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ALDA MERINI

AND THE MAKING OF LYRICAL PSYCHIATRY

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Introduction: If poetry could have a word

This chapter explores the idea that lyric poetry – understood as non-narrative account of experiences, understandings, emotions, and feelings often spoken in the first person – can be a primary source of psychiatric knowledge.¹ My starting point is the perspective of Alda Merini (1931–2009), an Italian woman poet and patient who was incarcerated in a mental asylum for 10 years following a diagnosis of bipolar disorder and schizophrenia (1964–74).² Historically, this period precedes the enactment of the Basaglia Law, the Italian Mental Health Act of 1978 which contained directives for the closing down of all psychiatric hospitals in Italy (Foot 2015). This event – which had enormous impact on a number of countries, from Brazil to Sweden, and from the UK to USA – is considered ‘the most radical mental health legislation ever passed in any country’ (Burns and Foot 2020: 62). Merini’s poetic imagination foresaw the main political and scientific ideas substantiating this revolution. This chapter engages with some of these preoccupations and predictions thus illuminating poetry’s critical role in the evolution of psychiatric practice and knowledge in Italy and internationally.

According to different sources, Merini was given between 46 and 57 electric shock treatments during her hospitalisation and was sterilised at age 39 (Zinnari 2021: 427).

¹ I thank John Ødemark, Eivind Engebretsen and Mona Baker for allowing me to present this idea in its preliminary forms on two occasions: at the ‘Translational and Narrative Epistemologies’ symposium, University of Paris, 22 November 2022; and at the ‘Knowledge Translation and Incommunicability’ workshop, University of Oslo, 25 May 2023. This research is kindly supported by the ‘[Bodies in Translation Project: Science, Knowledge and Sustainability in Cultural Translation](#)’, The Research Council of Norway, University of Oslo.

² I gather this piece of information from Alessia Zinnari’s helpful article (2021). According to Merini’s daughters, during the period 1972–79 Merini’s mental health alternates between states of distress and wellbeing, an oscillation that resulted in times of sporadic internment up until 1979, when Merini was finally discharged. See the poet’s biography on her official website: <http://www.aldamerini.it/?page_id=8#1513806848988-e8fa5e55-760b>.

Two decades after this period of confinement, Merini described her experience as a patient in two works: the collection of poems *La terra santa* [The Holy Land] (1984) and the memoir *L'altra verità. Diario di una diversa* [The Other Truth: Diary of an Other] (1986), whose lyrical prose is interspersed with 11 poems and seven letters addressed to a fellow patient and lover. The present study focuses on the latter work as an example of the complexities linked to the recounting of the psychotic experience. I chose it fully aware that neither this type of narrative, nor such experience, can be pinned down to a single genre, register, or medium. This is why the composite structure and style of Merini's memoir presents itself as a privileged site, where psychiatric storytelling and episteme converge. One may object that using a mixed-genre memoir to discuss poetry is counterproductive or even illogical. In this situation, however, I believe that the opposite is true. Poetry and the lyrical necessitate a theoretical and conceptual expansion through which we may be able to fully grasp their potential as art forms, art works, and practices. Conceiving of poetry as a technical discourse for elite literary experts or passionate hobbyists is a double outlook error that places us at the two extreme ends of the reality spectrum. As Werner Wolf (2005: 23) points out, 'lyric', an umbrella term used for 'most versified literature (except for the epic and verse drama)', has become 'a synonym of "poetry" tout court'. In the present study, I use the terms 'poetry', 'poems', and 'lyric' interchangeably; and the adjectives 'poetic' and 'lyrical' to refer to Merini's non-narrative, non-linear, and non-chronological storytelling, one that can be defined at once as poetry, prose, fragment, memory, clinical report, psychiatric textbook, and philosophical essay.

If it is true that patients do not generally use poetry and/or literally-inflected speech to communicate with one another, their families, and health providers, it is nonetheless important to critically investigate the lyrical qualities (broadly understood) of their utterances. These include metaphors, silences, omissions, rhythmic pauses, non-verbal gestures, and oneiric elements as well as the embodied, performative aspects that are typically found in poetry more than in any other genre (e.g., Kristeva 1987). If we fail to attend to the inherently lyrical speech of the sufferer – that is if we fail to tune into the psychotic and poetic 'wavelength' generated by their words (Pearson et al. 2022: 2) – we risk oversimplifying, if not misunderstanding, patients' discourse, with consequences that can be significant at diagnostic and treatment levels.

It has already been demonstrated that, in psychiatric settings, poetry writing and reading can support meaning making (Pearson et al. 2022), suggesting novel understandings of psychosis (Pearson et al. 2020), and sustaining creative modes of recovery (e.g., Pennebaker 2014; Punzi 2021). Moreover, by way of its semantic obscurity (a difficulty that invites us to deeply engage with words), poetry can help us better understand ‘individuals’ illness experience as a grounding for the ethics of the clinical encounter’ (Kirmayer 2007: 21).

I draw upon these findings to develop the intuition that poetry can contribute to psychiatric science in a substantial fashion. Poetry, I argue, does not simply offer personal and invaluable insights into the lived experience of illness in general, and of mental distress in particular; neither is it solely a creative activity that can complement pharmaceutical therapies while accelerating recovery and enhancing wellbeing. Poetry has an active role in psychiatry and it should be considered on an equal footing with science.. When produced and considered in contexts of mental distress – as Alda Merini’s diary reveals – poetry is a source of psychiatric knowledge that asks to be beneficially exploited. By the same token, psychiatry has a submerged poetic nature whose presence, forms, and functions have remained secondary in the shaping and development of a discipline that, despite having a solid interdisciplinary core, privileges biomedical approaches at the expense of the poetic (Bleakley and Neilson 2021). Merini’s memories offer an important testimony to what I see as psychiatry’s lyrical underpinnings and workings.

The idea proposed here – where poetry provides a primary, non-ancillary perspective to the creation of psychiatric knowledge – does not take us on unscientific routes. In line with the principles of ‘critical medical humanities’, it rather highlights a methodological and programmatic correspondence that enables us to pursue an endeavour that is as scholarly rigorous as it is clinically relevant. My appeal to consider lyrical psychiatry (as I define it) an integral part of psychiatry tout court, not in opposition to, or in substitution of, it responds to critical medical humanities’ invitation to abandon the belief that humanistic knowledge is secondary or supplementary to medical knowledge. In fact, as Merini’s diary discloses, poetic knowing provides a compatible, comparable, and intersectional epistemology that has a similar authority to medicine’s (Whitehead et al. 2016: 35-36, Bleakley and Neilson 2021). As a result, poetry – as practiced by ‘lay’ subjects and providers – and biomedicine –

practiced by experts – jointly contribute to better understand psychiatric suffering in a way that erodes epistemic hierarchies.³

I first examine three distinct and interlaced processes of epistemic ‘othering’ at work in the production of psychiatric knowledge: the epistemic exclusion of the patient, the marginalization of psychiatry as a discipline, and that of poetry as practice and discourse. Second, I link this discussion to the study of Alda Merini’s memoir – where the three processes are concurrently present – by considering some of the nuclei of epistemic creation emerging from the analysis, namely: diversity, obscurity, and incommunicability. Together, I intend to demonstrate 1) a continuum between the seemingly irreconcilable discourses of poetry and psychiatry; and 2) that, in some of its forms, a lyrical psychiatry may help us to circumscribe epistemic injustice perpetrated in mental health care by showing ways of embracing degrees of unknowability. I also suggest that psychiatry and poetry are similarly disruptive sites of knowledge production, rather than the strongholds of opposite epistemic forms.

The triple Othering of knowledge: on patienthood, psychiatry, and poetry

Paradoxically, the first epistemic Other in the creation of medical knowledge is the patient, whose capacity as knower of, and contributor to, the diagnosis and treatment of their disease is often undervalued, if not all together ignored or displaced. This is particularly true in psychiatric settings due to the ‘persistent negative stereotypes that affect people with mental disorders’, who are often believed to be ‘cognitively impaired or emotionally compromised, [...] existentially unstable, [...] or psychologically dominated by their illness in a way that wraps their capacity to accurately describe and report their experiences’ (Crichton et al. 2017: 65-66). This unfortunate situation leads to a ‘credibility deficit’ (ibid.: 65) that is as widespread as alarming. Despite having ‘direct access to and knowledge of their experiences’, psychiatric patients have a certain epistemic privilege (Drożdżowicz 2021: 1); yet, as it has been pointed out, they are susceptible to even greater epistemic exclusion than people with physical illnesses (Crichton et al. 2017: 65), provided that a distinction between bodily and mental suffering is still one that we should consider.

³ I thank Alan Bleakley and Shane Neilson for their helpful and sensitive questioning of this idea, which invited me to look for a more sustainable and rigorous understanding of the relationship between poetry and psychiatry.

This form of ‘epistemic injustice’, to evoke Miranda Fricker’s (2007) pivotal concept, harms psychiatric patients as well as their families and providers, who cannot come to terms with a practice that is elusive and often unsuccessful. At the same time, the epistemic marginalisation of the patient produces unhelpful knowledge hierarchies that, in turn, generate significant epistemic losses. It has ‘detrimental effects on individual psychiatric patients’ in that it obscures their epistemic contribution to appropriate diagnosis and treatments (Crichton et al. 2017: 65). At an institutional level, epistemic losses of this kind limit the funding of psychiatric services while cultivating a dangerous distinction between, on the one hand, the ‘hard’ or objective evidence provided by the methods and results of biomedicine (e.g., randomized control trials, systematic reviews, X-rays or MRI scans) and, on the other hand, the ‘soft’ or subjective evidence offered by patients and their families (ibid.: 66; see also Engebretsen et al. 2020). As is often the case, fictional literature – from poetry to memoirs and, more recently, from blog writing to tweets and Instagram posts – captures this methodological, conceptual, and disciplinary dissonances that reflect the dominance of certain epistemic, social, and/or political paradigms at work in the production of science and knowledge. The reading of Merini’s work will help us glimpse this key, lyrical substance of psychiatry.

The dominance exercised by ‘hard’ science (that studies measurable facts and bodies) over ‘soft’ science (through which we attempt to examine emotions, perceptions, and the life of our minds) has led to the imperialism of numbers over stories and of quantitative approaches over qualitative ones, with destructive consequences for psychiatry as a discipline. It is a well-known, yet unspoken, reality that psychiatry is ‘itself stigmatised within medicine’ (Crichton et al. 2017: 68) because it is thought not to rely upon or generate medicine’s objective truths. From this perspective, psychiatry is an epistemic Other in itself, thus representing the second type of epistemic Othering examined in this chapter. Crichton and colleagues (ibid.) observe that, ‘despite the lack of objective truth in psychiatry, many psychiatrists are influenced by their general medical [and biomechanical] training and import this bias into the field’. Even though they acknowledge the ‘biopsychosocial model’ of mental disorders (Engel 1977) and, therefore, the need for a holistic approach when diagnosing and treating mental illness, ‘they often [and counter-intuitively] retain their biological orientation’ (Crichton et al. 2017: 68).

This diagnostic, conceptual and epistemic inconsistency causes moments of friction between, and across, mental health professionals and sufferers, whose voices remain covered and/or distorted by dominant, biological paradigms. The situation is aggravated by the fact that psychiatry – as a body of professionals, a discipline, and an institution – ‘continues to be seriously challenged in the face of recruitment difficulties, unfilled posts, diagnostic controversies, service reconfigurations and public criticism of psychiatric care, in addition to other difficulties’, including ‘criticism concerning the medicalisation of normal behaviours and states of mind’, ‘anti-therapeutic ward environments’, and the ‘denial of patients’ families as partners in care’ (Yakeley et al. 2014: 97).

In a ground-breaking editorial published in the *Psychiatric Bulletin* in 2014, Jessica Yakeley and colleagues (ibid.) announced that ‘psychiatry is on fire’; for them, the sovereignty of positivism (as in hard science), accompanied by the dismissal of subjectivity and emotions in psychiatric training and practice, has compromised the credibility and sustainability of the discipline. To contain this critical and clinical damage, they promote a double intervention, or movement, whereby the subjective (e.g., patients’ knowledge) can be objectified, and the objective (e.g., clinical reasoning) can be subjectified (ibid.: 100). They continue by saying that ‘promoting awareness of the subjective and emotional aspects in psychiatric training and practice’ does not mean to ‘undermine the position of psychiatry within the natural sciences, nor erode the still fragile evidence base for the aetiology of mental disorders or efficacy of their treatments’ (ibid.). Rather, what the authors suggest is that a ‘better integration of the subjective and objective paradigms’ will help us address ‘unhelpful splits in our epistemological thinking, increase our tolerance of uncertainty and ambiguities within [...] clinical work’, and ‘enhance creativity and innovation in psychiatric research’ (ibid.). Such integration has the potential to increase not just clinical benefits for patients, but also forms of disciplinary, societal, structural, and/or personal stigma, considering that ‘people with mental illness often accept and internalise [the] negative stereotypes’ attached to them (Crichton et al. 2017: 68). As Merini’s experience shows us below, this unified paradigm represents a valid way forward in that only a truly interdisciplinary effort can enable us to capture, and respond to, the complexities of mental disorders, their management, and societal impact.

The integration between biomedical, research-led perspectives on the one hand, and subjective, patient-produced knowledge on the other, is a creative act not just because it reveals a largely unknown territory, one that asks us to try different and/or new explorative tools, but also because it continuously posits the question of reinvention. Each person is different from another, not just genetically, as personalized medicine shows us, but also culturally. Each one of us is also different in relation to her/himself throughout the course of their lives in that our identity is in flux, ever-changing and evolving (a description of this process is offered, for example, by Julia Kristeva's theorisation of the *subject in process* in her 1979 essay 'Le temps des femmes' [Women's Time]). As a result, prevention, diagnosis, and treatment strategies should reflect biocultural diversity in all its forms – genetic, biological, linguistic and/or cultural – especially in the case of psychiatric disorders in which the boundaries between the somatic and the psychological, the biological, and the cultural blur.

By keeping in mind the creative energy necessary to, and resulting from, the encounter between the apparently opposite realms of the biomedical and the subjective, I now introduce the third epistemic Other as part of my analysis, that is poetry. Lyric writing has long been marginalized not just in the literary domain, where novels have more popularity and generate better revenues, but also in the field of narrative medicine (Bleakley and Neilson 2021). Emerged to 'skilfully receive the accounts persons give of themselves', narrative medicine challenges 'a reductionist, fragmented medicine that holds little regard for the singular aspects of a patient's life'; in doing so, it protests 'the social injustice of a global healthcare system that countenances tremendous health disparities and discriminatory policies and practices' in order to develop 'increasingly nuanced view of the workings of the narrative, relational, and reflexive processes of healthcare' (Charon et al. 2017: 1). The impact of this narrative revolution has been transformative; yet, as it has been observed, 'non-narrative poetry has not simply been overshadowed, but rather eaten whole, by narrativist approaches' (Bleakley and Neilson 2021: 3), with the unwanted result that narrative medicine and reductive biomedicine have often produced identical epistemologies instead of diverse, complementary visions (ibid.: 43 et passim). This is even more surprising given the similarities between poetic speech and patients' words in the vernacular.

Among others, Julia Kristeva (1987) has described patients' discourses as inherently poetic in that we, as patients, often use devices that are typical of poetry as a genre, such as embodied metaphor. Poetry's absence from the scene of narrative medicine is also striking if we consider another level of similarity, that is the 'shared characteristics' between lyrical poetry and clinical practice. In their seminal volume *Poetry in the Clinic: Towards a Lyrical Medicine*, Alan Bleakley and Shane Neilson (2021: 138) list and discuss eight categories of juxtaposition between the poetic and the clinical: 1. Character, achieved through approaching subjects 'slantwise'; 2. Intensity, depth and brevity with focus on particulars; 3. Epiphany or sudden insight; 4. Use of metaphors, with focus on invention and expansion; 5. Subjectivity and confession stressing emotion, mood and passion, or embrace of affect; 6. Tolerance of ambiguity embracing empathy; 7. Beauty (privileging quality over quantity, and form over function or the purely instrumental); 8. Orientation to here-and-now space and place rather than there-and-then time.

In the second part of this chapter, I will discuss Merini's creation of psychiatric knowledge by engaging with some of these categories. I will use the triple framework of epistemic marginalisation that I have just introduced as foundational ground for examining Merini's (and other poets' and patients') psychiatric knowledge. In doing so, I challenge the distinction between hard science (biological, mainstream psychiatry) and soft science (poetry) to suggest the idea that the subjective is as rigorous a method as the objective, especially given that all sciences, both hard and soft, retain a degree of interpretation (see Engebretsen et al. 2020), unknowability, and opacity. As mentioned above, Merini's writing samples are not used as a case study; they are a primary source of psychiatric knowledge offered by moving, accurate accounts of what it means to need, receive, and provide care. They are also more than a call for the reconceiving of care precisely by virtue of the fact that they fundamentally contribute to the making of psychiatric knowledge. From an epistemic angle, this approach has radical consequences; it implies that the vision of the disabled and sick is a valid one, and that we should seriously take it into consideration when trying to help the sufferer in their healing process.

Not a case study: Alda Merini and/as psychiatry

I examine here three main areas of contribution to the making of psychiatric knowledge by Alda Merini. In her memoir, they are presented through the triple marginalised lens of the poet-sufferer: diversity, obscurity, and incommunicability.

Before referring to processes of Othering often perpetrated against people suffering from mental illness – Othering that leads to stigma as well as to social and physical segregation in the confined space of the mental hospital – in Merini’s diary diversity is first and foremost a diversity of vision. The poet-patient’s understanding of the world is in tension with that of others, be they health providers, friends, or family; their alternative perceptions function as epistemic diversity, that is a type of gnoseological dissonance or divergence with which it is important to attune. In the ‘pandemonium’ (Merini 1986: 15), ‘infernal chaos’ (ibid.: 14) and ‘grave hell’ (ibid.: 20) that is the asylum, diversity becomes a mode of survival, the ontological differentiation of which manifests itself through a spectrum of stories, world visions, memories, dreams, and traumas that deeply challenge our expectations about who the patient is, and about what is their role in illness.⁴

Merini investigates epistemic diversity by offering the alternative perspective of the poet-patient as gnoseological agent, a type of epistemic Othering that I call ‘patienthood’. By challenging the often-undisputed authority of health providers, she claims at various points that mental suffering is often misdiagnosed and mistreated, possibly because of lack of attention towards the words and opinions of the patient. On the diagnostic level, she maintains that ‘mental illness does not exist’ (ibid.: 137); what do exist, according to her, are ‘nervous breakdowns, [...] family issues, the responsibility and effort of raising children, and the difficulty of loving’ (ibid.). The list could potentially go on to include other aspects of what is generally considered a ‘healthy’ life. However, Merini is not implying that cases in which mental distress proves to be pathological do not exist; her narrative is punctuated with episodes in which psychiatric suffering is detrimental for the individual to the point of altering and/or impeding the functioning and flourishing of their life. Rather than denying the

⁴ The English translations of Merini’s Italian original are mine. I used from the 2007 BUR edition of the *Diario* throughout. The page numbers of the Italian text are provided between parentheses. According to Alessia Zinnari, the *Diario* has never been translated into English (2021: 428). After an online search, I discovered that there exists at least one English-language translation authored by Serena Ferrando and published by L’Incisione, Milan, in 2007. However, since I could not retrieve a copy of this volume, I decided to translate the writing samples myself.

existence of mental illness, the author denounces the misunderstanding of its nature, thus offering an alternative epistemic perspective 1) on the aetiology of so-called mental diseases, which for Merini generate from affective and social disorders; 2) on the essence of so-called neurosis, which, in one of the poems that crisscross the memoir, she defines as a form of science (as in valuable understanding of facts and emotions); and 3) on the diagnostic sensitivity that is necessary to approach 1 and 2 above: a holistic gaze that is often lacking among her health providers: 'I wish that mental illness can be finally debunked and led back to its original foundations, that is the reality that it is an emotional disorder. I am not a psychiatrist, but I would have wanted to be one'. (ibid.: 120)

Merini (ibid.: 117) continues: 'In reality, there is no folly without justification, and each gesture that normal and healthy people doom to be crazy involves a mystery of unheard suffering that men and women have not grasped'. While, 'Man is socially evil, an evil subject. And when he finds a turtledove, that is someone who speaks too softly, someone who cries, he throw his guilts on them, and, in this way, the mad are born'. (ibid.: 123)

Thus, says Merini (ibid.: 41)

To each one of you I ask for a grace:
 To be still for an hour
 On the starry face
 Of a normal party's clock
 Then neurosis is science
 [...] Aren't we all mad?

While, 'Despite all the drugs that we took each one of us managed to remain oneself. We were promised happiness, the stabilisation of our instincts. But our instincts were the instincts that anyone else had, they were only distorted by a lack of love' (ibid.: 98), and 'Our nurses [...] made us believe at every occasion that we were "different" and that therefore we could not take part in their discourse or in their way of life. [...] They spent hours shut in Dr. G.'s office to come out of it with enormous files full of strange and absolutely wrong treatments to administer to the poor patients'. (ibid. 30-31)

As this last example reveals, Merini denounces forms of epistemic and psychological violence committed against the sufferers who ended up being Othered by their providers as well as being assigned 'strange and absolutely wrong treatments' (ibid.: 31). A discussion on

the acts of violence, psychological and physical, described in the book falls out of the scope of this chapter; what matters here is to take them into consideration when examining epistemic injustice as a form of violence itself.

Merini repeatedly denounces processes of misdiagnosis resulting in inefficient and/or erroneous therapies based on biomedical approaches such as psychotropic drugs, narcoanalysis, and electroconvulsive therapy (ECT). On the topic of mistreatment, the following passages offer but some cases in point:

Drugs deprived us of all contact with reality. My personal doctor, doctor G., argues that this was the case because of my illness. But I maintained the opposite. (ibid.: 118)

Certain beasts [as in people], under the effect of the poison of the drugs, had completely lost their identity. (ibid.: 28)

Under narcotic drugs my behavior was extremely negative and I screamed like an obsessed in the grip of the worst delirium. (ibid.: 30)

Naturally, in our ward soft therapies were inconceivable, therefore [the patient] was forced to receive an interminable series of electroshocks, after which the poor woman came out completely mad. (ibid.: 51)

In that asylum there existed the horrors of the electric shocks. From time to time we were crammed into a room and they would cast those horrible ‘spells’ on us. I call them spells because the only effect they had on us was that of brutalising our spirits and minds. On more than one occasion, doctor G. grabbed me by the arm and took me away from that torture. I used to start crying and then I wet myself because of so much fear. (ibid.: 71)

The room where the electric shocks took place was narrow and terrifying; even more terrifying that this was the antechamber where they would prepare us for this sad event. They would give us a premorphine, then some curare so that our limbs could not move anxiously and disproportionally during the electric shock. The wait was agonizing. Some cried. Some urinated on the floor. Once I took the head nurse by the throat, on behalf of all the fellow patients. The result was that I had to undergo the treatment first, and without the preliminary anesthesia, so that I could feel everything. (ibid.: 87-88)

In reading these passages, it is important to stress that, while pointing out the limitations of biomedical approaches, Merini does not dismiss them all together, but rather she believes them to be useful at times, for some people, and under specific circumstances. What she condemns without reservations is violence committed against the sufferer.

There are instances in which Merini's lyrical psychiatry engages more closely with biomedical discourse, thus making a direct contribution to psychiatric literature; this is apparent, for instance, in the passages mentioning the inefficacy of specific drugs to treat and/or alleviate patients' suffering (e.g., Serenase, Pentothal, Leptonizal, etc.). Here, psychiatry, bolstered by pharmaceuticals, resorts to literalism or the concrete, veering away from poetics. Drugs are used as blunt extensions of similarly blunt diagnoses. Here, the agent is pentothal (sodium thiopental), an ultra-short acting depressant and anaesthetic, infamously known as a 'truth serum' (an interesting metaphor – for what is Merini's 'untruth?'):

Doctor G., who was more and more convinced that at the origin of my psychosis was a trauma, started to treat me with Pentothal. Pentothal is nothing but the truth serum, which, administered in light doses, can provoke euphoria and push the subject to make unheard confessions; under its effect, there is no censorship. Personally, Pentothal made me shout and move animatedly claiming that a man was scaring me [...] up until doctor G., seeing that I was exhausted, suspended the treatment. (ibid.: 65)

When instead they gave me Dobren (ten injections per day), I was in a tragic state, I could not sit, I could not relax. That dreadful drug would keep me continuously awake, and I did not the so-called 'long breath', which neurologically is so important for our wellbeing. (ibid. 99)

Use of pentothal's is now discontinued. For Merini, it seemed that the drug unveiled the untruths of the psychiatric institution that was treating her, the untruths that the Basaglia Law intended to unmask. One of Merini's fellow-inmates warns that treatment itself can lead to symptoms that in turn call for treatment, so that the patient is caught in a vicious cycle:

Yesterday I received a visit from a discharged patient who told me these exact words: "At the beginning, I was hospitalised because I had a religious vision. I was immediately given a treatment based on Serenase, then they tied me up, and I was considered mad [...] After this episode, my cognitive capacities, my personality worsened. I did not have the perception of myself any longer. What is more, after taking the drugs I used to suffer inhumanly because, as is well known, psychiatrist drugs have violent side effects, to the point that the patient in the hospital cannot but cry for help. This request is usually met by tiding the patient up to the enclosure bed". (ibid.: 119)

Such a cycle, that **R.D. Laing** called a 'knot' and **Gregory Bateson** a 'double-bind', itself is a product of treatment meriting further treatment:

The asylum was a place of enormous pain, one in which the hospital cart was carried around to make us believe in some help that did not exist. Like an animal, I would jump out of my resting place and ran, ran towards the cart and overturn it, and after this I would certainly be punished with a high dosage of Largatil. (ibid.: 73)

[The doctor] gave me three injections of Valium [...] I believe that in those moments I had the perception of dying. The injection was so violent that I fainted and slept for three days. When I woke up I was tied up to the bed. (ibid.: 103)

In an interesting and arguably controversial section of the diary, Merini maintains that, whenever drugs were suspended (for example during pregnancy), she would not suffer from psychosis. This statement resonates with other patients' testimonies recorded in the book: 'When I was pregnant all symptoms disappeared and I could be back to be normal. All treatments were suspended and, without having a period, I stopped being hysterical'. (ibid.: 16)

Overall, what this section on epistemic diversity with reference to processes of misdiagnosis and mistreatment shows is that the psychiatric patient can be harmed in terms of their capacity as knower, especially on the ground of their experience of detachment from reality and/or what is supposed to be considered an inability to exercise their will, which I see a further element of epistemic discrimination. As Merini notes: 'Doctor G. maintained that for a long time I had lost contact with reality. But I have always doubted about it. Who can decide what reality is?' (ibid.: 121), where 'What kind of truth could emerge from a such an atrocious and unhealthy place?' (ibid.: 142), while she poses the existential question of 'Why a lunatic cannot be in charge of their will?' (ibid.: 16)

Such ethical reflections allow me to introduce the second epistemic principle: obscurity. This is a notion that partly explains psychiatry's and poetry's segregated positions within the disciplinary realms of biomedicine and the humanities respectively. Despite significant advances, both the nature and insurgence of mental illness remain largely mysterious as of today, and treatments prove particularly difficult, especially where pharmaceutical companies retained vested interests. For all its attempts to be as scientific a discipline as possible, with statistical models, reduction to brain mechanisms and biochemical reactions sustaining its course, psychiatry requires high 'tolerance of ambiguity', an aspect that is central to both the medical and the poetic imagination (Bleakley and Neilson 2021: 159). At times, ambiguity of interpretation can generate

areas of incomprehensibility and ignorance in which meaning is obscured. Merini's writing helps us to recognize 'epistemic darkness' as a necessary element of lyrical psychiatry and of psychiatry tout court:

We came out of that hell already bewildered. This was a further proof that our folly remained an inexplicable fact and that it would have never provided a rational truth. (Merini 1986: 37)

I had a thirst for truth and I could not comprehend how I could have ended up in that inferno. Naturally inclined to rationalism, striving to find out the "motive of all things", I was frightened by the obscenity of the ignorance that people had in that place. (ibid.: 38)

I asked my doctor the reason for my monstrosity. But my doctor has never been capable of giving me an exhaustive description. (ibid.: 43)

What was incomprehensible to me was how I ended up in that place. (ibid.: 65)

These words echo Eduard Glissant's concept of opacity; in his *Poetics of Relation*, the French Caribbean poet and translator insists that we must 'clamor for the right to opacity for everyone', that is 'the right not to be understood' (1997: 194). Epistemic unknowability, both on the part of the patient and the provider, should at times be protected for the medically just project to succeed. This is what enables Merini to say that marginalization, be it physical and/or epistemic, can be a 'social right': 'Psychiatrists should stop harassing us [...] just on the basis of the fact that, on an ordinary day, we lost our memories. This might have been due to the game of love, to the fatality of life or to a mechanism of self-defence. Marginalisation can be a social right'. (1986: 138)

The opacity affecting psychiatric understanding goes hand in hand with a difficulty of speech. Using words, formulating sentences, and making meaning when dealing with mental distress can be arduous and painful. Yet, psychiatrists 'depend on their patients for clinical information and are obligated to regard them as trustworthy' (Kious et al. 2023: 1). Merini registers this semantic gap by photographing moments of incommunicability, which is the third principle presented here, and once again one that applies to poetry and psychiatry alike. Patients' discourse is often non-verbal; they struggle and/or are forbidden to speak; they remain silent, whisper or scream; they misunderstand, yelp like animals or cry:

For the whole day they left us with nothing to do, without cigarettes or food other than lunch and dinner; even talking was forbidden. [...] Screaming yes, that was allowed. (Merini 1986: 19-20)

In the asylum they made us used to silence. In the morning they would make us stand in line on the benches, our hands in our laps, and with the command “do not say a word”. (ibid.: 96)

I got up after two days [...] and I began to cry, holding on to the bars of my window. (ibid.: 66-67)

I am still perplexed today, after twenty years I still cannot understand how a human being can misrepresent certain things. (ibid.: 67)

I curled up by my bed and started to yelp just like a dog. In mental illness the primitive part of our being [...] comes to the surface (ibid.: 68)

By way of a poetic imagination, Merini gives a difficult and important message, one that, by advocating for a lyrical psychiatry, is not always and not necessarily antagonistic to psychiatric science. This brief overview has touched upon the poet-patient's contribution to the understanding of psychiatric suffering, the formulation of diagnosis and treatment, and the necessity to accept opacity as an epistemic principle. The section has also shown that Merini's memoir does not serve here as a case study, that is as a piece of literature reporting a patient's experience of psychiatric incarceration and illness; instead, it is a primary psychiatric source that help us construct psychiatric knowledge.

Conclusions: if words could be science

The creation of clinical knowledge has been produced from the triply-Othered condition of the psychiatric poet-patient. My analysis of the production of the incarcerated patient contributes to both the contemporary debate around epistemic injustice in psychiatric settings, and to the field of critical medical humanities. Both psychiatric research and literary scholarship on Alda Merini can benefit from this discussion inviting disciplines to move away from their usual foci and methods of investigation. In this chapter, novel questions were asked, and alternative perspectives formed. Due to the richness, complexity and gravity of the topics considered, my analysis offers but an initial insight into the forms and meanings of lyrical psychiatry. Deeper discussion and attention to details are needed. I expect, and wish, that future research on Alda Merini's 'case' (through the critical medical humanities) will expand these preliminary thoughts. This will further articulate the dynamic equilibrium at work between epistemic obscurity and relativism, historical evolution (e.g., the Basaglia Law in the Italian context) and individual changes, social activism, disillusionment, and joy when

we try to investigate, deeply and fully, psychiatry's and poetry's strife for meaning. Let us leave the last word with Merini: 'With this volume I, Alda Merini, make my own experiences available to other people, so that psychoanalysis may have fruitful outcomes and psychiatry may undergo a humanistic emancipation'. (ibid.: 145)

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