One of the crossroads we face in the field of mental health, as a result of the reverberation of social stigma and mainly promoted by the family nucleus, is the secondary gain obtained by the patient, rooted in the culture and the concept of disability in Mexico. Culturally, being mentally ill, although not necessarily named as such, derives in this being the justification for the problems of the patient, the family and the situation. Most of the time, leaving out of this formulation the patient and the family of their responsibility to follow up the treatment, information and necessary modifications in the dynamics of the family system. Immediate and precise solutions are sought, in which the doctor, therapist, psychologist, social worker is called upon to provide univocal answers from science to explain the phenomenon. However, in the face of this panorama, the psychosocial factor that has also been part of the cognitive, affective and social conditions that aggravate, potentiate or trigger the disorganization and instability of the patient is left out of the framework of vision. As long as we avoid talking, naming, dialoguing and thinking about schizophrenia as a condition that implies limitations in cognitive, social, educational, labor and other functions, we will follow the same route where the possibilities of generating solutions focused on the needs, socio-cultural reality and abilities and interests of the patient are repeated and blocked.

Families tend to respond to sociocultural imperatives by treating the patient with incapacity, justifying their erratic aggressive behaviors by the idea that these are the product of the disease itself, leaving aside the fact that there are manipulative behaviors constructed and armed with a particular objective in mind. Facing the non-existence of the patient's "cure"[17] implies a de facto declared resistance, both by the family and by those around the patient. It implies a process of mourning before the fall of the ideals constructed by the family, on the member who presents the disease. Mental health treatment implies improving the quality of life of the patient, his family and the people around him, however, the historical, cultural, social, symbolic and imaginary burden that schizophrenia carries, The historical, cultural, social, symbolic and imaginary burden that schizophrenia carries, however, brings as a consequence the stigma about the medication and the condition translated into the attitude of confrontation and resistance that the family may initially incubate regarding the subject who suffers from it, as well as the attitude of social disengagement, added to this, the indifference of health services for care, are variables that paralyze and stop the follow-up and therefore, the treatment. Working with psychotic structures, as well as the discomfort represented for many -health professionals, families and society- by the lack of a rational explanation, of a clear etiology, as well as of a cure for diseases such as schizophrenia -i.e., that the patient will not stop presenting hallucinations and delirium for most of his life- and its symptoms, defy common sense and therefore, attempts to fit into a logic when trying to think about it, and understanding it as cause-effect, are usually one of the main obstacles that beyond allowing to find alternative ways, models and devices that can work for each case in contrast to the paradigm of a solely scientific solution, it should be considered that in "psychosis occurs as a form of failed adaptive strategy of the personality to an otherwise confused and chaotic state of affairs. It is a reaction to a strong mental tension when there is a high degree of confusion in relation to the outside world".[18] So far, answers have been sought where there is a vacuum in the face of the impotence of that which is unreasonable and incomprehensible, in that aspect, the cultural beliefs that frequently contribute to the patient remaining immersed in complex dynamics that, beyond achieving stabilization, promote the rupture with the social bond and self-absorption that can lead to isolation, since "the capacity to verify the reality test and its integrative function are

[16]World Health Organization, Update of Appendices 1 and 2 of the WHO Comprehensive Mental Health Action Plan 2013-2020-2030, Switzerland, 2020, Available at: < https ://www.who.int/docs/default-source/mental-health/document-for-the-consultation-plan-of-acci% C3% B3n-integral-de- [consulted: 20 February 2020]

[17]The concept of mental illness will have important variations in relation to how a particular discourse is constructed. Ruy Pérez Tamayo explains that the disease is "To understand the behavior of doctors and patients at any time in history it is essential to know the basic premises of their social interaction. The second is that like all human phenomena, the current concept of disease is a historical product, a consequence of a successive series of ideas that have been added over time" in The Concept of Disease (1988). Although this doctor makes this allusion specifically about the concept of mental illness, we will find historical variations that have determined his gaze and social, political and medical situation. Some authors, such as Roy Porter in Short History of Insanity (2003), will comment that "mental illness is the product of the impossibility of certain subjects to conform to social norms," as well as extensive bibliography on this concept, from which it has been derived that implies a pathology -pathos - that has a social connotation.

[18]Johan, Cullberg. Psicosis una perspectiva integradora. (Madrid: Fundación para la investigación y el tratamiento de la esquizofrenia y otros trastornos, 2007)

interrupted".[19]

Resistance to accepting that the patient has a mental illness is difficult to accept, as well as difficult for the family and, therefore, for the patient. The stigmatization associated with mental illness also contaminates family members. Some react by not talking about the disorder with anyone for years, not even among themselves, since it is not accepted or recognized for fear of rejection and hostility that implies the change of paradigms and routines within the dynamics of the family system.[20] The primary caregiver, who most of the time is in charge of monitoring and accompanying the patient, acquires a burden that also affects his or her quality of life and physical health, often being worn out and feeling marginalized from the therapeutic processes and without emotional support from public and private institutions. Paradoxically, this circuit drives the phenomenon of hostility on the part of family members, generating internal dynamics and tensions that affect and reduce the possibility of seeking support and appropriate help for the follow-up of the condition, recreating the stigma in a cyclical manner.

For some authors, one of the main obstacles to the "success"[21] of comprehensive treatment of people with schizophrenia is the stigma associated with it.[22] Although we agree with this position, it should also be noted that beyond thinking about the achievements and obstacles involved in treatment, the central axis would be to re-plan what are the possible solutions taking into account the skills, subjective tools and needs of the patient, as well as their limitations, cognitive impairment, decision to continue the comprehensive treatment, as well as to assume the context and reality of their condition, in addition to the support and real family network they have. Therefore, finding possible ways for treatment, establishing the limitations of both science and the humanities when approaching the work with the patient, families, community and the disease, would allow unifying the lines of integral treatment, looking for alternatives so that the intensity of external pressures are not so overwhelming. Although promoting awareness of the disease does not necessarily imply -only- reducing it to adherence to pharmacological treatment, but rather that the patient and family can over time identify the triggers, the environmental, family and emotional factors that generate breaks with reality, respecting and considering both the subject and the family the various points of enclave that allows the otherness of the condition, as well as their autonomy.[23] Beyond adjusting to a path of "normalization", it would be necessary to work on the encounter and disagreement that participation implies and the gap that opens up between expectations regarding what the patient "is" and could achieve as part of the social and family imperative.

Ignorance and fears marked by the social stigma left by schizophrenia have been the main promoters of the cultural image around the subjects suffering from mental illness. As well as the debate that has involved the introduction to the public and legal sphere that of terms used by the field of mental health, used as antithesis according to the contexts, with a sense opposite to the one they were intended. "Stigma, community care, participation, biopsychosocial rights, science, recovery, autonomy, equity, early care are some of the concepts that sometimes have been translated into simple concepts and an empty discourse that surprises with who spends the words and wants to say the opposite".[24] Approaches such as, those who suffer from schizophrenia are a subject without autonomy, uncontrollable and unpredictable, are beliefs that have been propagated, rendering them useless and depriving them of the possibility of finding possible alternatives to improve their quality of life.

Device in Casa de Medio Camino Querétaro, Therapeutic Community, a Specific Work Model for Possible Links with the World

Treatment models for patients with schizophrenia are varied, however, each one has a reason for its existence, as well as specific scopes and orientations. In working with patients with psychiatric experience, it is not a matter of discarding, annulling or stigmatizing the functioning of each one, since each one brings a series of specific orientations.

In the case of the Therapeutic Community,[25] "normalization" is not sought, a statute that has been identified as one of the most common axes to be achieved in different social and institutional spheres, and therefore, the result thus oriented produces a series of complex resistances both in the patient and in his environment. In this sense, to propose ways in which each patient can find ways that, starting from the difference, can build solutions for a coexistence without excess of discomfort; emphasis is placed on the unique and non-stabilizable psychic processes, which at the level of psychotherapeutic work, implies enormous efforts, not only of the patient, but also of the family, psychologists, workshop leaders and

[19]Ibidem.

[20]Franco Mascayano, Walter Lips et al. "Estigma hacia los trastornos mentales:características e intervenciones". vol. 38, (2015).

[21]Note that this is often a problem in language that when we talk about treatment with psychiatric patients. The metrics that qualify the "success" of a treatment change according to the sphere: medical, psychological or social.

[22]OPS, 2005 ; Sartorius, 1998 en Runte, 2005

[23]We refer to the importance of the term autonomy, which is not necessarily linked to independence.

[24]Mikel, Munárriz. "Compartir la mirada. Siete años de AEN". Revista Española de Neuropisquiatría, 42 (2022): 11.

[25]Maxwell Jones, a doctor, specializing in psychiatry who at Northfield Military Hospital in Birmingham, England, in the mid-1950s, begins with the model of a therapeutic community that consisted of treating psychopaths and labeled as social misfits. Hence, Northfield is considered the cradle of English social psychiatry, where he began with group psychotherapy and grupoanalysis.

doctors who accompany the patient.

The aim of the Therapeutic Community[26] is that each subject can find possible ways to solve situations of discomfort generated by social, family and occupational demands. A question to which those of us who work with this population are exposed to is how to propose these lines of work without deviating from this objective, what is the boundary between the real possibilities of the patient, his family, medical and social context, leaving aside the socio-cultural idealizations that constantly expose the patient to situations of rupture with the reality that is proper to him? However, this is not resolved only in questioning how the treatment has been approached and therefore, the visibility that the patient has in front of the disease, his family and society, the disconnection "between" discourse, actors and socio-cultural and political factors crystallize as well as vindicate the historical status that has been assigned to the stigma of the patient of psychiatric experience.

When we talk about device, it is because it implies a series of guidelines and work axes that seek to address the problems related to the autonomy and functionality of the patient, as well as their families and/or primary caregiver. With device we also refer to clinical, ethical and social principles that are worked from "a daily life" in common. It is important to differentiate as stated by Dr. Maribel Campo and Manuela Crespo in their article History of the International Classification of Functioning, Disability and Health (ICF) an instrument that allows to differentiate "between" concepts, its evolution and application both culturally and historically, how these classifications have taken a turn in direct relation to the type of treatment, environment, condition and context in which a subject lives therefore its scope and limitations. For this reason we emphasize the term social inclusion, because it implies a remarkable distance between concepts such as rehabilitation, reintegration and care. For us, inclusion implies a voluntary effort of the subject and his support network to find ways to integrate into the social nucleus. This is a form of "normalization", we cannot leave aside and question that there is a social framework, which allows us to coexist with others, it can be close, create links or simply create interaction relationships, however, social constructions exist, we are not exempt from them: the social look is part of the references that precede and allow interaction with others, however, the border and boundary between the self and the outside is where we find an emotional breaking point. The regulation of emotions, frustrations, allow us to a certain extent to function, to make a social bond, "being" in the world in a way that allows us to build bridges with others. It is important to consider that the social and cultural variables proposed by globalization imply imperatives directly linked to the idealization of success, results, the multiplicity of information accessible on the network, the connection with others in an anonymous and depersonalized way, the vertiginous relationships established with the world, the economy, social networks, politics, sexual identity, etc., all of which trace abysses between the ideal, the should be and the possible construction of what one is and what one has at a singular level. Unfortunately, this gap is becoming more and more accentuated in the face of the constant demands of capitalist discourse. The exposure to scenarios where the split between mind and body, between life and death, between one's own body and the constructed body, becomes a constant, an imperative that seems to condition one's own existence. To respond to normalization would imply leaving out the conditions of the singular and the ways in which each subject can manage to build bridges that allow him/her to be on the outside without so much excess of discomfort that the right of the similar other would then be interrupted. Therefore, otherness and respect for the existence and difference of the other is central to the shaping of the social bond. However, how to work these abysses in which the vertiginousness with which today's society also presents radical fractures in the construction of bonds with others, in the respect of otherness, how to work with the patient with schizophrenia so that he can resume the social bond, functionality, autonomy when the people who inhabit a society are also exposed to the constant and recurrent fragmentation of the social fabric? These are data that we continue to question and rethink in our clinical-psychotherapeutic work. That is why we work from the singularity of the case.

Casa de Medio Camino Querétaro is a Therapeutic Community[27] that represents for patients with psychiatric experience an alternative after hospitalization. It is the next step. Unlike the treatment and support provided by the hospital, which has a function of containment and pharmacological stabilization, the Therapeutic Community presents as part of its scheme, the voluntary admission and the right to the patient's choice to reside for a specific time in it to work on finding cognitive, psychosocial, occupational, therapeutic tools that allow him/her a way to solve and be in the social without so much discomfort; it is a voluntary pact, where the guest[28] accepts to follow a personal process to identify the triggers of frustration that become complex in his daily life to process, reflect and accommodate cognitively and

[26] Now for its acronym CT.

[27]Therapeutic Community, also known as Casa Loohl, founded in 2013 in the city of Querétaro.

[28]In Casa de Medio Camino Querétaro- Casa Loohl, we call them guests as they are considered as people who will be living in a space alien to their family core for a while. The concept of hospitality considered by J. Derridá, linked to reflection on law and duty, law and justice.Hospitality for this author necessarily involves simultaneously thinking of the foreigner and hostility. For Derridá the unconditional and conditioned law of hospitality move and transgress each other: "The unconditional law of hospitality needs the laws, it requires them. This requirement is constitutive. It would not be effectively unconditional, the law, if it should not become effective, concrete, determined. It would run the risk of being abstract, utopian, illusory, and therefore transformed into its opposite. To be what it is, the law necessitates so the laws that nevertheless deny it, in any case threaten it, sometimes corrupt it or pervert it. And they must always be able to do it. " Derridá. Force of law. (Spain: Tecnós, 1997).

emotionally: It implies accompanying him/her in a "knowing how to do differently" with the stimuli generated in the daily atmosphere and his/her interpellation with others with whom differences, lifestyles, comparisons, ideals are presented, which in schizophrenic structures become of the order of intolerance that lead to a great extent to explosive crises. Likewise, their pharmacological treatment is followed up, always guided and oriented by their treating physician. This implies maintaining a sustained dialogue with the doctor.

It is conceived as a process where they will be stabilized and will resume social activities that were suspended for various reasons prior to joining the community. It is a space that has internal and external activities; it is an open-door space whose basis of socialization is not coercive discipline, but is sustained on the basis of respect and agreements among all. It is a properly communitarian device in the "everyday life" where everyone's abilities, interests and unique ways of "being" in the world are respected; the factor that ties the interaction is the link and relationship between different subjects, who share a suffering.

To speak of community implies at the beginning to evoke a group, however, the community device does not leave aside the subjective construction and the types of stabilizations that each subject can achieve in relation to himself/herself and with the other similar. The community model also implies from the outset a work of links. This is the vertex with which the patient with schizophrenia has to cope, most of the time alone, either because the social and/or family links have been constructed leaving out that which escapes the concept of "normality", or because the subject does not manage to link the loose pieces that leave him/her outside the - shall we say - established social circuit. The work that emerges in the Therapeutic Community implies a network work. In order to clear the equation from case to case, all the above mentioned dynamics must be taken into account, adding the basic organic and stability elements. The patient must be medically stable, hydrated and the vital signs must not show high or drastic variations. Because sometimes the habits that have generated in their home of origin are often very difficult to change. In many cases patients arrive decompensated and with altered organic dynamics such as: irregular sleep cycles, coffee consumption 24 hours a day, high intake of sugar and carbohydrates, inhalation of 3 to 5 packs of cigarettes daily, food based on binge eating and flour, low levels of hydration.

Another of the central characteristics of this model is the indirect participation of the social atmosphere, this implies that the Casa de Medio Camino Querétaro is located in the core of the city, with the objective of propitiating the conditions for social inclusion. This entails a series of complex circumstances in which sometimes culture and society continue to maintain ideas of strangeness and lack of sensitivity to otherness, which combine with the dynamics promoted by the social stigma about the disease. However, this scenario also implies an effort by the guests to reduce certain attitudes and behaviors such as some eccentricities like raising the voice, soliloquizing and/or manifesting uncensored when passing a neighbor, person or visitor, going out without clothes or presenting some type of behavior that socially can be "dangerous" or extravagant. Although this is an issue that rarely happens, what becomes complex is the daily coexistence with contingent and external stimuli to the community that do not necessarily escape the self-reference and ideas of suspicion that may represent neighbors or people passing by on the street. One of the issues that is worked on daily from the stabilization is the search for strategies that allow to short-circuit the infinitization of self-referential ideas. Although it is a constant, the same community, dynamics and interactions that you have between guests, psychologists and workshop people allow to dampen more easily these phenomena that come from the outside/outside. Therefore, within the CT a series of dynamics are identified that allow the interaction with the other, affirm the existence of another and build bridges to make social bond. One of the particular characteristics of patients with schizophrenia is the radical rupture of social and occupational ties.

It is important to note that not all guests can necessarily have encounters with the stresses involved in work framing, this depends on several factors: firstly, the level of cognitive impairment, age, daily medication doses, but mainly the lifestyle and habits promoted mainly by the family context. Those who achieve this allow them a greater autonomy and quality of life focused and focused on preserving a personal and interpresonal structure, but above all stuck to the consciousness of disease and therefore to the importance and emphasis that they put on seeking ways and channels for its stabilization at a singular level. While the above is an important factor in considering the scope that each case can achieve according to the goal of the therapeutic community as a link, regulator and driver for clinical-therapeutic-social work, also as part of these considerations, it works with different tallerist as who promote and behave from their sphere of knowledge the interaction of the guests with activities that manage three factors: cognitive skills, creativity and the management-production of individual and collective projects. While not all workshops are often refined by all in the same way, what is at stake are the tools provided by the workshops and their framing to generate concrete experiences to recognize themselves in the interaction with others, the physical sensations that pass through the bodies by making use of it to develop a common activity, in addition to the impact of building a common objective, among many.

The work that is carried out within the Casa de Medio Camino Querétaro Therapeutic Community, is complex mainly due to

resistance by asylum and care models that have anchored as a principle the conception of mental illness as dangerous, without a possible solution or cure. However, the main tool with which we work on this device is with a qualitative, subjective and singular praxis that in everyday life is undertaken as part of a process of conception inseparable from the autonomy and functionality possible that each case from its subjective resources manages to build, making use of a support network. The support provided and provided by the CT is the link and the process of social inclusion, based on the appropriation and approach sketches of the problem "no" without the complex interaction characteristics that allows group and collective work. Bearing in mind the alterity and ethical responsibility of each member who constitutes it.

The work within the CT implies that everyone has a series of activities to carry out, it is a collaborative integration process. For the same reason, interactions are oriented towards interventions that are done in the everyday. Which is just too complex. In this sense, the training of the clinical psychologist who collaborates in the device has to be centered on the function that allows it to lead, regulate, articulate and integrate the dynamics, encounters, disentanglements, frames of concrete situations that are being calibrated according to the situations and interactions of the bodies that are in motion and interaction in the sharing the same space; the psychologist will have to put into practice the flexibility to make use of heterodox tools without deviating from the rules applied for community coexistence. This is where we are again faced with another crossroads: the formation of the clinical psychologist. In Mexico, emphasis has been placed on quick resolutions and responses to anxiety crises. from very specific protocols, unfortunately this to what can reach is the momentary containment of the stimulus, however, not necessarily to the clinical work of the subjective structure of the subject, which results in tensions between non-logic and the logic of what "would have to be answered." Being in daily interaction presents hostile and complex attitudes that sometimes discolocate the mental health professional trying to find reasonable answers when the patient is not out of the question. Vocational training is limited to diagnosis but not to field work with the patient, family and support network. Being in daily interaction presents hostile and complex attitudes that sometimes discolocate the mental health professional trying to find reasonable answers when the patient is out of the question. Likewise, it is identified that, for mental health professionals, the emblem of "being the professional," wearing a robe or a badge that distinguishes it from the "sick" is what allows it a much physical distance, mental and work, however, when these badges are not part of the model, and on the contrary, interaction is sought mental health professionals begin to present complex difficulties in separating their role and function, sometimes blurring the border between: professional, friend, partner, family member. One of the elementary teachings to which this obliges us is to put into practice approaches that are constructed from the multiple transfers and experiences that emerge from the problems of each case, without neglecting, the interaction and group atmosphere.

The training of clinical psychologists at university level has been mainly reconsidered in providing immediate tools for containment, however, this does not ensure at all the sensitivity and call, as well as the clinical-therapeutic training for the work with patients with schizophrenia. The model that reproduces is the asilar, that of looking at the patient as a dangerous and delusional subject that can be an object of study from the framework of science and humanities. However, working, being present, accompanying, sustaining and identifying the unique structure and stabilizations are a topic that very few mental health professionals are willing to address because the patient within the CT model is not categorically referred to as sick. This can sometimes cause a breakdown and bewilderment in the mental health professional as it identifies how the stigma is rehabilitated from vocational training. "Madness" for many is often captivating and even in some seductive way, however, in working with patients of schizophrenia one of the teachings presented to us is the ease of breaking ties with the world and with the other like, as well as the contradictions that social norms imply, the law of the other and the possibility of understanding what others say in relation to what they do. The patient with schizophrenia reacts to the contradictions that others, society, politics, economics, the law emphasize and emphasize, evidencing the impossibility of maintaining the affective bond from idealization, the duty to be and logic-reason. While it is complex to follow up a patient in private consultation or in the office, either at one-hour intervals times per week, the dynamics of living in a therapeutic community are even more complex, as they play group dynamics that reproduce from their family core, putting into play dynamic between the different actors that accompany them: guest-psychologist, guest-guest, guest-institution, guest-family. Working with these interactions is where the training of those interested in mental health becomes complex and difficult to distinguish.

Possible Stabilizations and Projects from the Singular to the Collective

In Casa de Medio Camino Querétaro, we work from the uniqueness of the case, however, being a Therapeutic Community seeks to set the singular task with the exterior. The unique feature of each case presents a series of tensions with what is clinically worked, including the difficulties due to the experiences that involve being and living with the other similar meeting certain norms and limits. It should be noted that although these collaborative construction processes are through the way of creation and art, "no" all guests join it.

It shows us, that at the cultural level in Mexico, art is not necessarily the stabilizing way of construction for psychosis, mainly because not all guests, have interest, skill or because it was not a transmitted educational, pedagogical and/or familiar means by which it has been transmitted. However, being a collaborative work, each one participates from his interests and contributions; from what is unique, the inventions, subjective resources and skills of each guest are respected in community projects. This makes it possible to re-establish social and family ties, as well as social recognition in two ways: that of an "external" other that serves as a witness to the collective action and that of the same companions, family and work network of professionals who are in the Therapeutic Community. The collective work is possible only thanks to the support, coordination, disposition and creativity of the clinical team, their participation is guide and bridge for the execution of the projects. The involvement of psychologists within the community is fundamental to the realization and completion of each project. This is sometimes a complex task due to the indispensable communication, tolerance, respect, interaction and cohesion as a team, as well as the commitment of each of the members that make up it, however, working with psychiatric patients requires constancy, commitment, transfer and daily practice: attitudes and skills that are not easy to find on staff. The workshops that take place within the community also allow the gestation of projects in collective. The role that the talleristas acquire is relevant to the guests as part of the work team, although they are external. These include community projects, as well as the establishment of support networks for guests. Each workshop has a specific reason to operate, it is not just a class given to a "special group," or to "engage" in something, each workshop is planned with four objectives:

1) Stimulate executive functions, to reduce cognitive impairment

2) Work psychomotor and language skills

3) Promote community bonding through unique contributions

4) Build bridges between the guest, his family and the social

In this case it is not treated, nor does it focus on promoting art as an academic avenue, nor is it about guests developing artistic skills, it is about integrating the peculiarity of each into a collective in which what is produced is integrative creativity, sensitivity and empathy towards the other like with whom you live in a daily life.

Each of the guests of the community contributes from his own invention and small creative constructions avenues that establish connections with the other social. However, this is not always easy work. First because in working uniquely with each case it is indispensable to regulate the interests and thoughts of suspicion, as well as that, not all of them have the same age, interests or abilities. However, objective and concrete guidelines are laid down in Community projects. It is the function of the team of psychologists to combine and integrate it. Secondly, because in working in a community way it is essential to plan, design and construct among all a project that has a concrete unifying vision in collective.

Currently, we have developed, edited and published within the community, two books that have been the product of effort and work among several: "Disqualify the imagination" (2019), "Huddled Feelings: Deep Surfaces" (2022). As well as two books that were the product of the invention and creation of two guests: "You are the verse I feel, for my executed" (2020) and "Gossip of Farandula Night Centers" (2022). Likewise, we have made photographic exhibitions, presentations of the books, and recently in May 2023 we presented a compilation of monologues that were made during the period of pandemic Covid-19 within the Therapeutic Community entitled "Monologues: among the folds of memory." Actfully, we are editing and working on the screening of a video where the guests mounted a Japanese dance choreography.

Each case poses its own impossibility at the level of structure, however, this implies a challenge to listen and accompany the guest in his subjective times, as well as in his abilities. The counting figure that acquires each of the psychologists that is in the community, is different, this allows the work from different and multiple transfers. The above manages to identify with each figure different forms of approach, but in a comprehensive way with each case. Identify repeated circuits, as well as the orientation of the case; their scope and limitations. The questions that then arise regarding the clinical case, give rise to the possibility of unfolding to a certain extent, the certainty of which in the psychotic structure is brought about. The strategies in the community are sufficient, however, the orientation that calls us is the line on which with creative and daily interventions "it is intended to cut the invasion of the real of what suffers the psychotic."

It is essential to note that a Halfway House as a device does not necessarily focus on working from a Therapeutic Community model; few institutions in Mexico promote and work from that point of view. The presence, the body of another that is accompanying in the slippery terrain that involves working with patients with schizophrenia is achieved with a thorough and constant work, which has to be formulated from a singular and collective process. The Therapeutic Community as a model implies the autonomy but also the systemic interpellation of the group that makes it up. It is not only a question of carrying out activities for the purpose of entertaining or engaging, but among several projects can be carried out in common that allow to build bridges of solidarity, empathy, collectivity and recognition. It necessarily implies the concept of social inclusion.

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Conflicts of Interest

The author confirms that this article content has no conflict of interest.

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