International Review of Psychiatry

ISSN: 0954-0261 (Print) 1369-1627 (Online) Journal homepage: https://www.tandfonline.com/loi/iirp20

A problem of institutional psychiatry: exclusion as a social and psychiatric category

Franco Basaglia & Franca Basaglia Ongaro

To cite this article: Franco Basaglia & Franca Basaglia Ongaro (2018) A problem of institutional psychiatry: exclusion as a social and psychiatric category, International Review of Psychiatry, 30:2, 120-128, DOI: 10.1080/09540261.2018.1436324

To link to this article: https://doi.org/10.1080/09540261.2018.1436324

Published online: 14 May 2018.

INTERNATIONAL REVIEW OF PSYCHIATRY
2018, VOL. 30, NO. 2, 120–128
https://doi.org/10.1080/09540261.2018.1436324

Taylor & Francis
Taylor & Francis Group

ARTICLE

A problem of institutional psychiatry: exclusion as a social and psychiatric category*

Franco Basaglia[a] and Franca Basaglia Ongaro[b]

[a](San Polo, Venice 1924–1980) Founder of Democratic Psychiatry; [b](Venezia, 1928–2005) Democratic Psychiatry

Introduction

> Imagine now a man who is deprived of everyone he loves, and at the same time of his house, his habits, his clothes, in short of everything he possesses: he will be a hollow man, reduced to suffering and needs, forgetful of dignity and restraint, for he who loses all often easily loses himself (Primo Levi: If This Is A Man, 1947)[13].

Once the Cartesian dualism had been overcome, the man discovered himself as an object in an objective world, as well as the subject of all his possibilities, and psychiatrists have to face with this reality. Understanding such a premise, it is possible to explain the crisis of a science that, instead of dealing with people with mental disorders in the society in which they live, has gradually constructed an ideal image of man, in order to guarantee the scientific validity of the castle of disease, which imprisoned the symptoms. Traditional psychiatry has limited itself to define the syndromes for labelling the patient, ripped from his environment and alienated from the social context, and 'forced' to adhere to an illness that is an abstract, symbolic, and, as such, *ideological* disease.

However, objectification of man into a syndrome has had irreversible consequences for the mentally ill; patients were originally objectified and restricted within the borders of their illness, and science has confirmed that this category is outside what is human, since there is the need to exclude what it is not understandable.

However, a scientific approach—regardless to the specific topic—searches for causes of a phenomenon isolated from the superstructures and ideologies. In the case of mental disorders, if the intention is to tackle it scientifically, the first step must be to 'set aside' the disorder and the way it has been classified, in order to consider the patient's behaviour, which seems to be approachable.

Taking this background into account, the aim of the present paper is to analyse the problem of patients with mental disorders according to a way of being that is the same as healthy people, beyond every pattern and definition of disorder. The pattern of excluding and be excluded—if these can be part of human relationships—represents the basis of psychotic experience—as exclusion from reality—as well as of patients with mental disorders, excluded from the society.

Every society whose structures are based only on cultural, social-classes differentiations and on competitive systems creates its *compensation areas* for its own internal contradictions, where it gives a concrete form to the need to deny or to fix and to objectify a part of its own subjectivity.

Searching for a patsy (or scapegoat), for someone to exclude and on which to focus aggressiveness, can only be explained by man's desire to delineate and exclude his own fears. Racism—in all its forms—represents this need for compensation areas. The asylums, as a symbol of 'psychiatric sanctuary', such as the apartheid against blacks or Jews, represents the desire to exclude the unknown and the inaccessible which frightens the society. Psychiatry—as a discipline—has justified and scientifically confirmed this desire, considering the studied object as incomprehensible, and listing it among the categories to be excluded.

The human being—faced with own fears and with the need to assume his responsibilities—identifies in others the part not able to dominate, and to exclude the *other* in himself as his contingency. This represents a way of denying it in himself by denying the other, leaving and excluding the groups in which these fears have been identified. Discriminating behaviours and social exclusion—having the right to socially exclude from society a group representing all

*Originally published in Italian in *Rivista Sperimentale di Freniatria e Medicina Legale delle Alienazioni Mentali*, vol. 90, n° 6, dicembre 1966, 1484–1503.

the evils of the world—cannot be considered only as a personal opinion and, therefore, acceptable as many others. It has an impact on the way of being and it represents a global perspective: the choice of a Manichean world in which the bad part is always represented by the other, precisely by the *excluded*; only by this act of exclusion I can declare my strength and my identity[1].

From an historical viewpoint, people allocated in the category of the *excluded* are decreasing due to the acknowledgement of their role of scapegoats. Patients with mental disorders represent the unique category of *excluded* persons who cannot become aware of the fact that their condition of exclusion is due to the disorder or to the society. Patients with mental disorders are not able to define the boundaries of the disorder and, in this *inability*, there is the social tragedy of mental disorders. What patients know about themselves and about their own disorders is the role that society and psychiatrists give them; therefore, patients believe that every attempt at changing and rejecting their rough living situation is merely an expression of the disorder, without freeing them from the forces dominating them.

Society has the responsibility of excluding undesirable groups, although these groups still have the possibility of redemption—at least through violence and aggressive behaviour. For patients with mental disorders, society and psychiatrists have an important responsibility: they are denying every possibility of opposition, of refusing reality and, therefore, of liberation—providing care into asylums and labelling their actions. The patient with mental disorder is *excluded* and, in the nowadays society, he will never be able to oppose those who exclude him, because every patient's action is determined and defined by his illness. Therefore, only the psychiatrist—with the twofold medical and social role—can help the patient with mental disorder to understand the mental illness and the role of society in excluding him. Only by becoming aware of the exclusion that the patient will achieve, will rehabilitation from the institutionalized condition be possible. Acknowledging a dialectic approach, which is essential in every human relationship, patients can protest against reality, against psychiatrists and against their illness as a social monstrosity, and it will finally be possible to approach them as patients asking for treatment.

The classical definition of psychosis was based on the lack of insight into the illness and the increasing level of awareness of their pathological state defined the subsequent recovery. In a process of rehabilitation of patients with mental disorders, patients should become aware of having been considered a biological as well as a social monstrosity and of having been excluded due to the prejudices of unpredictability and dangerousness.

The anthropological and clinical problem of exclusion

If human existence means to be in contact with others, everyone can behave by overcoming his own situation in relation to others and to the world, in choosing his aims and his purposes.

Due to the nature of man's material existence—defined by childbirth and death—he has to accept himself and choose being free for himself. This means that he is *condemned* to become one among many, to live with the anxiety derived from this factual situation, without any defence mechanism. When faced with anguish, stress and sorge, he is not able to accept his own responsibility and freedom; he defines and alienates the parts of himself that he is not able to dominate. If he can be aware of his subjectivity only in choosing and accepting himself, and the "other" which he has inside himself—the presence of his objective corporeity—in the absence of this choice (which would reveal his taking possession of his own corporeity and of the world), he externalizes the dark area, he objectifies himself in others, alienates himself, and gives himself to the world. He does not take possession of the world, but behaves like an object of the world, whose relationships with others can only be objective. The dark part of himself, that he is unable to consciously possess, leads him to possess other objects like himself.

The anthropological analysis of the excluded, as a man made into an object by other and by himself, is linked to the relationship between the ego and the other, according to Hegel's[2] interpretation of the relationship of lord-slave. The lord, objectifying slaves, and *excluding them* from a dialectic relationship for changing their condition, is denying and excluding a part of himself, removing it through the objectivization in the slaves. On the other hand, the slaves—facing the responsibility implied in being free—deceive to deny and leave their fears. They rely on the person who defends them, abandoning any possibility of control of their own lives, being objects for their lord and deprived of their freedom. In this misinterpreted relationship, the slave—receiving only his lord to cover his anxiety—becomes the justification and the *reason for being* of the lord, who is able to live only by objectifying in the slave the part of himself that he is not

able to dominate. This is how the slave is reduced to being the scapegoat for a paradoxical defence of his lord, since the slave embodies the evil and the lord removes it by limiting it to a well-defined space: the space reserved for the excluded.

The mechanism underlying this relationship of exclusion defines the boundaries of one's own range of possibilities, interests and relationships. By objectivizing oneself in the other and excluding him, the range of one's own subjective experiences is gradually reduced, since excluding others from oneself is merely the concrete expression of one's personal limits, symbolized in the institutionalized regulations.

The excluding behaviour—analysed from the inside—is closely linked with the process of appropriation of reality, in which the man excludes the other that he is not able to incorporate. If the process of appropriation of reality takes place in an encounter or in recognizing the other person as opaque materiality and as the starting point of an ego functioning[3] as I am, in accepting my facticity (my being an opaque and passive body, and at the same time the subject of this passivity), I have to accept the *other* in myself, the outsider that I am as the object of a subjectivity that is not mine. I have to recognize the other as a subject who can objectivize me as much as I, the subject, can be objectivized in his eyes. This means that, in accepting my facticity, in choosing my body, I accept and choose the other as I accept and choose myself in my corporeity. In rejecting the other, it is again myself, my alterity that I reject and exclude, in rejecting myself as materiality detached from the ego, which gives it intentions and meanings.

An example is given by the problem of bodily experience. The creation of barriers and boundaries able to maintain a distance between the ego and its own anxiety, highlighted in the exclusion of the other as a body, expresses the weakened process of appropriation of bodily reality. The part of the self not identified and incorporated by the ego, through a harmonized process of appropriation of reality, is objectified in the other, reified and, therefore, rejected. Feelings like *shame*, *decency* and, in particular, disgust for the *obscene*, represent the projection of one's own body onto the other, considered as an object: a failure to incorporate the other, as a failure to incorporate oneself.

The *Erlebnis* of the *obscene*, i.e. the rejection of one's own body in the other, covers the anxiety faced with acceptation of one's own *facticity*, a way of transcending this contingency which—held at a certain distance from the ego and, therefore, not incorporated into it—is not acceptable and, as such, is *obscene*. Therefore, the response to it must be rejection of the other as a body to be excluded. Obscenity represents the distance between the ego and its own body, a distance expressing itself in the Erlebnis of experiencing the other as obscene, in order to separate it from me (removing and excluding it), under the illusion of removing, denying and excluding the body that I did not originally incorporate.

In experiencing the other as obscene, as an objectified and reified body, as excluded by me, the central issue is still my *own body*. The problem of appropriation of reality of my relationship with the other, keeping the necessary distance at which I may appropriate the body and make it mine in order to become one separated from the many, which includes—in a dialectic alternation—an objective subjectivity and a subjective objectivity.

From an anthropological viewpoint, the *exclusion* phenomenon embodies the limits, the shortages and the lessening of the *excluder* rather than of the *excluded*, in the sense that the latter should be considered as being merely the embodiment, objectification and denial of what the excluder rejects, in a failed process of appropriation of reality.

How does the *excluded* passively accept his *exclusion*? This mechanism should be sought in the process of identifying the *excluded* with the *excluder*, with the lord with the slave, but only in a ghostly relationship. Bettelheim[4] and Steiner[5] agree that the survivors of Nazi concentration camps, through a ghostly adhesion to the values of their lords, almost justify the subjection in which they were forced to live. The dialectic lord–slave relationship reaches a level of reciprocity, which appears paradoxical and mystified in the same projection mechanism: the lord makes a projection of the 'bad' rejection onto the slave, while the slaves project onto the lord their need for well-being and for strength, which is betrayed by his exploitation.

Applying such an anthropological consideration to the clinical practice, the problem of exclusion can be considered as an 'unhealthy' issue when considering the behaviour of patients with mental disorders when facing reality and the way they adopt or *exclude* it.

Natural science has considered the concept of *exclusion* only as passive: the patient with mental disorder was *excluded* due to his dangerousness, given that his objective character was confirmed by recognizing him as an object of study encompassing the presumed biological causes, responsible for madness. Jaspers' interpretation, introducing the concept of comprehensive psychopathology, continues to limit

the patient with mental disorders in a strictly objective context, when—for the incomprehensibility of their ways of behaving—abandoning further approaches, in order to relegate the patient among the *excluded*, objectified by the science.

The mentally ill patient is excluded due to his incomprehensibility and his dangerousness, and he is still kept beyond the border of humanity, confirming our dehumanization and our inability to understand.

However, due to the new psychiatric humanism, research has been oriented towards the ways reality is experienced, accepted, endured and *excluded*. This means that we cannot limit ourselves to considering delusions as an external factor consuming existence like a foreign body. We find ourselves recognizing it as a significant mode of the psychotic person himself, and as such it is motivated and stimulated. If this is true, the delusional patient gradually *excludes* the reality that he is not able to incorporate and chooses a utopian world in which the difference between reality and unreality, between yes and no, does not have the dramatic character of a dialectic, but the softness of a world he is able to handle.

According to this perspective, the *incomprehensibility* of Jaspers—objectified by our lack of understanding—becomes the subject of the action of excluding reality. Reality has revealed many times its inability to dominate it. The limits, the reduction, the lessening and the psychotic regression result from the slow process of excluding reality that the psychotic patient is no longer able to cope with. Betrayed by reality, which continues to appear as a threat because the patient cannot dominate it, he covers his failure by *excluding* it, taking shelter in the delusional utopian world, where no opposition and no limits are faced[6].

On the contrary, the neurotic patient presents a form of *exclusion* from reality that could be defined as ideological, in contrast with the utopia of psychotic patients.

The organization of the neurotic personality—from a traditional and an anthropological viewpoint—is characterized by the reduced capability of the neurotic person to cope with their own emotional needs, losing spontaneity of their own bodily experiences. The neurotic person—unable to live immediately and spontaneously with his body—is forced to create an image of it, an ideology[7] capable of relating him to the other, since he cannot cope with the social exclusion. This impasse can be explained as due to a poor mental functioning, as the expression of a particular way of being in the world or as the result of an altered interpersonal relationship and maladjustment to cultural and social rules. The neurotic person always appears inhibited, unable to accept and choose his own existence and, therefore, to choose himself, so that he has to reach a *compromise* in order to have interpersonal contacts. This is the neurotic expressivity, by *excluding* its own contingency, coming true in the choice of an ideal image of its own body, which must be as close as possible to the *other person*. On the other hand, separating the ego from the body will cause a state of uncertainty, insignificance and doubt, in which the neurotic person is forced to live. The neurotic patient has not been able to take possession of his own body and, therefore, cannot take possession of his own individual identity and freedom towards the *other*, whom he cannot oppose. Therefore, he is unable to accept his own *facticity*—due to the level of anxiety felt in encountering the Sorge, rejecting and excluding his body, which he cannot accept as a mean of his own experiences, but only as emotionally separate and distant from himself. The neurotic person cannot counteract the multiplicity in order to become one (therefore, to protest against the other persons and the world). However, since he is obliged to remain in the shared world, he prefers to *exclude* his own corporeity that he has not incorporated, developing an image of himself, an ideology of his own body upon the values of the other persons, which can give him the illusion of being accepted by the other persons.

The sociological problem of exclusion: authority, power and regression

Following the anthropological analysis of the concept of *exclusion* and the clinical analysis of *excluding* in patients with psychotic and neurotic behaviours, there is still the problem to evaluate the condition of patients with mental disorders *excluded* from society.

If the social context is not considered for analysing the phenomenon as it occurs in patients with mental disorders, now it is necessary to isolate the mental disorder in order to assess the social context in which the disorder is developing.

The psychotic and neurotic *exclusion* processes, which produce narrowing and regression, have been described. Further narrowing and regression—overcoming the previous ones—can be identified in patients with mental disorders when they are considered in relation with society only as *excluded* persons. In this case, it is an *institutional regression*, which is due to the seclusion in asylums—established for caring and protecting the patients—but too often has

became an attempt to protect the healthy from the excesses and dangers of the mad.

Therefore, the origin of mental disorders can be explained on the basis of *exclusion* and isolation forced by society, in the prisoner's state of annihilation and in the slow process of destruction due to seclusion. It is beyond the asylums that classical psychiatry has demonstrated its failure, since, for solving the problem of caring for patients with mental disorders, a negative option has been selected, by excluding them from the social context and excluding them from their own human nature. In experiencing the incomprehensibility of psychopathology as a socio-biological monstrosity, the person with mental disorder has always been excluded twice: (1) in being considered as an incomprehensible entity, which science prefers to deny through a fantasmatic approach to the disorder, rather than admit its own incapacity; and (2) in being socially excluded, due to the incomprehensibility of the pathological world.

For this reason, asylums are usually based in the suburbs of isolated areas, limited by high walls for a clear-cut of separation, split and boundary. The person with mental disorder, as an expression of a split from normality, must be kept at a distance in order not to disturb the social rhythms, which need adjustment areas for relieving aggressive impulses they are not able to manage. However, this need to separate, isolate and exclude the person with mental disorder also represents the weakness and lessening of the society, which tries to remove everything that may interfere with its expansion, without considering the degree of responsibility in these processes.

The condition of patients with mental disorder is a social problem which should be solved outside the society itself, with no one—except the victim—having to pay for an illness that is classified as incomprehensible and dangerous, and as a severe threat to society. The act of *excluding* these undesirable elements from the system seems paradoxically to be society's *acting out*, as it symbolically relieves on these adjustment areas, aggressiveness and violence, which have little in common with mental illness, but their 'relief' ensures that order is maintained.

In any case, this is the society in which people become ill. This society, stepped in diffidence and pessimism towards the mentally ill person and his illness, builds high walls around asylums in order to defend itself, and it creates their own regulations. This is also the society in which the psychiatrist is trained, being the delegate to taking care of persons with mental disorders. What can be the psychiatrist's actions towards patients? What are patients' demands to society and to its representatives—the psychiatrists? What is the role that society gives to psychiatrists?

The situation may be summarized as follows: places for treatment have been built for isolating the mentally ill, delegating the psychiatrist to protect his state of isolation in order to protect society from its continuing fear of mental illness. However, together with this defensive activity, society also asks the psychiatrist to care for the ill person.

These intentions that society gives to the psychiatrist present an evident internal contradiction. Patient care (not only pharmacological treatment, which brought the patients into the medical field via the magical solution of his biological monstrosity, without approaching the patient as a human being) is not possible in the environment of fear, repression, defensiveness and protection in which society (therefore the psychiatrist himself) continues to live. The care for mentally ill patients must be oriented towards regaining their lost freedom and overwhelming individuality: this is exactly the opposite of what is meant by the concept of protection, defence, separation and segregation implicit in the regulations of our institutions.

Historically, the asylum was built in order to protect the healthy population. When treatments were not available, the walls helped to *exclude* and isolate madness, to prevent it from invading our own space. Asylums still play such a role of dividing, separating and defending the healthy population by excluding those who are no longer healthy. Beyond the walls, let the psychiatrists do what they can. Whether or not they have tools for working, whether or not they are allowed to treat their patients, they are *first of all* responsible for the safety of society, which wants to be protected from the mad, and for protecting the mad person himself.

If the patient, before becoming a patient, must be considered a *danger to himself and to others*, the procedure for hospital admission is based on dangerousness and not on the features of the disorder. This is why the mentally ill patient who usually comes to our psychiatric hospitals is oppressed, flattened and objectified in the institution, whose organization and efficiency have always been more important than the patient's rehabilitation and re-inclusion in society: only these processes really ensure the safety or physical protection of society and of the mentally ill person himself.

For this reason, when the patient is *excluded* from society, he—limited by the restrictions of his

illness—comes in a new dimension, where he has to abandon every personal and vital thing he still has, for the good functioning of the institution and for making easier the life in the asylum. The *moral career* of the institutionalized person—as defined by Goffman[8]—starts here; its stages are marked by the gradual narrowing of personality, loss of interests, lack of relationships with the outside world, with his previous life—that no longer belongs to him—and with the future, not having the possibility to develop any personal project, due to the humiliating and mortifying institution's rules. The patient accepts as logical the loss of his individuality, the inferiority status and the rejection of accepting his human dignity from the protecting institution, allowing him to retain a minimum of independence and responsibility while ill.

The patient has a limited range of possibilities—with no way out, with limited participation or limited personal intervention in order to keep order and efficiency and, therefore, has no choice but to humble himself, accepting the model of exclusion and objectification by the rules of the institution that make him *institutionalized*.

The concept of *institutionalization* is not new. The old term, *products of the loony bin*, accepted passively as the unavoidable consequence of a prolonged hospitalization, refers precisely to specific behaviours—very often considered as symptoms of the mental illness—observed in patients living in the asylum, which leads to the overlapping of another disorder on the original mental illness through compulsory and authoritarian models. Some examples of this syndrome are apathy, lack of interest, slow, monotonous and meaningless walking up and down in the rooms or courtyards, with the head bent, certain unjustified impulses (too often referred to the illness), the remissive behaviour of a tame animal, stereotyped complaints and dull eyes, since there is *nowhere* for focus, an empty mind with no aim to achieve. These aspects represent the slow, gradual, unnatural adaptation of the power—originally established for protecting and caring—using the last mean to be used: the use of force.

The institutionalization defined by Barton[9] as 'institutional neurosis', by Goffman[10] as 'total institutionalization' and by some American authors[11] as 'social breakdown syndrome', is a kind of regression, which overlaps with the original illness in people already psychologically fragile or ill, by the process of annihilation and destruction of their individuality in the asylum. A syndrome is developed, which is often confused with the symptoms of the illness itself: inhibition, loss of initiative and loss of interests.

The perfect patient, at the highest point of this distressing career aiming to destroy himself, is someone very calm and docile in obeying the nurses and the doctor. He allows himself to be dressed, cleaned, fed and put in order in the same way as his room is tidied up in the morning. He is a patient who does not complicate things with his personal reactions, but who adapts passively to the authority protecting him. This patient is defined as the patient adapted to the environment and collaborative with the nurses and the doctor, who behaves well with the others and does not cause complications or opposition[12]. We congratulate ourselves, because the patient referred to us, in order to treat him by restoring his human dignity, no longer exists as a human being, and we are happy that his impulses and personal needs are no longer capable of interfering with the organization and management of the institution.

If the patient is not dangerous anymore for himself and for the community, he can leave the hospital—where he lost himself for being protected—and he will hurl to the world that has no place for him, because he is overwhelmed by the force that he cannot resist, since he is not used to relying on himself.

> Imagine now a man who is deprived of everyone he loves, and at the same time of his house, his habits, his clothes, in short of everything he possesses: he will be a hollow man, reduced to suffering and needs, forgetful of dignity and restraint, for he who loses all often easily loses himself.[13]

These words, summarizing the experience of the institutionalized patient annihilated in our asylums, have been written by a forced man in a Nazi concentration camp and describe the progressive process of personal destruction, from the first steps in the camp to the complete breakdown. This process is not very far from that of institutionalized patients living in our asylums. The example of the process of regression, reservation and isolation by Primo Levi[13] shows that the role of mental illness in the process of dehumanization and regression could be accidental.

The fact that the *excluded* in the Nazi's concentration camps has the same appearance as the patient with mental disorder does not mean that the inmate develops mental disorder because of deprivation, hardships and torture, but rather that, when forced to be in a place where the rules are mortification, humiliation and arbitrariness, any human being in every mental state will gradually objectify himself and identify with the regulations of the custodial model. The shell of apathy, loss of interest and insensitivity that he constructs represent the last defensive action

against the world that excludes him and then annihilates him: the ultimate personal resource that the patient, like the inmate, uses to defend himself from the unbearable experience of living in awareness of his social exclusion[14]. The authority is the main reason why psychiatric patients are annihilated and excluded from the society.

An organization based on the one and only principle of authority, whose primary aim is order and efficiency, must choose between the freedom of the patient (and the opposition that can oppose to him) and the good course of the hospitalization. The choice has always been the efficiency, and the patient has always been sacrificed.

However, with the introduction of psychotropic drugs, this model of care became incomprehensible. If it represents the severe condition of institutionalization of society—objectified in its rules and myths—and does not know how to break with the past or to renew, then the psychiatrist cannot continue to be its disinterested spokesman. It is frustrating to realize that it was necessary to wait for the discovery of drugs in order to give human conditions back to patients, denied by the segregation.

With the introduction of psychotropic drugs, the idea of the patient with mental disorders as an ill person and not only as a person dangerous to society—and therefore to be excluded—has been welcomed. This society will always try to protect itself from what frightens itself. Moreover, society will always try to pose restrictions and limits to the organizations treating patients with mental disorders. However, psychiatrists cannot keep watching patients' destruction anymore. Until now, society and psychiatrists have thought that the best way to treat patients with mental disorders was by using force. So, in front of the new proposals for the liberalization of the hospitals, psychiatrists are afraid because they do not want to accept that freedom, which implicates overcoming of the cold relationship with the patient. This phenomenon implies that psychiatrists should revise their position, which remains ambiguous on its demands and mandates, both with respect to institutionalized authority and society.

This society will always defend itself from its own fears and will impose its system of restrictions and limits on the organizations delegated to care for the mentally ill. However, the psychiatrist cannot continue to witness the destruction of the patient entrusted to his care, who is reduced to an object by an organization that continues to dialogue with itself rather than engaging in a dialogue with the patient.

The psychiatrist plays the main role to give to society the possibility to understand the meaning of psychiatric patients' aggressiveness, to not simply considering the patient as a danger that must be avoided with the power of authority and institutionalization[15].

The most important change concerns the relationship between psychiatrists, staff and patients and the building of modern asylums. Psychiatrists had the power over patients through authority and institutionalization. Nowadays there is the risk of the same relationship of power through patients' feelings of gratitude and devotion to their psychiatrist. In this kind of relationship there isn't equality: there is a distance between the patient and his psychiatrist, between generosity and gratitude, but there isn't between right and duty. In this kind of relationship, the patient is not considered as a man excluded from society, but he is considered as a man who needs care, and so he is slowly annihilated through a method called 'soft institutionalization'[16].

All organizations must respect the patient's freedom and his way of life, otherwise it will have a negative power over him. For these reasons it is important to make psychiatric patients living in asylums aware of their protest against authority. The emotional emptiness of their condition can replace the rage and protest to be free. That does not mean chaos and anarchy. The role of authority is to offer protection, support and coordination, not to control or to impose. This means that we must always highly consider the need of freedom of people.

In psychiatric hospitals, institutionalized patients spend their time inactively, so the first thing to do with these *excluded persons* is to awaken their feelings against the institutionalized power. This awareness of been excluded and the acknowledgement of society's responsibility could replace the *emotional emptiness* in which the patient has lived for years into personal aggressiveness. This will end in a contestation of the reality that the patients now reject and that is no longer considered as a consequence of illness. This awareness shows to patients that they cannot bear the situation anymore, so freedom becomes a patient's achievement rather than a gift given by the strongest. This should not result in chaos and anarchy. On the contrary, to be aware means to understand how power can be a coordinative, supportive and protective element and not only a source of authority, imposition and control. Moreover, power represents a source of never-ending conflict between itself and the person entrusted to it. Finally, to be aware means

living in a state of mutual tension, in which there is reciprocal consideration of the other person's requirements and need for freedom.

However, it is not easy to change rules, institutions and prejudices—which have been present for centuries. Our society tries to protect its citizens from any perturbation that could upset the fragile equilibrium built. However, as soon as the citizen becomes mentally ill, society no longer acknowledges any responsibility towards him. The same citizen—whose protection was demanded by society—suddenly loses his protection's rights and becomes one of those beyond the boundary, one of those from whom society wants to be protected.

Mental illness will continue to be excluded by society until the fear, the rejection and the exclusion disappear; radical changes in social structures are needed. It is also necessary to bridge the gap between health and illness and to remove the barrier between prevention and prejudice through mutual acknowledgement. The development of new, organized and modern psychiatric hospitals as little worlds for addressing every need will not put an end to the problem of exclusion without radical and structural changes. Once our feelings of guilt towards mentally ill patients have been compensated by building new hospitals, we will end up transferring our hierarchical-authoritarian structure within transparent but not less threatening walls as a constant source of exclusion and regression.

If the patient, with his exclusion, has guaranteed the safety of society, now it is time for psychiatrists to come forward and create new hospitals where patients can work and gain freedom. However, we have always considered the patient as being relegated to an inferiority position and this is not easy to overcome (it is difficult to change our leading role); an attempt can be made trying to live patient's daily needs and to create a relationship that, beyond any institutionalized model, is based on mutual risk and mutual contestation.

The problem will be how to organize a community led by a power for orienting and coordinating rather than determining or controlling. All the experiences of all who place themselves in this dimension converge; once they refuse to use *force* to *objectify* the patient, they refuse to keep the same distance through feelings of dedication and compassion that would annihilate him, transforming him into an object by their pity. It is time for those who share these principles, even if with different backgrounds, to develop a new model of care, searching for a method of care that is not necessarily structured in rules and codes. It is time to face the needs of a new organization, to immediately exceed and destroy it. It is time to manage events from the top level while waiting for these to form and develop from the bottom level and facing the task of defining a new type of relationship between patient, doctor, hospital and society; finally, it is time to maintain a conflict level in order to stimulate, rather than repress, aggressiveness and the power to contest reality, even if we are a part of it.

Summary

The authors examine the problem of exclusion as a sociopsychiatric category, dividing their findings into three parts:

1. After a brief digression on the traditional bases of psychiatry, they analyse the concept of 'exclusion' as a sociological mode, in the sense that, through this mechanism, areas of mutual compensation are created in which society can isolate and ostracize groups that, for various reasons, impede its evolution. In such a way, the phenomenon of the scapegoat is interpreted as the key point.
2. Following the introduction, the problem of the psychiatric patient as an excluded person is examined from the clinical and phenomenological perspective, examining the neurotic and psychiatric aspects. In the first case, an exclusion from reality through an ideological transformation of itself is recognized; in the second case, exclusion through refuge in a utopian reality that becomes more manageable: both, however, lack the possibility of treating reality dialectically.
3. The problem of the excluded person within the institutional framework is then examined, with reference to the mental health organization, attempting to define precisely—from the sociopsychiatric point of view—the ways in which the patient—already excluded and restricted by the limits of his illness—enters the category of those excluded from society. Finally, the authors analyse the possibility of replacing the crystallizing effect of the institution with the development of a dialectical reality, in which those working for the rehabilitation of the excluded person—patients, nurses and doctors—can work.

Disclosure statement

No potential conflict of interest was reported by the authors.

References

1. Sartre, J.P. (1947). *Refléxions sur la question Juive*. Ed. Gallimard, Paris.
2. Hegel, G.W.F. (1976). *The Phenomenology of Spirit*, The Master-Slave Dialectic.
3. Husserl, E. (1931). *Cartesian Meditations*. Meditations V.
4. Bettelheim, B. (1973). *The Informed Heart*, Penguin Books Ltd.
5. Steiner, J.F. (1966). *Treblinka*. Ed. Fayard, Paris.
6. Basaglia, F., & Pirella, A. (1966). *Deliri primari e deliri secondari e problemi fenomenologici di inquadramento*. XXIX National Congress, Pisa.
7. Basaglia, F. (1966). *L'ideologia del corpo come espressività nevrotica - Le nevrosi neurasteniche*. XXIX National Congress of the Italian Psychiatric Society, Pisa.
8. Goffman, E. (1961). *Asylums - Essays on the social situation of mental patients and other inmates*. Anchor Books, New York.
9. Barton, R. (1959). *Institutional Neurosis*. Ed. J. Wright, Bristol.
10. Goffman, E. (1961). *Asylums - Essays on the social situation of mental patients and other inmates*. Anchor Books, New York.
11. The program Area Committee on Mental Health. (1962). *Mental Disorders*. American Public Health Association, New York.
12. Martin, D. (1955). Lancet, 2, 1188.
13. Levi, P. (1947). If this is a man.
14. The problem of people being excluded from society has been analyzed by the psychiatrist Frantz Fanon, referring to the particular case of black: an interpretation that can be extended to all categories of rejected people. His interpretation aligns with that of Sartre concerning the problem of Judaism and seems perfectly adaptable to the analysis proposed here for the mentally ill as an excluded person, in that it reveals the process of projection with which the lord (in his case the white person, in our case the society) manages to embody in the slave everything that he rejects in himself. 'Insofar as I discover in myself something that is strange or immoral, I have only one solution: to get rid of it, attributing its origins to other people. In this way I can protect my mental balance … In Europe, Evil is represented by the Black … the Black Man is the executioner, Satan is black, we talk about darkness, when a person is dirty is black … In Europe, the black—real and symbolic—represents the negative side of the personality … In Europe, the black has a function: to embody inferior feelings, evil inclinations, the dark side of the soul … The scapegoat for white society (based on myths: progress, culture, liberalism, education, light, finesse) will be precisely the force that opposes expansion and the victory of those myths. It is the black who provides this brutal force of opposition … (Il Negro e l'altro - It trans. Sears - Ed. Il Saggiatore - Milan, 1965) … It is the colonizer who has been and continues to be colonized … From birth, it is clear to him that the restricted world sown with prohibition cannot be re-examined, except through absolute violence … The colonial world is a world of 'compartments' where 'aesthetic forces of respect for the constituted order create an atmosphere of submission and humiliations around the exploited, thus making the task of the forces of law and order considerably easier … The native is a being imprisoned in an enclosure, apartheid is just a means of dividing the colonial world into compartments' (Les Damnés de la Terre, Éditions Maspero - Paris, 1961).
15. Sartre, J.P. (1960). *Critique de la raison dialectique*, Gallimard, Paris.
16. Basaglia, F. (1965). *La distruzione dell'Ospedale Psichiatrico come luogo di istituzionalizzazione*. Annal Neurol Psich, I, Anno LIX.