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Controlling madness
An introduction

by Stefan Sjöström, Luigi Gariglio, Mario Cardano

This issue of «Rassegna Italiana di Sociologia» is devoted to social control in the context of madness. As editors, we have seen a need to revive a subject that appears to be situated in the outskirts of our discipline, and to provide a reminder of sociological perspectives that have been applied successfully to the phenomenon of madness and its government. And not least to assess how these are relevant to understanding the developments in the mental-health field in the 2020s. Our ambition has been to highlight one type of sociological analysis, namely social control aspects of mental illness. We maintain that social control has been a dominant feature in the sociology of mental illness, and moreover one that has lost some of its appeal in recent years. We are curious as to why this has happened, and consequently what is going on today within this seemingly dated style of research. The six contributions here all draw on the tradition of social control research into psychiatry. In different ways, they apply their own additions while being aware of contemporary developments. After reading them, we are optimistic about the future of social control approaches in sociological studies of the mental health system.

1. *The sociology of madness*

Let us first acknowledge how the emergence of sociology as a discipline has one of its deepest roots in an investigation of

The present article is the result of the authors' shared writing. Stefan Sjöström is the author of the Incipit and Section 1, Luigi Gariglio of Section 2, and Mario Cardano of Section 3. All together are the authors of Section 4.

mental distress: Émile Durkheim's *Suicide*[1]. *A study in sociology*, first published in 1897. In this seminal work, Durkheim convincingly demonstrated that suicide cannot be reduced to individual or biological sources, but demands acknowledgement as a social fact. He then famously identifies social circumstances that impinge on the probability of someone committing suicide and proposes a typology of three different kinds of suicide: egoistic, altruistic and anomic. Mental distress in itself was not at the core of Durkheim's interest, but by directing his gaze toward behaviour related to mental distress, his work was not only crucial in the formation of sociology as a discipline, but also for the sub-discipline that engages with mental as well as physical health.

So, while this special issue could be described as an attempt to revive an outmoded paradigm within a field that has become a relatively unnoticed sub-specialty of our discipline, it is important to remind readers of the broader sociological relevance of the topic that the authors have engaged with here. Blair Wheaton (2001) has observed the dual roles occupied by sociologists of mental health. The first role involves the value of sociological analysis outside the discipline (for Wheaton primarily issues of social causation). That is to say what we provide for other scholarly fields that take an interest in mental illness, and perhaps also those with more urgent, practical relations to the phenomenon: to patients, professionals and others. Here, the rise and success of the stress model as a tool for understanding the more proximal causes of mental illness serves as a prime example for Wheaton (see also Freund 1990). More concretely, an array of sociological concepts and approaches has been applied to the study of psychiatry and contributed to a more thorough understanding of its complexities: for example, sociologies of prison, organization, profession, knowledge, power and sexualities.

Wheaton further points to how the study of the worlds of mental health is more broadly fruitful for sociology. What can we learn from this domain that transfers sociological investigations into phenomena relating to family, work, migration, organizations,

[1] In the light of the contemporary debate on euthanasia and assisted suicide, we want to make clear that suicide is not necessarily a result of mental distress per se. It can also be an ir/rational decision that one can chose in order to overcome what might be perceived as an unbearable condition.

crime and the like? Historically, empirical research into psychiatry has created new concepts that have been applied broadly in other domains, prime examples being Erving Goffman's (1961) discussion of total institutions and Thomas Scheff's (1966) development of labelling theory. It can be argued that for such a minor sociological subfield, the sociology of mental illness has contributed exceptionally to sociological theorizing at large. We would suggest two possible reasons for this: first, how mental health highlights the divide in considering mankind as biological and social; and secondly, by the extreme nature of mental illness and the measures taken to manage it.

A longstanding role for sociologists amongst other scholars has been to insist on how all human phenomena have social and cultural elements both in their constitution and in their further ramifications for the world. An illustrative example would be how Bruno Latour and Steve Woolgar in their book *Laboratory life* (1986) show how even the discovery of something as concrete as a chemical substance must be understood as a social construction. Returning to Durkheim, it should be noted how much efforts he dedicated to dismissing extra-social factors such as – following his definition – psychopathic states, heredity, cosmic factors (climate, weather), and imitation (which Durkheim considered to be a purely psychological phenomenon). In the constantly recurring discussions of the social vs «real» nature of various worldly phenomena, it seems that the manifestations of mental illness provide fertile material for specification of arguments, nuances and contexts. Mental illness is defined as a medical condition, thus something of a neuro-biological nature. However, among medical ailments, it is widely acknowledged that it is somehow less obviously «medical» than, say, a cervical tumour, a fractured Coccyx or a burn injury to the skin. Moreover, many symptoms of mental illness transcend the individual's mind and are manifested in behaviour that is assessed against norms of appropriateness (Engel 1977). Both these characteristics include mental illness among the most «social» of illnesses, and thus particularly salient for sociological analysis.

The other characteristic of madness that makes it a fertile ground for theorizing is its extreme nature. Madness can be seen as extreme in the suffering it brings to those affected, in the deviant behaviours of those diagnosed as mentally ill, and in the extreme measures taken to manage and control madness. Potent

theorizing often derives from particularly productive examples, or cases. In an article about how to build social theory, Eisenhardt and Graebner (2007) emphasize the role of theoretical sampling, that is, finding critical cases (see Cardano 2020, 78-83) that are particularly suitable for illuminating extending relationships and logic among constructs. Especially when building from single cases, they favour those that provide the opportunity to «explore a significant phenomenon under rare or extreme circumstances» (Eisenhardt, Graebner 2007, 27). Something similar is accomplished by breaching experiments and «Garfinkling», when unspoken rules of behaviour are ingeniously breached in order to analyse the workings of norms and people's reactions to violations of norms (Garfinkel 1967). Whether psychiatry was chosen consciously as a case to theorize about total institutions or not, it seems that it allowed Goffman to make astute observations about their nature and extend his ideas to other examples that he did not himself investigate empirically (e.g. orphanages, prisons, boarding schools and monasteries). Similarly, drawing on a phenomenon that could be regarded as insignificant in its extremity and rarity, Durkheim found a vehicle that enabled him to further his ideas about anomy as a social phenomenon, and furthermore about social facts as an ontological notion.

Bruce Cohen (2017) distinguishes between two separate approaches that sociologists and other social scientists have applied to madness: conservative and critical. The former aligns with medical perspectives on mental illness and plays the role of sorting out social aspects of the nature of mental illness. This is similar to the first of the two roles of the sociology of mental health discussed by Wheaton above and comprises detailing the «social causation» of mental disorder (Hollingshead, Redlich 1958), organizational and interactional aspects of psychiatric treatment, investigating the experiences of service users, the role of service user organizations as well as social policy directed at assisting those diagnosed with mental illness. Research within this approach is epistemologically realistic and treats mental illness as a factual phenomenon. This kind of sociology of mental health is often carried out with the aim of contributing to the improvement of psychiatry as a legitimate institution to address mental health problems.

The latter, on the other hand, often adopt a social constructivist view of mental illness. These critical approaches problematize the

existence, definition and nature of psychiatric diagnoses. Such research can also be positioned within the sociology of knowledge. A prime example here is labelling theory as developed by Tomas Scheff (1966) in his book *Being Mentally Ill: A sociological theory*. Scheff saw the formation of psychiatric diagnosis as a societal reaction to deviant behaviour rather than a description of abnormal inner states on the part of those diagnosed. There is variation in how radically the constructivist approach has been applied. Some scholars have held that psychiatric diagnosis can be dismissed as a myth in accordance with Tomas Szasz's (1961) arguments; others have been open to acknowledging that people may suffer from some kind of internal distress, but they have pointed to the scope of interpretation of such distress and how the construction of labels is affected by a number of social processes having little to do with the affected individual. A later development of critical constructivist scholarship can be found in the formation of theories about medicalization associated with, among others, Ivan Illich (1975) and Peter Conrad. These works on medicalization represent another example of how a sociologist's ventures into psychiatry has led to theoretical development that has become widely used by other sociologists. Conrad chose the case of hyperactive children, what eventually has been defined as ADHD, to refine his theory about medicalization. Similar to Goffman's investigation of the asylum and Scheff's labelling theory, medicalization theory can be seen as part of the sociology of deviance (see also: Conrad, Schneider 1980) where madness is only one of many variations of deviance.

The sociology of mental health also encompasses several orientations that do not lend themselves to a clear-cut distinction as being either realist or constructivist. This is true for Marxist outlooks, where some contribute to social causation research by examining how the outbreak and further course of mental illness is contingent upon class and features in capitalist society. Others are more inclined to explore how in neoliberal society social problems are increasingly perceived in terms of psychological dispositions, thus taking a more constructivist approach to mental health concepts (Cohen 2016). Something similar can be said about queer and critical race scholars who address madness. Some studies can – taking a realist stance – explore issues like discrimination against certain groups within psychiatric services, whereas other (constructivist) investigations are occupied with

finding patterns in how certain illnesses or diagnostic traits are gendered or racialized (Ussher 2011; Moodley *et al*. 2017).

A final field that needs to be mentioned is the expanding research into those who are diagnosed with mental illness and those close to them. Such research investigates the life situation and collective action of those diagnosed with mental illness. Again, we find a multitude of theoretical starting-points here, with empirical studies into experiences of illness and/or being a patient, of everyday life, recovery (Fixsen 2021), advocacy (Funk *et al*. 2006), users' involvement in research (Beresford 2013) and their involvement in service provision (Lewis 2014). The diversity in perspectives is reflected in terminology. The groups in focus here can be referred to as patients, service recipients, service users, consumers, survivors and so on. Theoretical and normative considerations are also necessary for choosing other notions. How should we refer to the problems associated with the groups just mentioned? Mental illness, disease, distress? Taking a constructivist approach, we would like to avoid reducing and reifying this complex phenomenon by using one specific term. We thus oscillate between medicalized terms such as illness and more colloquial words like madness.

The specific theoretical concept that unites the texts in this issue is social control. Under this umbrella, most of the texts focus on coercion as a particular form of control. When coercion is applied, it is typically seen as a last resort, something that is necessary in critical situations when other controlling measures have failed. Psychiatric clinics are among the few institutions in modern society where this exception from democratic principles of freedom of choice is allowed. Virtually all democracies today have specific legislation in place to regulate this exceptional form of control (Molodynski *et al.* 2014). In existing laws, coercion is typically legitimized according to two principles, either to protect society from the mentally-ill patient, or as a society's duty to treat a patient in vital need of cure regardless of his/her wishes (Wynn 2006)

Most of the approaches mentioned in this introduction contain elements of social control. In queer terms, psychiatry could be viewed as an agent controlling people behaving contrary to hetero-cisgender norms prescribed by patriarchal hegemony. Again, parallel conjectures can be retrieved from critical race or Marxist scholars. The agent of control remains the same, but serving different interests and norm systems. The way labelling occurs

is also described by Scheff as a response to norm violation, and reactions can thus be regarded as a form of control. In this case even more is at stake: it seems that breaking what Scheff calls «residual rules» is a threat to basic norms holding society together, norms precluding the sort of politicalized norms at stake in patriarchal, capitalist and post-colonial control. Hitherto we have considered control on a macro-level in the interest of large-scale institutions. But social control also transpires to protect norms and institutions that are less grand. Research into clinical practice has shown how controlling practices are effectuated to manage quite trivial everyday affairs and to facilitate the smooth running of a clinical unit. Such control can be invoked for the sake of (other) patients, but also as a means for staff to devote their time to the most urgent tasks.

2. *Coercion as a form of social control*

'Social control' is a loaded sociological concept that has been the subject of sociological theory since the years of the institutionalisation of sociology. It encompasses both 'external social control' and 'internal control' (Giddens, Sutton 2017). Until the beginning of the XX century, the main interpretations of social control focussed on the institutions that provided social order by emphasizing consensus rather than conflict and coercion (Coser 1982). Amitai Etzioni, a prominent sociologist of organization, suggests a useful typology for organizations[2]. In *A comparative analysis of complex organizations*, Etzioni (1961) proposes three sociological approaches to social control focusing on three separate explanations: *i*) the hierarchical distribution of force (coercion); *ii*) utilitarian and economic relationships (interest); *iii*) normative elements (value and norms) (*ibidem*)[3]. Accordingly, the sociologist distinguishes among three different kinds of organizations, which he terms *coercive*, *utilitarian* and *normative*[4]; those distinctions

[2] After the publication of *Asylums*, Goffman (1961). During his lectures on «social control», Goffman challenged the usefulness of the concept of «social control» maintaining that it could almost be considered synonymous with sociology (Chriss 2019).

[3] Wrong (1994) readopted the same simplified heuristic model referring to the philosophers who originally introduced those lines of explanation.

[4] «Coercive organizations are organizations in which coercion is the major means of control over lower participants […]. Typical cases are: concentration camps, prison-

are neither clear-cut nor fixed. Etzioni illustrated the coercive dimension of social control, characterizing «coercive organisation»; yet he suggests that norms and interests would be in the picture too.

With the expression «medical social control», we refer primarily to a type of social control that occurs through «medicalization» (see Schneider 1988; Conrad 1992). The labelling and medicalization of deviance consist of a kind of «intervention» in which there occurs a

> growing use of medicine as an agent of social control, typically as a medical intervention. Medical intervention as social control seeks to limit, modify, regulate, isolate, or eliminate deviant behaviour with medical means and in the name of health (Conrad, Schneider 1980, 29).

By the expression «medical social control of madness» (henceforward «control of madness») then, we identify a type of social control that occurs to a person whose «way of being in the world» is interpreted by psychiatry as a clinical condition. By this process of psychiatrization a person is constructed as mad and s/he is more likely than not to remain under the life-long control of psychiatry – that goes along with cure and care – «in the name of health». As we said above, the control of madness can occur in two different ways: i) «internalization» and, ii) «external control» as we briefly address below.

The «internalization» of the medical social control of madness implies that the mad person can urge him- or herself to seek help autonomously or following the indication of family, friends, GPs, psychotherapists, psychologists, exorcists, or any significant other. In both cases, s/he can proceed voluntarily by requiring voluntary admission, voluntary medication and even voluntary mechanical restraint (Gariglio 2021) if s/he decides that the situation calls for it. Paraphrasing Giddens and Sutton (2017), we can state that mad people are their own censors and do much of the «policing» of their own behaviours by themselves like everybody else.

ers-of-wars camps, the large majority of prisons, traditional "correctional institutions", and custodial mental hospitals» (Etzioni 1961, 27). *Utilitarian organizations* are «organisations in which remuneration is the major means of control over lower participants» (Etzioni 1961, 31). *Normative organizations* are «organisations in which normative power is the major source of control over most lower participants, whose orientation to the organisation is characterised by high commitment» (Etzioni 1961, 40).

On the other hand, «external control» of madness can be exerted over the person by a medical agency of social control either non-coercively or coercively with a varying degree of discretion. Psychiatry, nursing, general practitioners, social services and other agencies of social control cooperating with them, such as the police, have the authority to respond coercively to a so-called psychiatric disease to an extent that is unknown in the "normal" people who have no problems with the law. In Italy, some coercive practices such as involuntary assessment (*accertamento sanitario obbligatorio*, ASO) as well as involuntary treatment and admission (*trattamento sanitario obbligatorio*, TSO) are regulated by law (833/178). Other common coercive measures such as «mechanical restraint» and «anaesthesiological restraint» are not, and it is as yet unclear where these two practices are situated in the continuum between *extra legem* and *contra legem* practices. The issue is contested and the legality of one or the other might vary from case to case (Algostino 2020).

2.1. *Coercion in the coercive organization and beyond*

Coercion is a widespread concept with heterogeneous meanings in the social sciences; it encompasses both power and will. In this introduction we consider it as an implicit component of any treatment of madness

> [C]oercion may be considered either as a formal compulsion, which includes measures sanctioned by mental health, law, or as informal coercion, including all other pressures applied to encourage treatment adherence or to change the patient's behaviour in other ways. While compulsion is defined by law and is thus relatively easy to measure, informal coercion has proved harder to operationalize (Molodynski, Rugkåsa, Burns 2016, 2).

Etzioni suggests that some coercive organizations and other institutional settings such as rehabilitation-oriented and «open» institutions as well as, we can add, psychiatric-community care and the care of the elderly, may apply predominantly to normative means of social control, only making secondary use of coercion when the situation calls for it (see Sjöström 2016). However, Etzioni adds «[e]ven when control relies directly on other means, indirectly it is based on force» (Etzioni 1961, 27; see Sharp 1975). A particular degree of coerciveness, either explicit

or tacit, formal or informal, symbolic or physical, characterizes any particular institution that controls madness (Etzioni 1961). Moreover, the degree of coerciveness is not a fixed quality of any institution. It varies over time, space and geography and impinges differently on particular hierarchical power-laden interactions between particular human beings, also depending on the sociodemographic characteristics of the actors involved.

Although the use of coercion is rarely visible publicly, the non-coercive control of madness is grounded on the fact that coercion lies between the lines (Etzioni 1961), not only in asylums and other custodial environments but also in community settings (Sharp 1975), where, at any time, an involuntary admission or medication order, as well as other coercive tools of negotiation, can be issued.

Social control is grounded on an «implicit coercion logic» (Gariglio 2017). Any interaction between staff and patients is based on the tacit knowledge that coercion is always «around the corner» and will be used – with varying degrees of discretion – if the situation calls for it. Here we do not intend to overestimate coercion at the expense of cooperation and consensus. We rather want to bring the often tacit, hidden dimension of coercion to the fore, maintaining that coercive social control still remains a useful framework to comprehend other – more consensual and cooperative – forms of social control of madness.

Although coercion can be thrust over the mad if necessary, an array of non-coercive «tools of negotiation» is the standard day-to-day means of cure, care and control of madness.

2.2. *«Tools of negotiation» for controlling madness*

The sociology of madness and the literature on social control show convincingly that coercion alone is neither sufficient nor efficient. To comprehend the social control of madness, it is useful to situate coercive practices within the more general framework of the «tools of negotiation» used by staff – both health care professionals (HCP), social services, security, and custodial staff – to control the mad, as well as other inmates and users, and by doing so, possibly enhance, or at least influence, their internal control. We propose an updated yet provisional typology of «tools of negotiation» (see Gariglio 2017, 43-55; see also Liebling *et al.* 2011) that is an analytical tool to understand

what practitioners do when they go about their business. The typology can also be adopted for training purposes with HCP and custodial staff. The table crosses two main dimensions: vertically, each tool is organized into three categories according to its degree of coerciveness: non-coercive; symbolically coercive; physically coercive. Horizontally, each tool is organized referring to its grade of legitimacy, distinguishing between high, low and a so-called grey zone. The distinctions are more likely to be fuzzy than clear-cut, incomplete rather than definitive (see Tab. 1). Although Tab. 1 shows a broad spectrum of this configuration, here we can only touch on the legitimate tools in capital letters in the first column.

TAB. 1. *«Tools of negotiation» for controlling madness (Adaptation from Gariglio 2017, 44)*

	Legitimate	*Grey area*	*Illegitimate*
Non-coercive *(see 2.2.1)*	**Persuasion**	Manipulation with incomplete and/or ambiguous information	Manipulation by false and/or incorrect information
	Inducement		
	Word-therapy and ergo-therapy		
Non-physically-coercive *(see 2.2.2)*	**Symbolic threat of coercion**	Verbally coercive enforcement of a non-clearly legitimate order	Verbal abuse, yelling, joking. Verbally discriminating or provoking
	Credible threat of coercion		
Physically coercive *(see 2.2.3)*	**Use of force**	Use of physical coercion if not strictly necessary or for more time than strictly necessary	Use of physical coercion for personal-egoistic organisational-hypocritical, non-therapeutic or punitive reasons
	Space-time coercion (detention)		
	Forced mobilisation between institutions		
	Holding		
	Mechanical restraint		
	Chemical restraint		
	Anaesthesiological restraint		

2.2.1. *Non-coercive tools of negotiation*

Persuasion and *inducement* are two of the basic tools of social interaction in the social contexts tackled in this special issue; they structure the day-to-day relationship between staff and the mad. *Persuasion* is intended as a form of communication aimed at convincing another person to arrive at some consensus on any particular issue only by dialogue and reasoning; in other words, without any material or symbolic incentive. It is embedded in the frame of reciprocal recognition and requires a most open disposition and a considerably unpredictable amount of time to produce the desired outcome. In theory, it is a valuable tool of negotiation to control madness, but practical constraints make it less likely to work than inducement.

Inducement is predicated on the perception of the other's symbolic or material interests. It is grounded on exchanges, not necessarily of material nature. Inpatients and prisoners can be induced to cooperate with the staff simply by staff addressing their basic needs (*ibidem*). Inducement also has disadvantages. It might imply reciprocation of favours facilitating corruption. Notwithstanding these problems, inducement is used in day-to-day practice in Italy and helps staff working with scarce resources to manage the «unmanageable» without recurring to more severe coercive tools (see next section). *Word therapy and ergo (work) therapy* have been used in asylums since the XIX century; Vincenzo Chiarugi in Italy and afterwards, Philippe Pinel in France, and Samuel Tuck in the UK, introduced 'moral treatment' and would use 'ergo therapy' (Babini 2009). Both are means of re-socialization to hegemonic values and norms. Users can be either persuaded or induced to cooperate simply by offering them the possibility of access, or threatening the denial of access, to therapy and work because both can offer symbolic and material remuneration and gratification.

2.2.2. *Non-physically-coercive tools of negotiation*

Non-coercive tools of influence do not always suffice to solve issues that staff see as problematic on the part of patients: from little acts of resistance such as refusing a meal to aggressive behaviour toward self or others. Although coercion is always

implicit there, sometimes staff threaten more coercive manners both with words or behaviour and this is usually enough to restore the situation to speaking terms. *Symbolic threats* of potential physical coercion are somewhat tentative in their presentation. Nurses or doctors might verbally express the possibility of using force, restraint, and even calling the Police to enforce control. Such threats can be performed by one single staff member and can remain in the air for quite some time before a situation is resolved by actually enforcing the threat or not. More often than not, a symbolic threat is enough to address the critical event effectively.

A *credible threat* is more imminent than a symbolic threat, for instance when a group of nurses or the Police emerges, signalling to the patient that the situation has escalated to a new level and an order to use force becomes likely. But such an assembly of physical powers does not necessarily mean that physical coercion will be enacted – it can simply be another level of symbolic threat. Facing a display of physical coercion, patients accept the therapy, stop trying to escape and become more docile.

2.2.3. *Physically coercive tools of negotiation*

In this section, we list the main coercive tools used to control madness, some of which will feature in the empirical papers in this issue. The first type is the 'use of force' and is likely to be used to enforce all other six types of coercion. There are then two types of coercion constraining the liberty to move around, and four coercive types that involve restraining the body either mechanically or chemically.

Use of force is not likely to occur frequently; often the threat is sufficient. The use of force is a «disturbing event» (Garland 1990: 222) that institutions try to hide from public sight as much as possible. «The sight of violence, pain or physical suffering has become highly disturbing and distasteful to modern sensibilities» (*ibid.*, 223). This tool of force can be used to stop a person from harming oneself or assaulting others, to restrain a patient, to forcibly fasten an old patient to the bed, or to force prisoners to re-enter their cells. Although the use of force is not easily visible, we agree with Etzioni (1961) that it is an all-present

option even in seemingly open and cooperative contexts such as therapeutic communities (see Sharp 1975).

The *space-time tool (detention)* is perhaps the most characteristic type of physical coercion of total institutions (asylums and other smaller psychiatric organizations, prisons, nursing homes for the elderly, immigration detention centres, and the like). This can occur with different degrees of severity: from being in detention in an asylum to being an inpatient in a locked ward to being isolated in a padded room (Gariglio 2017). Even in its «lighter» forms, space-time coercion is an extreme type of physical coercion because it forcibly regulates the person's movement an liberty. In all cases staff would intervene immediately to persuade or physically coerce the user who breaches this type of coercion.

Forced mobilisation between institutions entails the forced removal from one place of detention to another and has been observed both in asylums and in prisons. Some «problematic» prisoners and patients are thus coercively transferred from one facility to another with the effect of controlling them (Sterchele in this issue). This practice is also used to provide relief for staff who struggle to manage a mad person perceived as particularly difficult. It is a severe and disorienting form of coercion for those experiencing it, as well as another institutional way to address recalcitrance that the institution had been unable or unwilling to control otherwise.

Holding is the practice of manually restraining the body of a person against (but occasionally with) his or her will. It is a very costly type of coercion because it requires a number of staff members to enforce it. It is often considered gentler compared to mechanical restraint since staff can responsibly adapt the restraint to the evolution of the situation. Although it allows close contact between the staff and the person being held, some staff prefer mechanical restraint because they feel that holding is very tiring, overwhelming and stressful. Others are critical because it drains available staff to hold the «difficult» ones, preventing them from catering to the needs of other patients. (Gariglio 2021).

Mechanical restraint, consisting of physically restraining the body of a person fastening it to a bed (in antient times it could have also be fasten to a pole or a cage) has continued since the Middle Ages at least in the UK where it was abolished in the XIX century. However, mechanical restraint has been routinely in use in Italy, overcoming and challenging Franco Basaglia

and other «radical psychiatrists» (Foot 2012) who first stopped the use of mechanical restraint in asylums and then abolished the asylums themselves. Italian sociological literature (Cardano *et al.* 2020) shows that mechanical restraint is a daily feature of everyday staff-patient interactions in most Italian psychiatric wards and nursing homes for the elderly (Miele in this issue) as well as other hospital departments. Staff justify its use in different ways, some even say – referring generically to clinical knowledge – that it can be therapeutic (Gariglio 2021).

Chemical restraint, in our view, occurs if and only if psychotropic drugs are used with the main goal of controlling the behaviour of people rather than curing them. Psychotropic drugs used to tackle extremely bizarre «ways to be in the world» – in clinical jargon to cure delusions and hallucinations – might have sedation and other conditions as side effects; yet those effects would *not* be considered as chemical restraint. Chemical restraint is an effective form of control in reducing users' resistance, inducing or forcing cooperation, and partially or totally impairing their functioning and mobility. It does not work instantaneously but needs some time to affect or immobilise the person.

Anaesthesiological restraint was defined by Cardano and Gariglio (2021) as the practice of using anaesthesia to control a person by sedating her/him very quickly. In Italy it is adopted by ambulance staff when necessary. More rarely it is employed in order to avoid using mechanical restraint in no-restraint wards. Both anaesthesiologic restraint and mechanical restraint should be as brief as possible.

After this *excursus* on controlling madness by social control and coercion, we now turn to a historical overview of the practices that have been used to control (and cure, if not care) madness: from medieval chains and towers to the asylum and, eventually, to community care.

3. *A historical outlook on otherness policies*

This section deals with the control of madness from a historical perspective, starting with a general overview of the government of madness in Western countries and closing with a focus on the Italian context. The focus on the Italian context only partially depends on the contents of the special issue presented here,

with four out of six contributions based on Italian empirical material. The Italian context is eloquent for its radicality – at least in intention – of the psychiatric reform that dismantled asylums, while retaining their coercive shadow with the formal regulation of involuntary treatment and admission. With all its limitations, the so-called Basaglia reform became a model for many countries. The historian of medicine Roy Porter maintains that madness «may be as old as mankind» (Porter 2002, 10). Following the line of an essay by Sigmund Freud, *Das Unheimliche* (The perturbing[5] or uncanny), we can define madness as a perturbing expression of otherness. Perturbing is something that is both frightening and familiar but also something that should remain secret, hidden but which became visible. In conclusion Freud maintains that in the perturbing, the profane sees the expression of forces he had not expected to find in his neighbour but whose presence he can obscurely sense in remote corners of his personality. The perturbing character of madness is at the root of the constant ambiguity of its government throughout history. For a long time, madness had been interpreted through a religious frame by considering mad people inhabited by demons or holy spirits: this probably occurred at every latitude. The fog around the representation of madness thins out with the birth of modern science and the gradual medicalization of this kind of otherness. In a religious or scientific key, madness has retained its perturbing character over the centuries, governed by policies of otherness which, like a pendulum, oscillate between the poles of separation and inclusion. The acritical reception of Foucauldian thought forces us to consider the XVII century «Great internment» as the beginning of the separation era. This is only partially true: before the invention of workhouses and, later, asylums, mad people were not allowed «to gambol on the village green or ruminate idly in the shade of the oak tree» (Shorter 1997, 1-2). Separation and inclusion operated both before and after the Great Internment. Before the asylum era in the XIX century, mad people lived the opposite experiences of exclusion and inclusion in the non-institutional context of family.

[5] The perturbing concept was elaborated by Sigmund Freud in a singular exercise of literary criticism, applied to Ernst Theodor Amadeus Hoffman's novel, *The Sandman*, published in 1817.

Edward Shorter quotes the testimony of a member of the House of Commons from an Irish district who said:

> There is nothing so shocking as madness in the cabin of the Irish peasant ... When a strong man or woman gets the complaint, the only way they have to manage is by making a hole in the floor of the cabin, not high enough for the person to stand up in, with a crib over it to prevent his getting up. This hole is about five feet deep, and they give this wretched being his food there, and there he generally dies (Shorter 1997, 2).

In a similar social context, in the rural community of Geel, in Flanders, mad people from Belgium and abroad were hosted by the local families who received substantial compensation. Mad people had their own rooms, shared meals with their families and lived in the village, taking care of animals and – when necessary – children, and drinking beer in the pub (Villa 2020). This singular community-care experience lasted seven centuries, before and after the asylum era.

Throughout history, the separation of mad people sometimes assumed a more violent character: suppression. This was the destiny of many heretics burned by the courts of the Holy Inquisition, as was the case of Joan of Arc. More recently, the policy of otherness constituted by suppression was adopted before the «final solution of the Jewish question», with the Aktion T4 programme in which 200,000 German «lives not worth living» (Aly 2013) were terminated. A considerable number of these victims were mad people. The inclusion pole, too, throughout history, assumed a dramatic shape. This was the case of subordinated inclusion of mad people as court jesters in the Middle Ages and, more recently Freak shows where abnormal people – the mad included – were exposed to a paying public to arouse terror and hilarity.

However, there is no doubt that the asylum constitutes the monument of the politics of separation. In its specialised version, the asylum emerged in the XIX century as a custodial institution meant to protect society from the dangers and scandal of madness. The function of cure took an embryonal shape for at least a century. The treatment of madness was empirical, rooted in a very basic representation of this kind of otherness. The prevailing ontologies of madness considered this condition a mystery that could be faced by counting on the residual rationality of the mad individuals – the moral treatment proposed by Philippe Pinel

(1745-1826) – or totally bypassing it through a set of shock or terror treatment. The paraphernalia of asylum treatments included «Bath of surprise», coercive rests, the induction of epileptic crises, malaria, and insulin shock, to which were added in the first half of the XX century electroshock and lobotomy. Effective as custodial institutions, asylums were a complete failure from the point of view of cure[6].

For most part of the XX century, and in most European countries, asylums dominated the provision of services – mainly of a custodial nature – for people inhabited by mental distress (Kozma, Petri 2012: 11). In the rest of the world the situation was similar, with the psychiatric hospital as the dominant monument for governing madness.

Things started changing after WWII with two related events, growing criticism of total institutions and the discovery of psychiatric drugs[7]. Even the doctor who promoted the abolition of Italian asylums, writes: «If the patient has lost his freedom due to the disease, the drug gives him [sic] the freedom to repossess himself» (Basaglia 2005, 20). The asylum scenario changed dramatically. *The Snake Pit*, described in Anatole Litvak's homonymous movie, suddenly became silent, again borrowing Mario Tobino's words: «The screams are silenced, the delusions are broken, the hallucinations with smoked glass» (Tobino 2016, 140)[8]. In this new scenario, the government of madness didn't lose its coercive profile. Established practices such as mechanical restraint continued to be applied, accompanied by a new, ambiguous coercive practice, chemical restraint, that can trigger both dialogue and

[6] The autobiographical novel *Le libere donne di Magliano* (Translated into English as *The Woman of Magliano*), written by a psychiatrist who worked in a female asylum in Tuscany (Maggiano), offers a touching representation of the government of madness during the asylum era. Asylums were institutions inhabited by «incomprehensible plants without roots, shadows without memory, babbling meaningless words» (Tobino 1953).

[7] In 1952, Henri Laborit, a French neurosurgeon searching for a treatment to avoid the stress and shock of patients undergoing surgery, discovered chlorpromazine. Laborit suggested using this molecule to treat the insane, and some psychiatrists accepted the challenge, successfully treating acute psychotic manifestations.

[8] Anatole Litwak's American movie, *The Snake Pit*, was distributed in 1948 and reached Italy the following year. The metaphor of the snake pit applies to the agitated female asylum where patients considered beyond help were placed together in a large padded cell and abandoned. Interestingly enough, the film was positively reviewed by Ugo Cerletti, the Italian inventor of the electroshock, who, in the political magazine «Il Ponte», wrote: «The formula "the snake pit" can be applied to many "agitated" wards of America and Europe» (Cerletti, 1949: 1373). Cerletti wasn't a rebel psychiatrist, so his critical view can undoubtedly be considered well-founded.

silence. Paradoxically, one of the most relevant neuroleptic side effects was the progressive reduction of dialogue and relationships. The American psychiatrist Loren Mosher dealt with this aspect in a solid and well-organized way. Mosher decided to replicate Ronald Laing's experiment of the Kingsley Hall community, based on a full-day cohabitation of patients and health care professionals. From 1971 to 1983, in a small community in the San Diego area, Mosher started the experimentation of Soteria Houses devoted to the treatment of the onset of psychosis mainly through the relationship between Soteria's guests and professionals, avoiding, at least for the first six weeks, the use of neuroleptics (Mosher 2004). Mosher framed his experimentation in the controlled-study form, finding evidence of the absence of significant differences in the health profile between people treated or not treated with neuroleptics (Calton *et al.* 2008). Evidence on this point is far from conclusive, but at least it documents the poverty of treatment based only on medication, an idea in line with Basaglia's thoughts[9].

Besides pharmaceutical innovation, what triggered the deinstitutionalization process that resulted in the progressive reduction of hospital beds for people with mental health conditions was innovations in both psychiatric cures and societal dispositions. In the United Kingdom, during the 1950s, the therapeutic community of Maxwell Jones deeply challenged the power relationships between patients and health professionals through the organization of assemblies and general occasions of democratic discussion. A few years later, in France, so-called «sector psychiatry» was introduced, a reform that rationalized cure and offered stricter integration between hospital and territorial services. Most of these small or large reforms were supported by left-wing social movements who identified total institutions as one of the most prominent symbols of societal oppression. The revolution of Italian psychiatry was launched within this scenario.

Among the reasons for the revolution in Italian psychiatry, the backwardness of the country is worth noting. The first law regulating mental health care dates from 1904. At that time a strictly biological orientation of psychiatrists characterized the

[9] There has been criticism of the long-term consequences of the use of neuroleptics too. Robert Whitaker's book presents, in an informative style, eloquent evidence on this point (Whitaker 2010). In Europe, an approach with some relevant family resemblance to the Mosher experimentation in the cautious recourse to neuroleptics was introduced in Finland by the psychotherapist Jaakko Seikkula: the Open Dialogue (Seikkula 2003).

Italian context. This double pressure triggered a set of resistance practices that led Italy to the abolition of asylums by Law 833,1978. It is a commonplace to identify Franco Basaglia as the protagonist of this Italian revolution. Franco Basaglia played an irreplaceable role in mental health care reform, but he was not the only one committed to this cause. According to John Foot (2014), the «long march» toward psychiatric reform involved many actors in the Italian peninsula: psychiatrists and militants in Perugia, Parma, Reggio Emilia and Arezzo were engaged in the battle, sometimes on the same page as Basaglia, sometimes not.

Basaglia's adventure started in Gorizia in 1961, when the young psychiatrist left university to become the new director of the local psychiatric hospital. In the asylum Basaglia met suffering humanity subjected to a useless, severe discipline, enveloped in a stench that immediately evoked that of the prison in which he was confined as a Partisan. At first, Basaglia tried to reform the system: he removed the bars from the windows, banned the use of electroshock and mechanical restraint, eliminated uniforms, and broke down the segregation between men and women. Following Maxwell Jones' therapeutic community, he promoted the active involvement of patients in the management of the asylum. All this was not enough; Basaglia persuaded himself that a simple softening of the asylum regime was nothing more than a form of «repressive tolerance», which did not resolve, but merely hid, its violence. He concluded that the asylum should be abolished. From Gorizia, Basaglia moved to Colorno and then to Trieste in 1971. Trieste was not only the last stage of a clinical journey but also a period of great political experimentation. Valeria Babini (2009) compares Trieste in the 1970s with Freud's Vienna, an effervescent political and cultural laboratory, the building site of a particular pedagogy of freedom. In February 1973, Basaglia's parade, made up of madmen, technicians, militants, and artists, invaded the city, headed by an enormous blue papier-mâché horse called Marco Cavallo. A symbolic action that preludes the mad return to society realized a few years later.

With the Law 833 Basaglia's utopia begun to take shape. He was sceptical about his goals, expressing reservations about the subsumption of psychiatry to medicine, perhaps foreseeing the organicist return of recent years. He also maintained a disconsolate pessimism about the decisive nature of the closure of asylums, fearing the emergence of widespread forms of little asylums nourished

by the business of madness. In reality, the closure of the asylums remained a project for many years, finding fulfilment only in the late 1990s when the last asylums were closed. Another custodial institution, high-security psychiatric hospitals (OPG), continued to occupy the political space. They were closed in 2015. Their history is described in the following essay by Torrente *et al.*

4. *Presentation of the articles*

The six essays in this special issue offer a multifaced representation of madness control. In *The closure of high-security psychiatric hospitals in Italy*, Giovanni Torrente *et al.* address how the reform that ordered the closure of the forensic psychiatric hospital In Italy has impacted the process of deinstitutionalization of mad prisoners who were diverted into different public and private institutions. The authors conclude by suggesting that the reform is incomplete and its effects unevenly distributed nationally. *Immobilization and forced mobilization*, by Luca Sterchele, thematizes what we have considered a physically coercive negotiation tool implemented to control and manage mad prisoners. This paper shows how coercion can be practised not only through immobilization of subjects but also through their forced mobilization, namely through «circuiting». In *On the persistence of coercive practices in dementia treatment*, Francesco Miele considers the social control of the elderly in nursing homes for people with dementia, focusing on the reasons for the persistence of mechanical restraint. He shows the challenges «encountered by workers in enacting the practices born in opposition to the use of coercion», and by doing so, Miele illuminates an aspect of the care and control of the elderly that has hardly ever gained empirical attention. In *Psychiatric power and adultcentrism*, Andrea González-Urbina accompanies us directly into a Chilean psychiatric ward. An analysis of a so-called assembly workshop illuminates how children and adolescents make sense of their experiences of coercion. The author shows double tension challenging children and young inmates: psychiatrisation and adultcentrism. In *Embodied stories of mental illness treatment of a loved one*, Micol Pizzolati uses a body mapping workshop to grasp the experiences of caregivers who take care of a close family member. This paper highlights evocative images and attempts to tackle the emotional responses of caregivers to the coercion of

their fellow family members. The research aims to open a window into caregivers' lived experiences, meanings and relationships with social and affective contexts. Jonas Ringström, in *Psychotherapy as a government of the self*, challenges the hegemonic interpretation of psychotherapy as a talking cure aimed at alleviating human suffering, underlining its potential for control of the individual. By addressing a particular kind of therapy – Acceptance and Commitment Therapy – he reinterprets psychotherapy through the lens of the «non-coercive tool of negotiation» (see 3.1), offering a convincing, though counterintuitive, reading of psychotherapy in the light of social control.

The stakes are always high when it comes to coercion. High in terms of dignity, in terms of potentially serious damage if no action at all is taken, and in terms of democratic values. These are part of the reason why the articles in this issue are important. But they are also important as sociological interrogations into an extreme phenomenon of the kind that might challenge theoretical presuppositions and give rise to new ideas and further conceptual development. Today, Durkheim's work on madness is primarily remembered as a model for sociological analysis and for providing an early case study of the concepts of social facts. A less-appreciated quality of *Suicide* is the author's dedication to normative issues enabling him to connect his dry, statistical undertakings to questions about how to reduce suicide rates and contribute to improving the world. As a final point, we as editors would like to draw attention to this quality of sociological work and the importance of how the articles in this issue engage with day-to-day, flesh-and-blood experiences, and difficult normative topics, and thus transmit crucial knowledge for improving the life circumstances of people diagnosed with a mental disease.

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Controlling madness. An introduction

This contribution deals with social control in the context of madness. It is divided into three sections. The first one, *The sociology of madness*, illustrates the origins of this field and shows how it has contributed to the development of Sociology as such. The second, *Coercion as a form of social control*, begins by illustrating the intertwined concepts of social control, medical social control, and medical social control of madness. It procedes to present a set of tools of negotiation for controlling madness organised into three categories: non-coercive, non-physically-coercive, and coercive tools of negotiation. This include, for example, negotiation, inducement, use of force, mechanical restraints and chemical restraints. The last section, *A historical outlook on otherness policies*, deals with the control of madness from a historical perspective, starting with a general overview of the government of madness in Western countries and closing with a focus on the Italian context

Keywords: social control, coercion, sociology of madness, mental health, mechanical restraint, Basaglia

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