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"Too soft for real psychiatry"? Gendered boundary-making between coercion and dialog in Italian wards[AQ: 1]

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Abstract

Psychiatric practice has always entailed a coercive dimension, visible not only in its formal expressions (e.g. compulsory treatment) but in many informal and implicit forms. In fact, contemporary psychiatric practices are characterized by an interplay of coercion and dialog to be interpreted not as binary categories but as extremes of a spectrum. Within this perspective, it becomes crucial to draw boundaries attributing meaning to professional identities and practices in psychiatric work. This is particularly relevant in acute wards: to explore this issue, we selected two cases according to a most-different-cases design, one ward with a mechanical-restraint approach compared to one with no-mechanical-restraint. We argue that gender, mobilized to performatively draw distinctions and hierarchies in order to define and justify different approaches to psychiatric crises along the continuum between coercion and dialog, is a key dimension in the boundary-making process. The analysis identifies two main dimensions of drawing gendered boundaries: inter-gender boundaries (overlapping the binary distinction between masculinity and femininity with a more coercive or relational-dialogic approach to crisis) and intra-gender boundaries (distinguishing and ranking of different masculinities and femininities), associating a less coercive orientation with a devirilized masculinity.

Keywords

acute mental health care, boundary-making, coercion, gender, no restraint

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Introduction

Psychiatric practice has always entailed a coercive dimension, representing the oldest and most controversial problem of mental health institutions (Steinert et al., 2014). The ethnographic exploration of acute mental health settings has underlined that dimensions of control, coercion and violence permeate these contexts (Johansson et al., 2006; Katz and Kirkland, 1990; Morrison, 1990). Since Goffman's (1961) seminal work *Asylums*, coercion is portrayed as part of asylum life, in terms of both involuntary institutionalization and daily non-consensual practices such as forced medication. Descriptions of mental hospitals as spaces where the territories of the self are systematically violated, self-determination denied, and freedom of action curtailed, emerge also from accounts of European, including Italian (Babini, 2009), asylums of that time. The process of deinstitutionalization changed mental health services profoundly, especially in those countries—such as Italy—where asylums have been dismantled and psychiatric care provision has been moved to general hospitals and community services. Moving on from Goffman's conceptual framework, contemporary ethnographic explorations of life in psychiatric wards developed an alternative analytical model, and a shift from the model of "total institution" to that of "permeable institution" has been advanced (Quirk et al., 2006). Efforts to achieve less coercive mental health care have characterized deinstitutionalization processes, although they are not entirely new: the history of psychiatry has seen many attempts to abolish coercion, none of them completely or convincingly successful in any period or country (Steinert et al., 2014). Today, coercion is not only visible in its formal expressions (e.g. compulsory admission and treatment regulated by law), but permeates psychiatric contexts and other coercive organizations in many informal and implicit forms (Gariglio, 2018; Hoge et al., 1997; Sjöström, 2006). The boundary between voluntary and involuntary treatment is fuzzy in practice, because of the ever-present threat of compulsion and the hospitalization of "pseudo-voluntary" patients (*coactus voluit*) in locked wards (Pilgrim, 2012). Moreover, literature and epidemiological data show how psychiatric coercion is predicted by social group membership, as it is correlated with race, age and gender: black, younger and male patients show a higher risk of coercive management (ibidem) **[AQ: 2]**.

Due to the complexity and the many contextual features affecting the phenomenon, contemporary psychiatric practices are characterized by an interplay of coercion and dialog, because they need to achieve a somewhat ambivalent goal: to care for but also to manage and control people going through a "crisis" or characterized by what is contextually defined as "disruptive behavior" (Cardano and Gariglio, 2021). The complex coexistence of apparently contradictory aims, which leads one to interpret coercion and dialog not as binary categories but as extremes of a spectrum, calls for deeper investigation. Apart from a few exceptions in the sociological field (Sjöström, 2006) and some relevant insights provided by nursing studies in psychiatric settings (Hamilton and Manias, 2007; Johansson et al., 2006), little is known about how mental health care is provided today in acute wards (Quirk and Lelliott, 2001). Apart from contexts that represent excellence with respect to deinstitutionalization and restraint abolition, such as the Trieste model (Mezzina, 2014; Okin, 2020), literature on the Italian situation is very limited (Author 1, 2023; Mauceri, 2017). This article contributes to expanding existing

knowledge, focusing on the processes of boundary making that shape care and coercive practices, explored ethnographically in two Italian psychiatric units.

Coercion and the issue of drawing boundaries in contemporary psychiatric practice

Coercion exercised within psychiatric institutions is a complex, sensitive issue raising clinical, ethical and legal questions concerning human rights and challenging fundamental values such as patients' autonomy. The application of coercive measures is usually justified in medical discourse as a means of helping the patient overcome a crisis and regain rationality (Kaltiala-Heino et al., 2000). The potential threat of some patients' disturbed behavior to themselves or others can result in a paternalistic approach according to which patients have to be protected from themselves (Richter and Whittington, 2006). The adoption of compulsory measures is further justified on the basis of patients' alleged lack of insight into their illness. Albeit undesirable and ethically loaded, coercive interventions are sometimes considered inevitable to manage violent, suicidal or otherwise potentially harmful conduct: a necessary evil to ensure safety (Perkins et al., 2012).

Despite its longstanding relation to psychiatric care and its investigation by mental health literature, a specific definition of coercion is not readily available. Instead, the term is used to refer to a heterogeneous set of practices ranging from undue interpersonal influence to the explicit use of force (O'Brien and Golding, 2003). Moreover, distinctions have been underlined between "objective" and "subjective" coercion, the latter referring to the subjective experience of feeling strong pressure on one's free will or unintended threats. The phenomenon has been described as a "coercive shadow" that looms over mental health care: patients can "voluntarily" accept medication or hospitalization mainly to avoid fear, stigma and humiliation related to compulsory measures that might be applied if they do not comply (Szmukler, 2017). Attempts to measure levels of coercion as perceived by patients at the time of admission have been made: a US study indicates that approximately 10% of legally voluntarily-admitted patients felt coerced (Hoge et al., 1997). Further research conducted in Europe (Ireland) using the same assessment tools shows that the number of "coerced voluntaries"—those formally admitted on a voluntary basis who experience negative pressures, implicit threats and defective procedural justice—can be quite significant: 22% of voluntarily admitted patients perceived equal levels of coercion to those admitted involuntarily (O'Donoghue et al., 2014).

The difficulty in defining and measuring coercion, and the blurred line between coercive measures and patients' voluntary acceptance of treatment encouraged some scholars to avoid clear-cut classifications and focus on the concrete ways in which coercion is performed in everyday clinical practice (Sjöström, 2006, 2016). According to this perspective, attention is paid to the way in which social practices are constructed as coercive (or non-coercive) and justified within the specific cultural and organizational settings in which they take place. In this work we embrace such orientation toward a situated inquiry, investigating coercion in its concrete processual occurrence instead of as a decontextualized object of inquiry. Starting from the assumption that notions of care and

constraint have unstable meanings that vary depending on local traditions and ideologies of treatment (Brodwin and Velpry, 2014), we focus on contextual enactments of coercion and care. The aim is to expose the underlying "boundary work" (Gieryn, 1983) through which «people bring some social objects inside a category or concept whereas they push others out of the definitional frame of this category or concept» (Åkerström, 2002: 517). Such boundary work is of particular relevance in acute psychiatric contexts permeated with «otherwise exceptional social activities of forcing people to comply with strict rules and arduous treatments, to perform body searches, and to restrain and administer injections by physical force» (Sjöström, 2016: 132). In these organizations, mental health providers face dilemmas that have to do with the ambivalent negotiation between their preferred self-image of caring and competent professionals and the necessity to carry out coercive treatments (Brodwin, 2014). Ordinary psychiatric practice is therefore imbued with everyday ethics, as decisions dealing with «right and wrong, the obligatory and the forbidden, and the legitimacy of professional power» (Brodwin, 2013: 29) are made in the ongoing flow of everyday clinical work.

In this boundary work, various categorization processes—such as social classification, racialization, (dis)abilitation—are involved in attributing meaning to professional identities and everyday cure and care practices. In this article, we focus on gender as a categorization process mobilized to performatively draw (in discourses and practices) distinctions and hierarchies in order to define and justify different approaches to psychiatric crises. In this perspective, we will show how genderization encompasses some characteristics—namely determinism (the claim that men's and women's conduct is determined by physiological processes) and essentialism (the belief that categories of individuals possess innate and permanent characteristics)—that Heidi Rimke includes into psychocentrism (2018).[1]

The application of a gender perspective to the study of mental health contexts is not new: recent ethnographic fieldwork in psychiatric wards, for example, have highlighted how hegemonic masculinity is performed and reproduced by hospital security guards who are rewarded for their embodied authority to coerce, control and intimidate, verbally or symbolically, through their uniformed presence (Holmes et al., 2014). These hypermasculine performatives are in tension with discourses more related to the dimension of care, empathy and compassion, specularly constructed as features of femininity. The ward environment emerges from literature as characterized by highly gendered codes of behavior and relationships among predominantly male guards, predominantly female nurses, and patients (ibidem).

Adopting an approach to genderization as a process of boundary-making, we investigate how gendered meanings are attached to professionals' and patients' practices, and how they work to draw boundaries along the continuum between coercion and dialog.

Context and methodology

In Italy the so-called Basaglia Law (Law n. 833/1978) reformed the provision of psychiatric care, closing down asylums and gradually replacing them with community-based services. Within such a system, hospitalization is carried out only for acute crises and

short periods of time. The so-called "Servizi Psichiatrici di Diagnosi e Cura" (SPDCs) are diagnostic and treatment wards, situated within general hospitals and hosting a maximum of 16 inpatients, admitted either voluntarily or compulsorily.

This work discusses the results of an ethnographic study conducted within Piedmont's SPDCs between 2019 and 2020. The original research, entitled "Psychiatric interventions. About TSO and mechanical restraint," was a multidisciplinary study, comprising clinical, sociological and juridical perspectives, focused on involuntary treatment and the use of mechanical restraint in acute psychiatric wards. The research was a multicenter, retrospective and prospective study combining quantitative (to study the clinical and sociodemographic profile of those subjected to the practices under scrutiny) and qualitative research (to investigate the organizational and cultural features of these phenomena). After a rapid ethnography of all Piedmont's psychiatric units, six SPDCs were selected according to the most-different-cases design (Cardano, 2020): three contexts that seemed to normalize mechanical restraint, and three which were trying to reduce or abandon the use of this measure. In these six units, a multi-sited team ethnography was conducted along with a parallel interdisciplinary discussion between ethnographers and medical and legal experts (Cardano et al., 2020).[2] The study has been approved by the Ethics Committees of the hospitals involved.

For the present contribution we focus on a subgroup of two cases, fictitiously called the Yellow Ward and the Blue Ward, located in two different Piedmontese provinces, where we conducted our observation. The Yellow Ward employs mechanical restraint on a regular basis: we observed several, and sometimes simultaneous, cases of people restrained by mechanical means because of their actual—but sometimes potential, expected because of substance abuse or reputation—aggressive behavior, agitation, night wandering, or non-compliance (e.g. attempts to leave the ward despite being under compulsory treatment). On the contrary, the Blue Ward was trying to implement different strategies to avoid this coercive measure, with some tensions concerning this ideological and organizational change in the approach to critical situations: the same conduct that led to mechanical restraint in the Yellow Ward as well as in other psychiatric units were managed here by means of dialog, de-escalation techniques and pharmacological means. Despite their radically different approach to "crisis," the two wards are very alike in terms of bed capacity (16 beds), staff composition (psychiatrists, nurses and healthcare assistants,[3] all involved in the three shifts when feasible), heterogeneity of the admitted population (people with a psychiatric diagnosis as well as alcohol or substance abusers, people with behavioral issues due to organic conditions, elderly people, but also "social cases" and overtly criminal conducts), and door policy (ward doors were kept permanently locked by night and day). Our methodological choice is consistent with the fact that definitional processes and boundary work are particularly well suited to exploration in comparative ethnography, contrasting contexts that—despite their structural and organizational commonalities and geographical proximity—provide different answers to the problem of demarcation between acceptable and unacceptable practices.

The empirical material that forms the basis of our analysis consists of fieldnotes and transcriptions of 31 (15 in the Blue Ward and 16 in the Yellow Ward) discursive interviews conducted with mental health professionals by the authors between 2019 and

2020. The textual material has been analyzed according to the principles of template analysis (King, 2012), combining codes derived from theory and those emerging from data, with the aid of the CAQDAS NVivo. Such analysis allowed us to identify two main dimensions of boundary-making by doing gender, both discursively and enacted. The first refers to the construction of inter-gender boundaries, overlapping the binary distinction between masculinity and femininity to a more coercive or relational-dialogic approach to crisis. A second dimension concerns intra-gender boundaries, namely distinguishing and ranking different masculinities and femininities: criticism of a less coercive orientation is associated with a devirilized masculinity, too soft and out-of-place in a context—, the psychiatric ward—seen as requiring a more "muscular" approach.

"Three grown men on duty": constructing inter-gender boundaries

Coercion is acknowledged as an intrinsic, and usually implicit, trait of psychiatric practice. The plurality of definitions provided by extant research and literature on this topic encourages a situated approach to the phenomenon, which we choose to investigate in its situated occurrences. A key feature of coercive practices is constituted by the way in which actors involved in their performance define coercion and the "critical situations" that it should respond to.

In the management of critical situations and in the consideration of the possible use of coercion, several factors come into play, including the status of the actors involved and their reputation within the psychiatric unit. This has emerged particularly in the interaction between health care staff and inpatients: the combination of the characteristics of the former and the latter—partly due to previous encounters, such as repeated hospitalization—play a crucial role in the evolution of the situation and a potential resorting to coercive methods. Gender is one of the features contributing to the construction of such a reputation and to the shaping of specific expectations.

In particular, within this section we focus on the definition and performance of inter-gender boundaries and hierarchies, namely the construction of differences between masculinities and femininities as a way to account for the legitimacy of more or less coercive approaches. As we shall show, we found many instances of an essentialistic and deterministic (Rimke, 2018) gendered division of psychiatric practices entailing a muscularization and masculinization of coercive interventions as opposed to a femininization of relational and dialogic care.

The relevance of these boundaries emerged from the narratives provided by the interviewed staff as well as from fieldnotes concerning the organization of shifts. A belief rooted in both the Yellow and Blue Ward is that, especially for the night shift, having male staff on duty lowers the risk of critical situations and guarantees proper and safe management of them should they escalate into more challenging (i.e. violent) forms. The pivotal role of male nursing staff emerges clearly from the words of Giulio, a nurse working in the Blue Ward, who states: «When you are on duty with a woman, you are practically alone». The following excerpt from the interview with the nurse Ada is eloquent in this respect.

Ada (nurse), Blue Ward: If the staff were mainly with males, yes . . . because the patients . . . not the hospitalized "lassies," but the hospitalized males . . . facing someone who is a big bull . . . who has a power . . . or our colleague who is absent because of injury, he is under five feet-nine, but by his approach, the way he speaks,. . . you feel calm during his shift because he has a way of . . . "Enough is enough." They [patients] are like little children, they listen to you like puppies.

In this excerpt, a series of interesting elements emerges. On the one hand, the interviewee's colleague is described by stereotypically masculine characteristics—authority, determination, self-confidence—even in the absence of other typical features related to physical appearance (height and muscularity, well represented by the metaphor «big bull»). On the other hand, a double feminization is performed: female inpatients are infantilized as little girls («lassies»), while male inpatients are diminished and compared to «children» or «puppies». Both inpatients and female staff are discursively constructed, in a deterministic view, as protected by the paternalistic presence of the male nurse. To corroborate this vision, we also quote from fieldnotes the description of Salvatore, a male nurse with high seniority and prolonged experience in post-asylum wards (SPDCs opened right after the psychiatric reform in 1978, which in some cases reproduced practices that were typical of the asylums they were meant to improve upon), who portrays himself as being always «ready for action», someone who does not shrink from physical intervention when needed.

Fieldnotes, Blue Ward: [Salvatore] also says that when it is necessary to be tough he can be tough, and if force has to be used he does not avoid it. He says that the modality of [critical situations'] management depends on the doctor but also on the nurses on duty: when there are more men on duty, patients are more intimidated, while with women they take more chances.

Another excerpt from fieldnotes quotes the textual words of Ciro, a very aggressive patient who addresses the female psychiatrist on duty peremptorily, stating that he spares her only because she is a woman and she is a «pussy», thus sexualizing and objectifying her.

Fieldnotes, Blue Ward: Ciro tells the [female] doctor that he is holding himself back only because "You are a woman and a pussy; otherwise I would have slapped the shit out of you."

A similar framing was noticed in the Yellow Ward, where the presence of male staff on duty was often the main feature considered when deciding upon the initiation or removal of mechanical restraint. The following excerpts refer to the emblematic case of a man in his sixties, Valerio, who has a dual diagnosis (personality disorder and alcohol addiction) and has been hospitalized because of an «alcohol-induced psychosis». When he is admitted to the ward, he is described as agitated, delusional and under the effect of excessive alcohol consumption, and he is immediately mechanically restrained. The day after his arrival restraints are removed for a few hours but his behavior, which has been described to the researcher as «unpredictable» and «verbally aggressive», accompanied by persistent delusions, led the staff to restrain him again for three more days. On day

number four, as can be read in the following excerpt from fieldnotes, an attempt to remove restraints was again considered during a turnover between shifts.

Fieldnotes, Yellow Ward: Luca [nurse] asks his colleagues if they agree to try to interrupt Valerio's restraint. They all agree, and Fabio confidently adds: "We are three grown men [on duty]."

The number of days that the man spent under restraint and, more importantly, the gender composition of the shift, three male nurses and one female, led the staff to agree with Luca's proposal of trying to interrupt restraint for a few hours. The relative degree of confidence that emerges from the quotation above seems closely related to the fact that «three grown men» are on duty, and that they can easily and safely intervene should they believe that Valerio needs to be restrained again. The relevance of male presence in decisions about coercive measures implying a degree of risk for the ward is also evident in the case of another meeting, in which the staff refuses to take that risk because of the female composition of the shift.

Fieldnotes, Yellow Ward: After a brief summary of the morning's events, Nina [nurse] says that in the afternoon they could try removing Valerio's restraints. The reaction of her colleagues is immediate: Livia gives her the middle finger, while the others ironically exclaim "Yes, of course!." Livia adds: ". . . Since they didn't untie him yesterday when the nurses on duty were all men."

Interestingly enough, the role played by male members of the staff in instilling some confidence in postponing coercive intervention is also acknowledged by psychiatrists, the medical figures deciding about the initiation or removal of mechanical restraint. In the following excerpt, psychiatrist Piera described to me the episode of a female patient who began punching and kicking doors and walls within the ward, but she is not restrained for a number of reasons: not only is she compliant with medical prescription by accepting the administration of intramuscular medication, but she is also a woman (a characteristic that, in the essentialistic view of Piera, seems to be less threatening per se),[4] and the majority of the staff on duty (three out of four) is male. This combination of features, together with the fact that the woman is not violent toward people but only toward the material environment allows the doctor to avoid resorting to mechanical restraint, or at least to postpone it, because the predominantly male shift should «make them all feel safer».

Piera (psychiatrist), Yellow Ward: She started kicking, kicking doors and walls . . . not people, even though she was a little aggressive. However she did not lay a hand either on me or on nurses. Besides, last night there were three men and one [female] OSS on duty, so I want to say also from this point of view they should have felt safer . . . specifically, [the patient] was a woman, not a man, so I told them to administer injective therapy, and the patient accepted it without making a fuss. Then she continued to punch, and immediately they asked me: "Can we restrain her?." I spent some time thinking about it and then I replied, I said: "Well, she has just had the injection, as we know, if these vials, these two vials which we injected should not have a positive effect within half an hour, you can think of restraining her later, but at the moment there are four of you, including three men." "Since she has not broken anyone's face" – I said – "it seems premature to me to make this decision". Then I left because it was almost 8 pm, the end of the shift, and even afterwards she was not restrained.

In addition to the ward's male staff members, psychiatric units can count on external forces such as hospital security guards and police officers, who can be asked to intervene as "enforcers" (Morrison, 1990) in particularly critical situations. More often than not, their involvement consists in a symbolic use of force (Gariglio, 2018) that the staff attribute to the uniform that they wear and to the implicit threat that they represent (mostly due to their arms, a generally unloaded holstered pistol). The de-escalation process that can result from their uniformed presence in the ward is evident in the words of nurse Ada quoted below:

> *Ada (nurse), Blue Ward: We had already had another patient, hospital guards were called. . . He was next to me, he didn't expect the guard to come. . . he [the guard] took him by the shoulders, like this, and said to him: "This nurse here [Ada] is my wife!," "Ah!". . . Since then. . . [I have become] his best friend. [. . .] Many [of the inpatients] cannot tell whether the guard is an internal [hospital] guard or a police officer, or military police: the uniform in itself already gives a sense of power, and then they cool down.*

In the situation described, the hospital guard is called to calm down an aggressive patient and his very appearance induces a de-escalation process. An additional, distinctive aspect of this episode is that the guard introduces himself, pretending to be the nurse's husband, which seems to produce a protective shield accompanying the woman well beyond the presence of the guard in the ward. The typical element of symbolic use of force, namely the theatricality of the uniform and its accessories, exercises a deterrent effect on patients, here reinforced by the fictitious identification of the guard with a protective patriarchal role.

The empirical material quoted and commented upon above allows us to highlight how inter-gender boundaries and hierarchies are mobilized and performed in both cases following similar patterns despite their different organizational logic and cultural orientation. In the Yellow Ward, male presence is directly related to the application and management of mechanical restraint: the measure is more likely to be postponed (while waiting to see if de-escalation strategies work) or temporarily suspended (to see whether a patient is "ready" to have restrictions removed) if male healthcare workers are on duty because their presence guarantees the possibility of prompt intervention should the situation deteriorate. In the Blue Ward, where mechanical restraint is not an option, male staff is preferred as a presence deterring inpatients from aggressive or otherwise problematic behavior. Moreover, external actors can be involved in the management of difficult situations according to the same logic that privileges muscular and symbolically threatening figures: this is the case of police or security forces called to intervene as enforcers within the ward to threaten or use force (Gariglio, 2018). Psychiatric care appears to reproduce a marked gendered division of labor which has naturalized, in an essentialistic perspective, both physical (the muscular man, the weak woman) and psychological (the assertive man, the dialogical woman) characteristics. Only in a small portion of cases is this frame challenged, as homosocial dynamics between men (e.g. a male inpatient and a male nurse) are associated with a sense of provocation that renders male presence counter-productive.[5]

"This is a real doctor!" Drawing intra-gender boundaries and hierarchies

A second dimension concerns intra-gender boundaries and hierarchies, namely distinguishing and ranking different masculinities and femininities: we observed processes of emasculation of relational care performed by professionals (e.g. a male chief psychiatrist with a dialogical approach to crisis stigmatized as performing too soft masculinity, mocked as homosexual) and services (extended connotation of the whole ward as "feminized"). On the contrary, health professionals and the ward itself can be self-represented as "macho" because of the reference to practices of hegemonic masculinity in the management of patients' everyday lives and acute crises.

The construction of the definition of critical situation and of the legitimacy or not of recourse to forms of coercion such as mechanical restraint turns out to be strongly linked to another dimension of the genderization of work in psychiatry: the differentiation and hierarchization of forms of masculinity and femininity. Here we can recall a consistent literature about practices of hegemonic masculinity, machismo and virilism in total institutions such as prison (Gariglio, 2018) or psychiatric hospital/wards (Holmes et al., 2016 **[AQ: 3]**) in which control is exercised over all aspects of patients' existence.

Hegemonic masculinity is defined as «the pattern of practice (i.e. things done, not just a set of role expectations or an identity) that allowed men's dominance over women to continue» (Connell and Messerschmidt, 2005: 832). It is distinguished not only from practices associated with femininity, but also from those practices that configure subordinate forms of masculinity which do not adhere to normative standards.

In the case of practices and discourses related to the most appropriate ways of managing critical situations, between dialogic and more coercive approaches, reference to hierarchies and inadequate forms of masculinity is often mobilized, which is the corollary of improper ways of managing acute situations. In this essentialistic perspective, there is a preference for staff members who best represent stereotypical qualities of the gender they belong to, such as young, tall, muscular men (hierarchically superior to older male colleagues, thin or less threatening, even in behavior), and thin, quiet, pretty (unthreatening) women. In this way, characteristics and practices expressing more gender conformity find greater recognition, favoring gender-typical (preferred) over gender-atypical (less preferred) subjects for both genders.

In the Yellow Ward, the forms of hierarchization of masculinity remain on a more tacit, implicit level, as emerges from these fieldnotes in which the masculinity of the doctor is in fact denied, or invisibilized, because of his age, now close to retirement: since it is necessary to transfer a patient for examinations to another area of the hospital, and there is the fear that he might try to escape, it is suggested that he be accompanied by a tall, muscular nurse.

> *Fieldnotes, Yellow Ward: They then inquire as to which operator is more appropriate to accompany him. Roberta [nursing coordinator] mentions the name of Dario [nurse], who immediately replies: "I can't [leave the ward] because I am the only man." In front of the doctor, Roberta exclaims: "Dr. P. is a man!."*

Similarly, a natural heterosexuality is staged that makes one potentially always ready to seize the opportunity, even if professionally rejected, which attributes the exercise of sexuality a therapeutic power comparable with, if not greater than, that of an anxiolytic drug.

Luca (nurse), Yellow Ward: It happened to me two or three times that they [female patients] really made advances, but clearly. . . you know, it is not that we are ascetics or anything, you know! If a fifty-year-old woman does it, and she's ugly, you say "I can resist," but if a young woman does it [laughing] [. . .] then I think, /I don't know if I'm wrong/ [whispering], that a healthy fuck /is much more anxiolytic/ [laughing] than a vial of delorazepam.

In the case of the Blue Ward, some nurses represent themselves, and are recognized, as the expression of a dominant masculinity which, as already highlighted above, guarantees order and safety not only through the possession of physical characteristics, but also of a determination and ability to face risks. This is witnessed by the return to service of the nurse Salvatore after an injury sustained while restraining a most aggressive patient:

Fieldnotes, Blue Ward: Two male nurses arrive at the same time. One of them is Salvatore, who appears as a leader;, recognized as an alpha male, he jokes by saying that he is the only man in the ward, that the others are only half men.

In a conversation during the lunch break, Salvatore endorses the muscular representation of the male chief psychiatrist of another ward provided by a new male colleague, openly opposing the dialogical attitude ("reasoning with everybody, even with junkies") of local doctors:

Fieldnotes, Blue Ward: Alex recounts that the previous head physician of another Piedmontese SPDC, when he learned that someone had insulted a woman, would call him in for a meeting, stare at him and then, when the patient started to say something, he would slap him and say "It won't happen again. This meeting is now over." Thus there were no recurrences and everyone respected the rules. Alex adds: "When Dr. T was in the ward, you could hear a pin drop." Salvatore comments: "This is a real doctor," and praises his method, criticizing instead the work of the doctors in Blue Ward who pretend to "reason" with all patients, even with drug addicts.

In the light of this display of machismo, the head physician in the Blue Ward is the object of jokes with a sexual connotation which cast doubt on his masculinity by insinuating that he is homosexual. This emerges in the insults of some patients which, however, are the background to the conspiratorial laughter of the nurses on duty.

Fieldnotes, Blue Ward: A patient keeps complaining, insulting the chief doctor by saying he's been giving blow-jobs to everybody to make a career. Nurses laugh.

In the interview with the head psychiatrist, he himself recalls words spoken to him by a nurse who did not recognize in him the temperament necessary to work in a psychiatric ward: an attitude that can be associated with authority, toughness, decision-making

ability, determination, military spirit, all of which related to hegemonic masculinity. In contrast, "talking too much" and "being gentle" are interpreted as weakness and subordination, essentialistically excluded from "real men." The possibility of caring (Elliott, 2016) and hybrid masculinities (Bridges and Pascoe, 2014), including elements of sensitivity (e.g. being welcoming, talkative, actively listening), conventionally attributed to women, emerges as a means to convey a different embodied vision of psychiatry[6] which is contrasted by some of the staff, as a signal of devirilization, in terms of inability to guarantee social order in the ward and safety for the personnel on duty.

> *Tommaso (head psychiatrist), Blue Ward: I remember that. . . at that time, when I was still in SPDC, a nurse told me that I was a community [psychiatrist], right? He said it half-joking, as if to say: "You don't belong to the SPDC, which has its own way of working. You are too . . . too good, too soft, for these situations. . . It works in the community, where there is no real psychiatry; real psychiatry is the one practiced on the ward, where you must have . . . [he smiles], you have to be very tough, very determined, able to see the worst and face the worst, [he sighs] and you're not cut out for that, you're the one who goes there and . . . talks. [. . .] I don't think psychiatry is that of the SPDC where the iron fist is needed . . . military-like, prison-like rules, but there is something else, and I was convinced that even in SPDC you could work differently.*

A case of mechanical restraint may represent the arena in which to confront the different discourses and related processes of genderization. The patient is Mario, a young man of 20, an ex-athlete with a sculpted muscular body, in hospital for the second time for a suspected suicidal attempt. After expressing growing impatience about his admission, in the late afternoon, the boy starts hurling himself against the door to try to get out and then running through the corridors from one point to another of the ward looking for a means of escape, trying to break through windows and doors. Finally, the boy barricades himself in the room, throwing objects and brandishing them threateningly. At first the hospital guard was called, then the military police were asked to intervene and finally the boy was restrained with difficulty so that sedative drug therapy could be administered. The head psychiatrist, who was at the end of his shift, and therefore actively participated in authorizing the intervention, recounts that he reflected at length on the events because restraint can jeopardize the therapeutic relationship that was being built. He also stresses that he tried to negotiate but that the level of aggression toward him and objects did not allow the relational approach. He admits, however, that he also wondered if, with other resources, perhaps with a larger number of staff on duty, it would have been possible to operate without restraint and perhaps delegate someone from the staff to work alongside the agitated patient.

The point of view of the nurses involved in the scene, Carla and Salvatore, is different. The turnover provided an opportunity to discuss the episode: Carla recounted the afternoon events, going into detail about the escalation of Mario's aggression and his restraint, and initiating a debate about the episode among those present.

> *Fieldnotes, Blue Ward: Carla reiterates that it was an episode of incredible aggressiveness, with a crazy escalation: she lets herself go with a few jokes to play down, saying that from now on she will call him "Fury" [someone calls him "Hulk," Salvatore says "he has Balotelli's*

physique"], emphasizing the fact that the patient embodies the characteristics of hegemonic masculinity (young, muscular, strong, aggressive). Salvatore comments very critically on Dr Tommaso's work, saying that he does not at all agree with his way of managing critical situations such as this one, and that he has directly mentioned it out to him. The topic of the dispute is whether the doctor "talks too much," over-privileging the relationship and delaying intervention. Regarding Mario's episode, he says "I stood next to the doctor and asked him "Doc, how long do we wait before tying him up?"", indicating that from his point of view it would be necessary to intervene before the patient reached such a high level of aggression that he would tore the place apart.

Here there is a clear divergence of views on how to manage crisis: on the one hand, a model focused on dialog and support designed to avoid coercive intervention; on the other hand, timely restraint that could have somehow prevented the aggressive, destructive escalation which subsequently took place. In this divergence of approaches, the dimension of the construction of intra-gender hierarchies emerges overwhelmingly. In the words of nurse Salvatore, the attempt to deal with the patient spiraling out of control with words is interpreted as an inexperienced, weak, preacher-like attitude, exemplified by Jesus Christ's non-violent "turn the other cheek" approach compared with the more macho "eye for an eye" approach. The doctor consequently deserves to be beaten back to the reality of a gender order where masculinity is expressed by toughness.

Fieldnotes, Blue Ward: Even the nurse who was present at the scene reiterates that they stood back, and that he did not endanger himself for "Jesus Christ" [so he ironically calls the head doctor, probably referring to both his physical appearance and "holier than thou" attitude]. And he adds: "He deserves to have his face slapped."

A further interesting aspect is that the gender-stereotyped qualities are naturalized and extended to the entire ward, thus the Blue Ward is "feminized" (as a psychiatrist states during the interview) and negatively connoted because it deviates from the image of classical psychiatry, the "real" psychiatry that is practiced in the SPDC (as first reported by the head physician in his recollection of the nurse's words), while the Yellow Ward appears more in line with the image of the "hard" ward symbolized by the above-mentioned «three grown men».

Conclusions

Through the analysis of two case-studies, the article demonstrates how contemporary psychiatric practices involve both coercion and dialog, interpreted not as binary categories but as poles of a continuum.

Following the research stream which abandoned clear-cut classifications, exploring the concrete ways in which coercion is performed in everyday clinical practice, we focused our attention on the "boundary work" (Gieryn, 1983) making distinctions and providing legitimation to contextual enactments of coercion and care. More specifically, we investigated how genderization, through the mechanisms of essentialism and

determinism (Rimke, 2018), emerges as a key process in attributing meaning to professional identities and everyday cure and care practices, in order to define and justify the different approaches to psychiatric crises.

Two main dimensions of making gendered boundaries emerged from the analysis.

The first entails the construction of inter-gender boundaries: the enactment of a full masculinity is associated with a more coercive approach and with the symbolic or credible use of force (Gariglio, 2018), while the adoption of a relational-dialogic approach is conventionally considered an expression of femininity. The second dimension refers to intra-gender boundaries, namely the internal distinction and hierarchies among different masculinities and femininities: the adoption of a more dialogic and relational orientation in male psychiatric professionals is stigmatized as an expression of devirilized masculinity.

One of the most relevant findings that emerged from our analysis is the widespread tendency to essentialize empathic and dialogic aspects of care, defined as "maternal" and feminine. Often, these characteristics are not recognized as professional skills, but rather as personal traits that can prove to be functional in the management of specific critical situations (e.g. a bipolar patient in a manic phase, with whom a small female nurse can interact better, being capable of adopting a "softer" approach). This essentialization process is thus conveyed by the taken-for-grantedness of the association between femininity and care.

On the contrary, discourses and practices regarding the work of male professionals are more explicitly focused on a gendered dimension, both in reaffirming hegemonic models of masculinity and in distancing from possible alternative models considered as forms of inadequate masculinity.

In the words of many participants, the psychiatric ward—in its specific mandate to manage acute situations—seems to be a particularly unsuitable context for the expression of "caring masculinities" (Elliott, 2016), which become the object of devaluation and derision through their devirilization. This is achieved through jokes, sometimes with a homophobic background, comparisons with expressions conforming to hegemonic masculinity practices, and forms of verbal and enacted dissent.

Gendering processes show their situated nature in both the contexts analyzed. In the Yellow Ward, they are evident in the choices related to the initiation and removal of restraint in consideration of the gender composition of the staff on duty. In the case of the Blue Ward, where an organizational and cultural transition toward a less coercive model is ongoing, resistance to change is also expressed through the mobilization of gender with the aim of reaffirming the greater effectiveness of locally consolidated practices by devaluing more innovative ones, and of delegitimizing the authority and competence of the head psychiatrist through his devirilization. In both contexts, the consolidation of hybrid forms of masculinity, capable of welcoming a relational approach to care work, finds little or no space, especially in the case of apical professional positions that represent the whole ward.

Further research in this direction might illuminate gendering processes that have inpatients as their protagonists, and that overlap with other dimensions involved in the definition of boundaries and hierarchies—such as ethnicity and age—thus exploring psychiatric practice through an intersectional lens.

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Notes

1. Rimke defines psychocentrism as "the dominant view that pathologies are intrinsic to the person, promoting a hyper-individualistic perspective at the expense of understanding social, political, economic, historical, and cultural forces that shape human experience" (Rimke, 2018: 17).
2. The composition of the qualitative group will be specified after the blind review process.
3. In Italy healthcare assistants (OSS), involved mainly in more bodily chores in patients' care, do not require a university degree. However, in psychiatric work, the professional boundaries between OSS and nurses are described as more blurred since nursing practice in mental health care is less technical and more relational.
4. This episode exemplifies the belief that men are more dangerous than women, a genderization process that plays a role in the decision to resort to coercive measures (cfr. Pilgrim, 2012).
5. Again, minor examples of reversed logic can be found in both the Yellow and the Blue Wards, as the following quotations underline: "*It is unlikely that anyone will attack me because I'm female and young. . . For a man it can be more risky because men usually fight with men*." [Claudia, nurse, Blue Ward]. "*Sometimes it happens that, I don't know, we have a patient who is basically hysterical, a woman, hysterical and borderline. . . she immediately competes with another woman. So, if you approach her, and maybe on that day you look pretty and you're all made up, you immediately piss her off: it is better to send a pleasant [male] colleague instead! The same is true for men: if a bipolar man in a manic phase – very agitated and somewhat aggressive – arrives in the ward and a large tall [male] colleague approaches him, there is nothing more to be done. It's like saying: "Let's fight it out right now and see who is more aggressive". If, on the other hand, you send a (perhaps calm and petite) woman, it definitely works better*" [Livia, nurse, Yellow Ward].
6. In the interview, the chief psychiatrist recalls the character of another male nurse, a source of inspiration and training in this alternative approach: "*In the management of psychiatric crises, [. . .] there is the one who ties you to the bed and administers double or triple medication*

[. . .] and there is the one who starts a relational approach even with the most acute patient. I remember that there was one nurse in particular . . . Gennaro, because for me he is a [he smiles] a point of reference . . . and when he was on duty I knew that anything could happen but we would never have lost control of the situation because we would have been able to find, even in difficult times, a way to treat, to manage the agitation crisis, to manage a hospitalized patient, even under compulsory treatment."

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