

De-institutionalisation in Italy : between ethics and politics *

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The purpose of this paper is to illustrate how the process of de-institutionalisation, which began in Italy in the early sixties and culminated with the psychiatric reform law of 1978, was the result of a long history of anti-institutional practices which have led not only to the closing down of the psychiatric hospitals but also to a radical refunding of the ethical and cultural underpinnings of Italian psychiatry. It should be noted that this process took place with great difficulty, very unevenly and with serious delays and, in fact, has yet to be fully terminated. However, the reform is a one-way street and any thought of returning to the past of the asylum is now both unthinkable and impracticable. In order to introduce our topic, it might be useful to give a brief historical profile of psychiatry in our country.

After the Second World War, the situation of psychiatry in Italy was characterised by a very serious human and scientific *backwardness*. Already behind with respect to other European countries, it was quite literally collapsing under the weight of an unrestricted policy of internment. This uncontrolled use of custody and repression, in which the medical and legal authorities and their respective functions of therapy and social control were confused, resulted in the construction of new asylums for the internment of the mentally ill, who were invariably considered as a threat to public safety. In theoretical terms, and consistent with its biological approach, Italian psychiatry maintained an organic

and anti-psychological view of illness, and established its identity around the perfection of its psycho-pathological *regard*. The ruling discipline was the *clinic*: observation, diagnostic classification, hypothetical outcomes. In terms of therapy, there was little to be done. The situation was dominated by convulsive therapies: insulin shock and cardiozolic therapy, and especially electro-shock, which had been invented by an Italian, Ugo Cerletti, in 1938. The use of drugs was very limited, for the most part bromides and barbiturates (the first neuroleptic, chlorpromazine, was discovered in 1952). Physical containment and other violent therapies, including psycho-surgery as a 'final resort', were universally adopted to deal with excessive or unacceptable behaviour. In short, the only real 'therapy' was internment in an asylum.

In legal terms, the applicable law was Act n. 36, which dated from 1904. This law, which would remain in effect for many years to come, was little more than a late version of the various forms of legislation regulating psychiatry and internment approved elsewhere in Europe in the previous century (the French law, for example, dates from 1838). The basic paradigm was identical to the earlier legislation, and provided for the mentally ill to be interned in asylums without exception in order to safeguard the public against the unpredictable and dangerous behaviour of persons affected with such disturbances. In fact, Article 3 of this law states that 'internment in an asylum shall be mandatory for individuals with an acquired or hereditary mental illness who are a danger to themselves or to others or who cause public scandal'. The basic criteria was that of a legal sanction by which the mentally ill person, who was presumed to be dangerous, was subjected to a mandatory internment, which was ordered by a magistrate based on medical certification and actuated by the police, and entrusted to the 'care' and 'custody' of the asylum institution. After a period of observation, a person recognised as being affected with a mental illness was registered in the Criminal Records file (together with those who had committed crimes), stripped of all civil rights and became an asylum inmate for an undetermined period of time. Release depended upon the asylum director issuing a medical certificate attesting to the inmate's 'cure', a responsibility which directors would only rarely assume. In most cases, therefore, internment was for life. In addition, by prescribing internment for 'whoever cannot be properly cared for at home', the law created a potential, and often real,

discrimination between the poor, who went straight into the mental institution and the rich, who had the economic possibility of being treated privately, and therefore could avoid the segregation of the asylum. However, given that the ‘illness’ of the insane is not like the illnesses of other people, but one which requires internment, it follows that whoever was not interned was not, strictly speaking, really mentally ill. Intervening therapeutically meant locking someone up in an asylum. This was the basis of the ‘paradigm of internment’ in which two requirements – medical and legal – merged in a mortal embrace which would last for years.¹

As is known, this paradigm had become dominant during the 19th Cent due to a progressive theoretical shift in which psychiatry began to concern itself more with forms of behaviour than with logical forms of thought. The question of what was *voluntary* or *involuntary* in behaviour, or the notion of instinct, organised the response to mental illness to a greater degree than the question concerning the distance between madness and reason, or the idea of delirium. In other words, modern psychiatry took as the new and principle object of its action the control of behaviours which departed from a norm (family, social, but also political) rather than the control of thoughts which where in variance with a ‘truth’.² As will be discussed in the course of this paper, the uniqueness of Italian psychiatric legislation and what distinguishes it from other forms of legislation and ultimately constitutes the richness of its ethical and political base, is this attention to the voluntary and involuntary which cuts across the entire field of psychiatry, both in terms of defining the nature of the illness, as well as the type of treatment to adopt.

After the Second World War, psychiatry began to be shaken by a profound surge for the renewal of its disciplinary makeup and a reform of its institutional apparatus, which led to the enactment of innovative legislation in many western countries (for example, the *National Act* in England, in 1959, the law for the organisation of ‘sector policy’ in France, in 1960, and the psychiatric legislation enacted under the Kennedy Administration for the establishment of *Community Mental Health Centers* in the USA, in 1963). Diverse experiences, such as the ‘therapeutic community’ in England and the French ‘institutional psychotherapy’, as well as the advent of psycho-pharmacology and the diffusion

¹ Cfr. R. Castel, *L'ordine psichiatrico. L'epoca d'oro dell'alienismo* (1976), It. ed. Feltrinelli, Milan, 1980

of psychotherapies, would steadily undercut the validity of the internment paradigm and inspire a therapeutic optimism which was traditionally unknown in psychiatry.

However, as already noted, Italian psychiatry was behind the times and credit must be given to Franco Basaglia, a brilliant Venetian psychiatrist with a solid university background in clinical psychiatry and psychopathology, as well as a keen philosophical mind trained in the area of phenomenology, for introducing the first innovations in our country.³ Due to his historic work in Gorizia, begun in 1961, followed by the experiences in Parma and especially in Trieste, as well as the many anti-institutional practices and experiences carried out in various areas of Italy, the manipulation perpetrated by the asylum institution and the scientific culture which underpinned it with respect to the reality of the mentally ill person was made evident, and with that revelation came the recognition that the real contradictions and needs of the ill person did not exist in this system, but only the needs of the institutional organisation. The illness disappeared in terms of suffering, because the institution took on the task of rationalising, organising and, ultimately, concealing that suffering. This formulation can help us to understand Basaglia's often misunderstood affirmation that it was necessary to *place the illness between parentheses*. 'By this I do not mean that the illness does not exist' he wrote in one of his essays, 'but that we produce its symptomatology – that is, the way in which the illness expresses itself – based on the way in which we intend to deal with it, because the illness always constructs and expresses itself with respect to (or in the image of) the means which are adopted in order to handle it'.⁴ The illness is managed by the institution, ie. by the way it – the illness - is organised within certain specified areas and by means of certain given techniques whose purpose is to dominate and suppress it. Science thus avoids responding to the reality of the suffering and the real needs of the ill person, and in their place it offers needs which are 'pre-packaged' and made to order to meet the needs of

² Cfr. M. Foucault, *Gli anormali. Corso al Collège de France del 1974.1975* (1999), It. ed. Feltrinelli, Milan, 2000

³ For the life and work of Franco Basaglia, cfr. *Follia e paradosso. Seminare sul pensiero di Franco Basaglia*, edizioni "e", Trieste, 1995; *Pensare la follia*, n. 285-286 of the review "aut aut", La Nuova Italia, 1998; P. D. Vittorio, *Foucault e Basaglia. L'incontro tra genealogie e movimenti di base*, Ombre Corte Edizioni, Verona, 1999; M. Colucci, P. Di Vittorio, *Franco Basaglia*, in preparation, edizione Bruno Mondadori.

⁴ F. Basaglia, "Ideologia e pratica in tema di salute mentale" (1975), in Id., *Scritti*, 2 vols., Einaudi, Turin, 1981-1982, vol. II, p. 357.

the institution. This process of rationalising and organising needs thus deprives the individual of the possibility of self-possession: the possession of their own body, their own illness, and removes them from their social reality and the environment in which they live.

The crisis of the asylum was thus the result of actions which were both *scientific* – revealing the anti-therapeutic value of internment which served to protect society rather than care for persons in a state of suffering – and *political* - denouncing institutional violence, immediately defending the hospitalised person, responding to their needs and restoring them their dignity and rights. *Practical knowledge* – which derived from the experience of shutting down and superseding the asylum and which, in a single leap, projected Italian psychiatry beyond the theoretical models which were originally used as points of reference –was no longer based on the observation of an object (the patient) in a context considered neutral (the asylum), in order to find the confirmation for what is already considered as necessary (internment). Instead, it was built upon the active and real participation of what was the object, but was now a subject, an individual who had acquired a personal history, and who could make their needs known and fight against exclusion from within their own social context. The essential nature of this practical knowledge is that it is a *critical* knowledge which arose out of a reflection and out of collective action. This is something which was clearly visible in all of those places in Italy which attempted to enact this reform, where the search for the solutions to the daily problems of, initially, the asylum, and then the community, took place in assemblies and by means of a direct confrontation with the population. It is a reflection which must be carried out all together within a community, a new way of thinking and acting through a practice – the only one possible and which has been acquired and learned over years of anti-institutional struggles – of taking responsibility and shouldering the burden of the needs of the individual user in the context of the needs of all. These needs are real and concern fundamental and irreducible aspects of every person's life: the right to health and well-being in one's relationships and living places, the right to a secure job that does not wear one down physically or morally, which guarantees professional training and a measure of creativity and satisfaction and, in short, goes beyond mere subsistence; the right to cultural enrichment and leisure time in a context of civil

co-existence, and the right to participate in the fight against the various forms of exclusion. These voices come from the lowest ranks of society and demand recognition. These needs challenge any rigid view of social organisation and exchange and require a legitimisation of their *subjective profile*, of their character which both relativises and individualises. They solicit a response which must go beyond any merely naturalistic and objective economic conception.

It was this practical knowledge which led to the psychiatric reform of Law 180, which was approved by the Italian Parliament by a large majority on May 13, 1978.⁵ The Law's very title, '*Regulations for voluntary and mandatory medical assessments and treatments*', indicates a radical change in outlook, for the object of the law is no longer the presumably dangerous nature of the disturbance, but the assessment and treatment of illness, the way in which illness is identified and the institutional responses which are activated, meaning medical structures and resources. This assessment and treatment of mental illness is, by law, voluntary. Only in very special circumstances can a person be subjected to a mandatory procedure, and in any case 'in respecting the person's dignity and civil and political rights guaranteed [by the Constitution] including, to the extent possible, the right to freely choose the physician and place of treatment'.⁶

In fact, the procedure for the mandatory medical treatment clearly delineates the three points on which the law is based, and such a procedure can only be adopted when all three conditions are present, to wit: 'only if there are mental alterations which require urgent therapeutic interventions, if such interventions are not accepted by the patient and if neither the conditions nor circumstances exist for adopting timely and suitable health measures which do not involve hospitalisation'.⁷ The three conditions are thus the illness, consent and the response of the psychiatric service.

The first point concerns the *illness*, or better, the attention given to the illness, and the physician's duty to act therapeutically by taking responsibility for the person's mental health rather than the protection of society. Here, we have a 'Copernican revolution' which, entirely on its own, can demolish the

⁵ It should be recalled that on December 23, 1978, Law 180 was absorbed, with some changes, by the more general Law 833, which established the National Health Service, as articles 33, 34, 35 and 64.

⁶ From art. 33 of Law 833/78.

foundations of the paradigm of internment which is based on the premise that the mentally ill person is dangerous.⁸ Now, this does not mean denying that mental illness can, in certain circumstances, result in aggressive or violent behaviour, behaviour which can be manifested with the same, if not greater frequency in everyday life, and by persons who are not affected by any psychiatric disturbance. What is denied, however, and decidedly so, is the anachronistic and invalidating prejudice that danger is implicit in and invariably connected with mental illness. Above all, what is refused is the notion that this prejudice can be validated by legislation regarding the medical treatment of persons affected with a mental disturbance, thereby transforming a scientific absurdity into a legal norm. The 1978 law excludes the legal system, or better, it excludes the investigative and sentencing powers of a magistrate who is given a mandate to determine the degree of danger of a given patient. Mental illness is a medical issue, in the sense that a person with a mental disturbance maintains the right to citizenship and, as such, the right to medical treatment and not to restrictions on their behaviour. The word 'danger' disappears completely from the text of the law. Neither a judge nor the police can in any way order a treatment or internment. The only legal figure who remains is the tutelary judge, whose sole function is to ensure that the person's constitutional rights are not denied or violated, even in the event of a mandatory medical treatment. The judge thus exercises his power only against eventual abuses in the application of the law, and in defence of the hospitalised person. All responsibility is left in the hands of a first physician who must propose the mandatory medical treatment, a second physician from a public health service who must ratify this request and finally the mayor who, as the highest municipal health authority, must order the hospitalisation. Thus what we have here is a decision which concerns a moral obligation to cure and a political obligation to protect a citizen's health, and no longer a legal obligation to punish the individual and protect society.

The second point concerns *consent*, or the doctor's obligation to take responsibility for the individual's personal freedom by taking all appropriate measures in order to guarantee consent in the event of a mandatory treatment. In other words, Law 180 poses that central and delicate question regarding *the*

⁷ From art. 34 of Law 833/78.

relationship between illness and freedom. And it does so in two ways: firstly, by asking to what degree we are truly free when we are prey to a serious mental illness? And secondly, and vice versa, how much freedom society can allow us when we are ill? The task which the law assigns to the physician is that of placing him or herself at the centre of these ethical dilemmas, a task which is both difficult and uncustomary because, in effect, in psychiatry has always oscillated in the past between imposing treatment on seriously ill persons without their consent, while permitting persons who were less ill the choice of whether to accept treatment or not. In this case, clearly what defined the degree of seriousness of the illness was not determined by the severity of the diagnosis but by the degree of danger which was presumed for the ill person's behaviour. In any case, it was not the psychiatrist's responsibility to seek the patient's consent, a consent which was, however, ultimately worthless. Anyone could decide whether or not to accept treatment, but the final word as to what degree of freedom would be permitted the individual within society was a matter for medicine and the law. Today, it is no longer enough to ask ourselves in the abstract which side we wish to take, that of protecting society or respecting the patient. Instead, we must place ourselves in the middle and ensure that there is a real encounter and confrontation between the two parties in question. It is no longer possible to affirm that 'society must be protected' when the request for such protection originates with the prejudice of the danger inherent in mental illness. Likewise, we cannot declare that the respect for the individual's freedom of choice must be guaranteed if this is merely a generic proposition which in reality masks the abandonment of the ill person to a condition of solitude and moral and material misery. The physician must commit himself to verifying in practical terms in what ways a legal protection and a formal respect can become an authentic ethical value and a concrete political project. In other words, in accepting responsibility for either the patient's consent to treatment, or his refusal, he must act in such a way that the person who is suffering is recognised and given a real voice within the therapeutic context. This means walking a very fine line between the temptation of control for health reasons and the opposite risk of social abandonment due to the refusal of treatment. The innovative spirit of the law consists precisely in

⁸ Cfr. M. G. Giannichedda, *Sul trattamento sanitario coatto*, in "Democrazia e diritto", 1988, n. 4-5.

this never-ending contractual process in which the physician must interrogate himself as to his own political responsibility as the mediator between the individual's suffering and the social and institutional dimension in which this suffering expresses itself.

The third point concerns *the response of the psychiatric services*. Here, it is not only a question of the person and his distress, but also of the psychiatric service and its response, which means hospitalisation when the service is either unable or does not know how to organise a different response ('from dangerous behaviour, one passes to the need for hospitalisation as the last resort of a system of services which has not organised an effective response for that specific case in the community').⁹ To put it another way, with the closing of any form of asylum 'precinct' in the community, it is the medical technician's duty to act in a way which is both strictly and broadly political in order to guarantee a structured health response in the community able to meet the needs of the members of that community and to ensure that effective therapeutic measures have been organised in order to avoid recourse to a mandatory treatment in a regime of hospitalisation. The Italian experience shows that de-institutionalisation does not end with a de-hospitalisation which dumps psychiatric chronicity in the community without concerning itself with the construction of an alternative network of psychiatric assistance services, thereby exposing itself to the risk of abandonment, to merely 'pouring off' cases into other segregative institutions with the inevitable and relatively rapid return to the old solutions offered by the asylum.¹⁰ De-institutionalisation is first and foremost the affirmation of a renewed therapeutic intention in psychiatry which must take responsibility, as already indicated in Law 180, for restoring the rights of citizenship to persons who are in a state of suffering.

Today, in judging the results of this law more than twenty years after its approval, one cannot but confirm – despite the administrative delays and the resistance to its application on the part of various corporations – the solidity of its legislative design and its ability to be taken as a point of reference at the international level (for example, the importance attributed to it as an example of legislation by the WHO). Of course, problems exist which, upon closer

⁹ F. Basaglia, M.G. Giannichedda, 'Legge e psichiatria. Per un'analisi delle normative in campo psichiatrico' (1979), in F. Basaglia, *Scritti*, cit., vol. II, p. 462.

examination, present important challenges of an ethical and political nature precisely because they introduce dilemmas for which there is no simple solution. We will conclude our intervention by indicating just one example, which concerns the organisation of community mental health services. Obviously, the law remains a principle without substance if it does not give rise to mental health practices that recognise, in real terms, the full rights of citizenship for persons with mental disorders. The supremacy of the medical model in the organisation of mental health services must be curtailed. This means avoiding that the only scheme which succeeds in absorbing all of the contradictions which mental illness brings with it is of the reparative type. And this is also why Law 180, extraordinary as it is, is only a point of departure. Care must be taken to ensure that a too close adherence or conformity to the medical model in dealing with mental distress does not exclude the complexity of its social and personal implications. In our view, in order to eliminate the centrality of the hospital, which is typical of this model and tends to perpetuate a logic of concentration and institutionalisation, it is necessary to transfer all psychiatric assistance into the community and reinforce the functions and the activities of the mental health centres which, if organised on a 24hr basis, must be able to guarantee the following: overnight hospitality/hospitalisation (including mandatory medical treatments), daytime hospitality, out-patient and home visits, individual, group and family therapeutic activities, rehabilitation, prevention and social-assistance support interventions, the management of residential structures (group homes, residential and therapeutic communities), consultancy work in hospitals and prisons, and activities aimed at job training and job placement for mental health service users.

In effect, we are dealing with the construction of a 'social space'¹¹ which is capable of confuting, manifestly and definitively, the logic and persistence of the paradigm of psychiatric internment thanks to its ability to place the suffering of the individual in relation with the context that produces that suffering (a relationship which the asylum does not permit). Within this space, it is necessary to stimulate the reactivation of the user's potential and the progressive re-appropriation of identity and diversity. In effect, their capacity for

¹⁰ Cfr. F. Rotelli, O. De Leonardis, D. Mauri, *Deistituzionalizzazione, un'altra via (la riforma psichiatrica italiana nel contesto dell'Europa Occidentale e dei "paesi avanzati")*, in *Salute mentale. Pragmatica e complessità*, 2

¹¹ Cfr. M.G. Giannichedda, *Sul trattamento sanitario coatto*, cit.

emancipation through the re-acquisition of contractual power which permits a real access to resources and the expansion of a social and support network and which also favours exchange, the capacity for self-representation and the democratic participation of each person in all the decisions and processes which concern their well-being and quality of life. In other words, the active participation of users and their families, their role as real 'players' in the process, and the involvement of the community as a whole, can represent a fundamental resource in the search for alternative solutions to the problems of mental distress through the integration of formal and informal networks, and by making the 'space' of the mental health centre a place which produces resources and opportunities for recovery, which 'invents health and facilitates the person's social reproduction'¹², and thus ultimately provides a place for the real exercise of citizenship. The aim is to move beyond a logic of welfare or assistance, in which the citizen is viewed as having little awareness about or responsibility for their own health, and where their role is that of a chronic and often passive beneficiary of services which, obviously, risk being standardised. The activation of diversified and personalised responses arises out of a vision of mental distress which is not limited to the clinical-diagnostic aspect, but which shifts attention from the illness to the person, from the subject's disability to recomposing their social identity. Indeed, in this space psychiatry may finally succeed in freeing itself from the obsessive search to conform to the medical disciplines in order to obtain scientific respectability and can instead devote itself to overturning within the medical organisation all of the contradictions which a practical experience of madness has taught it.

The ethical and political dilemmas in the expansion of the de-institutionalisation process in Italy originated and, at times, still persist due precisely to this essential aspect of the disciplinary role of psychiatry and its technicians. In the face of the profound and radical revision of this role brought about by Franco Basaglia and his group, and which became one of the guiding principles of the reform law, a part of this professional class mounted an extreme resistance in the name of a pseudo-scientific neutrality which, in real terms, meant an indifference to the fates of patients and their families and an abdication of their responsibilities vis-à-vis the contradictions which this

¹² Cfr. F. Rotelli, O. De Leonardis, D. Mauri, *Deistituzionalizzazione, un'altra via*, cit.

abandonment gave rise to in the community at large. However, it was precisely the family associations, the social volunteer groups and co-ops, and the user groups which insisted that the law be applied and not annulled. This meant that in Italy de-institutionalisation – together with its principles and practices – consolidated itself as a new way of conceiving of citizens' rights. This new culture, through a circular process, is being reinforced by means of governmental provisions and plans, such as the ministerial decrees for the closure of the last remaining asylums or the government's mental health objectives plan for 1998-2001.

This culture has also had an important impact on the ethical and political debate. In November, 2000, an important document was issued by the National Bio-ethical Commission entitled '*Psychiatry and mental health: bio-ethical orientations: syntheses and recommendations*'. With respect to the relationship between ethics and mental health, this report specifies in its conclusions a series of very progressive principles which are clearly inspired by the practices of the best services operating in Italy and by a full application of the Psychiatric Reform Law. The document states that in mental health practices a balance must be struck among three different principles:

- 1) the *principle of justice*, or the obligation of professionals to take into account the social consequences for third parties of every medical intervention and to attempt to reconcile the individual's welfare with the general welfare, in accordance with the principles of an equitable distribution of resources and services;
- 2) the *principle of beneficiality*, or the duty of professionals to promote the patient's welfare, safeguarding their life and health, also in terms of prevention;
- 3) the *principle of autonomy*, or the professional's obligation to respect the patient's freedom and wishes, when these latter are expressed in a responsible and self-aware manner.

Although the cultural paradigm of the doctor-patient relationship is changing from a model based exclusively on the principle of beneficiality to one which is based more on the individual's autonomy and self-determination, the 'lopsided' nature of the contract in certain cases, at least in terms of knowledge and social power, must not be underestimated. For these reasons, the

safeguarding of the patients subjectivity is the indispensable condition for the construction and development of freedom. However, and to avoid any possible misunderstanding here, *this does not mean believing that a person is always free, but rather working constantly to enable him to become free.* It should be emphasised that, in this process, persons with a mental disorder must be guaranteed the same rights as all the other members of the community, regardless of their real possibility to exercise those rights.

Dealing with the ethical problems which de-institutionalisation has generated primarily calls into question the political and professional sectors and for this reason, we direct our most important recommendations to them. We encourage them to:

- promote periodic national campaigns for the fight against stigma and prejudice;
- carry out continuous activities of primary and secondary prevention for mental disorders;
- guarantee and maintain full responsibility ('shouldering the burden') for the most serious and difficult cases, even when the treatment is not accepted by the person for whom it is intended, in accordance with general principles of safeguarding the dignity of the mentally ill person and avoiding the opposite extremes of therapeutic insistence and abandonment;
- guarantee the training of professional operators in accordance with bio-ethical goals which give a priority to the user's needs, the integration of competencies and the attention towards the different dimensions of the individual, the family, the group and the community through the planning and realisation of specific programmes;
- review the nature and functions of institutions such as the *forensic hospital* and related legislation, given that their continued existence is in clear contradiction with Law 180;
- avoid, through appropriate structures and interventions, the risk that the psychiatric services of diagnosis and care in the general hospitals reproduce asylum practices, thereby favouring the chronicisation of illness and not the patient's recovery. In particular, all physical containment must be eliminated, as a violation of the patient's dignity.

These principles attempt to respond to the so-called ethical dilemmas by means of political actions and courses of action and delineate a new and necessarily different form of professionalism for the operators involved with much wider profiles of responsibility. Only by recognising that an exclusively medical response impoverishes the complexity of the demand and reduces all problems of a social nature - such as poverty, marginality, the loss of contractual power and the rights of citizenship - to aspects of the illness, can the psychiatric question truly become an ethical and political question, capable of getting out of the institution and becoming a real patrimony for the general public through its involvement in the search for real solutions outside of the technical context. It is this which marks the transition from a narrow, specialised knowledge possessed by a few to the opening up to a practical knowledge of a collective nature (thus not only for the use of the professional and the politician, but also of the user, the family member and the general public) which characterises the uniqueness of the Italian process of de-institutionalisation: a process which can demonstrate how, from the specific context of psychiatry and from the particular issue of mental health, an anti-institutional practice and the recognition of individual rights can spread as a culture and become both the instigation and source for a more generalised demand for social change.
