



On the persistence of coercive practices in dementia treatment. When plans, spaces, and discourses matter

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Original

On the persistence of coercive practices in dementia treatment. When plans, spaces, and discourses matter / Miele, F.. - In: RASSEGNA ITALIANA DI SOCIOLOGIA. - ISSN 0486-0349. - STAMPA. - 63:4(2022), pp. 853-877. [10.1423/106247]

Availability:

This version is available at: 11368/3039742 since: 2023-02-07T12:43:20Z

Publisher:

Published

DOI:10.1423/106247

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On the persistence of coercive practices in dementia treatment

When plans, spaces, and discourses matter

by FRANCESCO MIELE

1. *Introduction*

Adopting a sociological perspective, madness can be defined as «any set of ideas or actions that is unacceptable or incomprehensible in terms of traditional social norms» (Wing 2017, 2). Consequently, it is a condition not objective neither immutable but it is socially and culturally constructed. Certain behaviors that would pass unnoticed in some cultural contexts are labeled as problematic in Western societies, and their causes are investigated using a range of spiritual, biological, social, and psychological explanations that can change over time (Dunlop 1988). Even the practices aimed at treating madness are not immutable: if segregation politics have characterized the management of people with unacceptable or incomprehensible behaviors for a long time, more recently, social movements (of which the most well-known is probably the anti-psychiatry one) have denounced the inhumane conditions experienced by people labeled as «mad» in total institutions, leading to the closure of old asylums. A particular criticism has been addressed to the use of *mechanical* and *anesthesiological* restraints¹ (Cardano, Gariglio 2020), aimed at limiting disruptive behaviors using body restraints and sedation, respectively.

Nevertheless, coercion is still widely used in modern facilities dedicated to «mad people». This work aims to explore the reasons behind this persistence, presenting the results coming

¹ According to Cardano and Gariglio (2020), the term «mechanical restraints» describes the use of physical contention for limiting the movements of «mad people» (the most well-known is the straitjacket). Meanwhile, the term anesthesiological restraints is adopted for conceptualizing the use of sedatives with the same aim.

from an ethnographic study conducted in two long-term care facilities dedicated to people with dementia. With this aim, I adopt a practice-based approach grounded on the theoretical and empirical reflections belonging to the so-called «practice turn» (as labeled in Schatzki *et al.* 2001) that took place in organization studies between 90s and early 2000s. In doing so, I use a theoretical lens that differs from the classical sociological approaches concerned with the social causes of coercive detention (i.e., social factors, such as social class or gender, that are the best predictor of institutionalization) or on the *labeling* processes connected to this latter (i.e., the processes through which some people are labeled as «mad,» permanently undermining their credibility; Pilgrim 2016).

The paper is organized as follows: in the next section, I explain why dementia can be considered a kind of madness. Subsequently, I present my theoretical framework and the methodological details of the empirical research. The core of the paper focuses on the three elements that seem to play a key role in favoring the persistence of coercive practices: plans of action, physical spaces, and discursive practices. As usual, the final section is dedicated to concluding remarks.

2. Three good reasons for framing dementia as a form of madness

Although dementia is no longer considered a mental illness, there are at least three specific reasons for which dementia can be framed as a form of madness.

The first is the persistent bond between dementia and psychiatry, the branch of medicine aimed at categorizing the different forms of madness and indicating correspondent clinical treatments. In 1797, Philippe Pinel, often considered one of the founders of modern psychiatry, classified dementia as a mental disorder, laying the basis for the wide institutionalization process of people with dementia that took place during the nineteenth century in several western countries. At the beginning of the twentieth century, dementia has made a transition from a mental issue to a group of neurological diseases, among which Alzheimer's disease is undoubtedly the most studied and diagnosed. Nevertheless, even today, dementia is included in the Diagnostic and Statistical Manual of Mental Disorders, being considered a condition with

several psychiatric symptoms (the most typical are wandering, biting, agitation, delirium, and physical attacks) disruptive for the community and hardly manageable at home. Here, I prefer the term «challenging behaviors» (Ooi *et al.* 2018) to that of «symptoms», leading attention to the ways through which social actors interpret and manage these apparently incomprehensible ways of action.

Second, dementia can be defined as a kind of madness because of its deep interconnection with the above-mentioned segregation politics. People with dementia were involved in this process at the end of the eighteenth century. From this moment on, workhouses, asylums, and, subsequently, psychiatric wards and long-term care facilities have become, for them, «the most convenient place to get rid of inconvenient people» (Scull 1980). In countries such as Italy (Tatarelli *et al.* 2011) and the US (Ballenger 2017), during the first part of the twentieth century, people with dementia filled psychiatric wards, which led to complaints of some psychiatrists that the care settings and methods traditionally adopted for mental disorders were useless for dementia. Nevertheless, people with dementia continued to be involved in coercive practices totally similar to those used for the behaviors of psychiatric patients.

The last reason for which dementia can be framed as a kind of madness is specular to the second one: in parallel with the criticisms that have arisen against the conditions of psychiatric patients, from the late 70s of the last century, the so-called *culture change movement*² (composed by relatives, patients, clinicians, psychologists, researchers, and other kinds of professional figures; Koren 2010) publicly denounced the negative effects of physical coercion (e.g., loss of mobility) and of the overuse of medications (e.g., side effects that overcome their benefits) on people with dementia. This movement criticized two cultural assumptions that have certainly favored the spreading of coercive practice: the *depoliticization* of challenging behaviors, represented as a direct emanation of brain damages (Wigg 2010); and *hypercognitivism*, an assumption for which the self of an indi-

² In Italy, this movement is well-represented by patient advocacy organizations, such as *Federazione Alzheimer Italia* and *Associazione Italiana Malattia di Alzheimer*, and by practitioners, such as Ivo Cilesi, that, for a long time, has implemented and promoted the use of the doll therapy (cf. the 5.1. section of this paper) for the management of challenging behaviors.

vidual gets lost along with his/her cognitive skills. Despite these cultural constructs, several studies have shown how challenging behaviors are stimulated or exacerbated by unsuitable care settings (e.g., noisy environments or lack of stimulating activities; Kitwood 1990). Furthermore, patients with advanced dementia still have manifestations of their identities, values, and beliefs (Sabat, Harré 1992). The contestation of *depoliticization* and *hypercognitivism* has led to the emergence of alternative practices aimed at reducing the challenging behaviors without coercion: the modification of the spaces to leave free the residents with dementia, safeguarding their own safety and the safety of fellow patients and staff (e.g., closing access to spaces external to the facility), the personalization of the scheduling of care activity on the basis of the moods of residents (e.g., postponing personal care activities if the patient is aggressive), and the adoption of non-pharmacological therapies (e.g., manual activities addressed to reduce the crisis).

For these reasons, dementia can be used as a relevant case study useful to explore the processes through which coercive practices, although they have been increasingly delegitimated in clinical and scientific communities, persist in organizations dedicated to people labeled as «mad».

3. *How do social practices persist in organizational contexts? Theoretical insights from practice-based studies*

Providing a detailed and exhaustive analysis of the sociological debate concerning social practices in organizations is not one of the goals of this paper (to have a complete map of this, refer to Corradi *et al.* 2010; Nicolini, Monteiro 2017; Gherardi, Miele 2018). Nevertheless, it is necessary to provide a definition of social practice and to define my position in this heterogeneous strand of studies.

In line with the family resemblances spotted by Nicolini and Monteiro in practice-based approaches (2017, 112-115), social practices are generally conceptualized by organizational scholars as long-standing phenomena that hold a number of sub-components (i.e., smaller units of activity), organized around an end or object, exist in configurations (i.e., each practice is interconnected with other practices), have a collective and normative nature, hold

a history, and are situated in a particular moment in time and space. This latter aspect is particularly important for the aims of the paper, given that «practices are not sporadic events as they entail an element of duration and perpetuation (which is different from identical “repetition”)» (Nicolini, Monteiro 2017, 5). These regimes of activity are kept alive by reiterated performances, by the socialization of newcomers, and by shared norms that empower certain courses of action over others. Under this perspective, practices are continuously refined in a «répétition sans répétition» (repetition without repetition, see: Béguin, Clot 2004), in a constant re-elaboration of their ways of executions (Gherardi 2009) and of their meanings (Nicolini 2007), being daily readapted to the changeable social and material conditions (Bruni 2011).

The research approach taken in this paper can be defined as situational that is aimed at understanding «how practices are actually accomplished, extended in time, and reiterated through doings, saying, bodily skills, and the mediation of artifacts, objects, and spaces» (Nicolini, Monteiro 2017, 121). In an organizational debate, the persistence of recurrent patterns of action has been explained as a way of eliminating search and simplifying choice among alternatives (March, Simon 1958) or suppressing deliberation even when it would be desirable (Staw *et al.* 1981; Gersick, Hackman 1990). Practice-based approaches have shifted from the search for the motivations that push actors toward common ways of doing to the exploration of the processual elements that, in certain organizational settings, favor this convergence. The fieldwork at the basis of this paper has underlined how three specific elements play a key role in the persistence of coercive practices.

The first is the existence of plans of action, generally inscribed in artifacts (e.g., organograms, models, guidelines, and protocols) that orient actors in the accomplishment of their work (Nicolini, Monteiro 2017, 114). Plans, instead of determining actions casually, can be considered resources for everyday action. Suchman (1987) distinguished maps and scripts (see also Schmidt 1997), in which maps are less detailed plans that do not aspire to control actions but rather offer a general orientation purpose (this is the case, for example, of a checklist with a sequence of tasks that need to be done in a specific order); in contrast, scripts not only describe an appropriate sequence of events, but

they try to allocate them in a specific context (see, for example, the production control protocol that should provide detailed instructions on how to initiate, coordinate, and conclude certain activities), offering «a limited selection of safe, secure, legal, valid, advisable, efficient or otherwise prescribed ‘moves’ while excluding ‘moves’ that generally would be considered unsafe» (Schmidt 1997, 144). Despite the differences, these concepts describe plans as resources for daily practices that establish constrictions, offer possibilities, and regulate interdependencies between actors. Following a practice approach, scholars should focus on the practices that arise around certain plans, paying attention to the interplay between reiteration (i.e., plans push practitioners to perpetuate certain units of activity) and innovation (i.e., plans are continuously reinterpreted, manipulated, and betrayed following the complexities that characterize daily life).

The second element that supports the persistence of social practices is physical space. From a practice-based perspective, spaces can be defined as «situational territories» (Goffman 1971; Suchman 1996), that is spatial arrangements that include architectures, bodies, and objects that shape daily social practices and, at the same time, are shaped by these latter. On the one hand, in an organizational context, «objects remind subjects of what they must do, prevent humans from doing things that may harm them, guide action according to intentions inscribed in their design, and make work and life comfortable, both materially and socially» (Gherardi 2008, 521). On the other hand, the enactment of social practices has become constitutive of working environments, transforming the spatial arrangements and the significance that characterize them. Practice-based studies, contributing to a wider strand of studies interested in exploring the role of spaces in contemporary organizations (Taylor, Spicer 2007; Halford 2008), avoid a certain kind of spatial determinism, where space is presented as something immobile and fixed that constrains action. A non-deterministic position on spaces is well represented by the study of Best and Hindmarsh (2019), which focused on the «spatial practices» enacted by tour guides and their audiences. The authors interpreted museums as workspaces in which the guide leads the audience on a path, including rooms and objects, which constitutes the landmark for the guided tour. In addition, the accomplishment of the tour would hardly be carried out without a continuous reconfiguration of the spaces

(e.g., the spatial orientation of the visitors is continuously changed by the guide, placing their bodies from room to room with the aim of continuing the tour). Hence, from this perspective, the persistence of social practices is allowed both by the proprieties of the workplace and by the possibility of reconfiguring it, modifying the spatial arrangements that hold together architectures, bodies, and objects included in a certain physical context.

A third element to be considered is the role of discursive practices. As well-known from the beginning of the practice-based turn, within the literature on the communities of practices (Orr 1996; Gherardi, Nicolini 2000), the verbal sharing of past experience is a vehicle for transmitting the rules and codes of conduct underlying a certain practice and showing novices what is legitimate and typical for an expert worker. Subsequently, practice scholars have looked for a wider theorization of the role of discourses in organizational life, framing them as a core part of «the sense-making process that supports the accountability of a shared way of doing things and which allows the continuous negotiation of the [...] meanings of a practice by its practitioners» (Corradi *et al.* 2010, 277). The notion of accountability was originally coined by Garfinkel (1967) as synonymous with «observable-reportable», referring to the propriety that has all usual activities in a certain society (i.e., they can be described, explained, understood, justified, and accepted). From a practice-based perspective, a stabilized way of doing things becomes a practice (or maintains such status) when it is comprehensible, both for its practitioners and for those who view it from outside. During the reproduction of a certain practice, practitioners keep it alive, refining its ways of execution and renegotiating the meanings associated with it (Yakhlef and Essén 2013), in a study concerning the provision of services for the elderly, showed how practitioners constantly renegotiate what it means to take care of others in a satisfactory way. At the end of the working day, experts and novices discuss their experiences, renegotiating the ways of executing a certain care practice and redefining the shared criteria that distinguish what is acceptable and what is unacceptable (e.g., in a short period of time, eating together with seniors to entice them to eat has shifted from being an unacceptable way of feeding the elderly to an acceptable one, as it is particularly effective).

4. Methodology

This paper draws upon a two-year ethnographic study in some long-term care facilities in northeast Italy. The private organization that managed these facilities contacted the Pa.S.T.I.S (Padova Science, Technology and Innovation Studies) research group of the University of Padua, to which I belong, asking for a sociological evaluation of the organizational change carried out by management with the ideation and implementation of the «New Path» project. The project consisted of the constitution of facilities dedicated to people with dementia and challenging behaviors, in which the adopted care approach was strongly inspired by the above-mentioned *cultural change movement*. The overall aim of socio-organizational evaluation in the New Path facilities was to understand if, in these facilities, the practices prescribed by this movement were adopted, giving life to care processes different from those that have characterized dementia care for a long time³. To understand if the New Path facilities had peculiar characteristics, I chose to include two facilities in the New Path project, comparing them with a «traditional» one. This paper focuses on the results gathered in the first two facilities, investigating the persistence of coercive practices, despite the adoption of a care approach hostile to them.

I gathered data mainly via four qualitative techniques:

- Participant observation (June 2019-February 2020), aimed at understanding the overall features of the facilities (organizational roles, routines and the ways through which they take place in the physical spaces).

- Shadowing (November 2019-February 2020), adopted with two care aides⁴ (one novice and one expert) for the facility. It was useful to reconstruct in detail the care practices addressed to people with dementia and the sense-making process through which they give meaning to their daily lives.

³ The socio-organisational evaluation aimed at: understanding the discrepancies and the convergencies between the planned changes and the ongoing ones; defining an emerging organisational model that describes how the considered facilities work in practice; reconstructing the barriers and the drivers that can prevent/support a full implementation of the principles of the cultural change movement.

⁴ This term refers to «operatori socio assistenziali», that can be translated in English as «social operators».

- Interviews with key informants (April 2019-June 2020), carried out with the founders of the New Path project (3), aimed at understanding its theoretical foundations and its key element.
- Ethnographic interviews with the staff (October 2019-December 2020). I interviewed 36 members of the staff, including care aides (21), managers, physiologists, educators, and nurses (three per category). The interviews tackled the following issues: the practices addressed to manage challenging behaviors associated with dementia, the use of mechanical and anesthesiologic restraints, knowing processes that take place among care aides and between these latter and other professional figures, Covid-19, and changes in the organization of work, and the perceived differences between New Path facilities and the other ones.

The combination of these techniques has been, in part, decided *ex ante* and, in part, when the study was already started, drawing on the well-known flexibility of qualitative research. One element that pushed me to recalibrate the design of my study was the inadequacy of participant observation for a complete analysis of the practices and the representations enacted by the staff. The facilities were characterized by the presence of places (e.g., the residents' rooms, spaced shared by the different facilities for recreational activities, meeting rooms only for some members of the staff, storage rooms used by care aides for making coffee breaks «away from prying eyes») from which, during the participant observation sessions, I was regularly excluded. Access to these spaces should have been asked each time to the members of the staff present at that time, a time-consuming strategy with uncertain results (depending on the availability, the hierarchical position, and on the personal opinion of the consulted professionals toward my research work). To overcome this problem, I renegotiated with my gatekeepers (the management of the facilities and the physiologists employed in that structure) my research goals, shifting from the observation of the facilities to the study of the daily work of the staff, with particular reference to care aides (the figures most involved in the daily management of the residents and of the challenging behaviors associated with dementia). In this way, I obtained access to all spaces crossed by care workers, and the participant observation became an exploratory technique useful for having a general idea about the main features of each facility before the shadowing. After the

Covid-19 outbreak, given the organizational guidelines that prevent the entry of non-workers into the facilities, I used ethnographic interviews to go in depth into the issues that emerged during the previous phases of the study.

The analysis was inspired by the constructionist version of grounded theory (Charmaz 2006) that put aside the presumption of constructing the analytic categories from the gathered data without the intervention of the expectations and of the theoretical background of the researcher. However, consistent with the tradition of grounded theory, the categories have been constructed gradually, respecting their classical steps: open coding, focused coding, and theoretical coding.

5. Exploring organizational elements that favor the persistence of coercive practices

In the following pages, I will pay attention to the following elements, previously introduced, that lay the basis for the persistence of coercive practices:

- Plans of actions, interpretable as scripts, that guide the staff in the enactment of coercive practices.
- Physical spaces – that is, the architectures (e.g., rooms, hallways, walls, and floors), the objects (e.g., mechanical restraints, medications, and security cameras), and the bodies (e.g., those of people with dementia and of the care aides) placed in the facilities that support both coercive practices and non-coercive ones.
- Discursive practices that produce an organizational setting in which restraints are still accountable (i.e., explicable, understandable, acceptable, and justifiable).

5.1. Plans of action

7 A.M. There are two care aides seated in the infirmary. In a while, other five care aides and, lastly, the nurse holding the list of the residents come in the room. Following the alphabetical order, she enunciates the recent medical issues of each resident. At a certain point, she starts to explain the case of Vincenzo, who has tried to climb over the bed rails. She announces to the care aides that, with the doctor, they have decided to use the «anti-fall sheet» (a sheet secured to the bed through elastic straps). (Ethnographic field notes)

In all considered facilities, the adopted script establishes the following sequence of events: *i*) the emerging challenging behavior is observed by care aides and discussed with the nurse; *ii*) the nurse decides whether to report the observed behavior to the general practitioner who is in charge of that resident; *iii*) the nurse directly consults the physician, who decides whether to immediately apply mechanical or anesthesiological restraints, to wait for a while and ask to the nurse and care aides to monitor the persistence of the behavior, or to consider other kinds of interventions (e.g., non-pharmacological therapies); *iv*) the doctor, with the help of the nurse and (in the case of mechanical restraints) of the physiotherapist, chooses the constraint most suitable to prevent a certain kind of movement (e.g., choosing between bad rails, anti-fall sheet, gait belt, and sanitary pajamas⁵), sharing with relatives this decision; *v*) the constraint is applied to the resident.

This recurrent plan can be framed as a script because it does not only indicate an appropriate sequence of expected events but it aims at guiding their execution in a particular organizational context (i.e., regulating the interdependencies among the professionals available in the facilities), establishing a hierarchy between the information provided by them (nurses are more trustworthy than care aides in evaluating the dangerousness of a behavior), and excluding moves generally considered unsafe in that specific situation (e.g., prescribing a sedative or a body restraint without the involvement of a healthcare professional).

This script guides the professionals in the reproduction of coercive practices because of the dissemination in the facilities of artifacts that, as argued by Goody (1986, 6), can be mobilized as a referential for clarifying ambiguities and settling disputes. These artifacts can support the reproduction of the sub-components of coercive practices (e.g., a form for the observation of challenging behavior guides staff in individuating the kind and

⁵ A short description of these devices are as follows: bed rails are self-adjusting lateral rails that should impede seniors to roll out or get out from the bed; anti-fall sheets are often used in combination with bed rails for the same aim and, moreover, are generally judged by professionals as useful tools for preventing «challenging behaviours», such as undressing or self-harming; the gait belt is a belt grasped by care aides for tying the resident to the bed or the wellchair, with similar purposes, when the other tools are not effective; finally, sanitary pajamas have a zipper on the back, aimed to prevent the patients from taking off the diaper or the pajama itself.

intensity of the behavior that should be treated), assure the presence of actors vital for the execution of coercive practices (e.g., the working shift schedule is filled following the rule for which at least a nurse must be present in the facility), and regulate the interdependences among actors (e.g., the regional guidelines for the nursing homes establish that general practitioners should have the role of taking a final decision about healthcare devices).

Although the script concerning the coercive practices guides the action of professionals in a specific organizational context, it renounces to represent the circumstances and the ways of facing them in all their concrete details. This «inherent and necessary under-specification» (Suchman 1982) of the script concerning coercive practices lays the basis for its success and, consequently, for the persistence of such practices.

1:00 P.M. The care aide is putting to the bed a senior lady, named Vincenza, that is wearing the anti-fall sheet. She explains me that in the past they had tried to use it, but «her son is arrived and he was so angry» (he was unaware of it). Only a fall happened in August has convinced Vincenza's son to agree to the use of the restrains. (Ethnographic field notes, Blue Residence)

The script can be thrown off in some of its crucial points, following the main end around which the coercive practices are organized: the reduction of the dangers for the residents. In the conducted interviews and observations, the staff often repeated that «in case of need», the nurse can decide if, in a specific moment (e.g., a high state of agitation of a certain resident), physical constraints are needed without contacting the general practitioner. At other times, the relatives are by-passed by the nurse and the general practitioner to limit the movements of an elderly lady. As illustrated in this excerpt, deviating from the script can violate the hierarchies that underpin it, bringing out new conflicts and laying the basis for new negotiations (e.g., the relatives that have protested for being excluded from the script tendentially will always be consulted; in contrast, in the cases in which relatives are generally favorable to the physical constraints, they can be dropped and informed *a posteriori*). These cases show how the script can be concretized in different practices that are refined and adapted to the changeable contextual conditions in «répétition sans répétition» (Béguin, Clot 2004).

The persistence of coercive practices is not only grounded on the existence of consolidated plans, at the same time flexible and vague, but also on the rigidity of the alternative ones. In the considered facilities, plans consistent with the *cultural change movement* have been adopted with the aim of managing challenging behaviors without constraints. This is the case with *doll therapy* (Mitchell, O'Donnell 2013), a non-pharmaceutical intervention that consists of providing a special doll to the residents with specific challenging behaviors (i.e., anxiety symptoms and delirium), reducing, or completely replacing the use of sedatives. During the intervention, the doll, designed to recreate the sensation of touching and holding a child in the arms, is delivered to the selected with the explicit request to take care of him/her.

The doll was carried out in one of the facilities by a trainer who also provided a detailed protocol concerning how the doll must be used.

The psychologist tells me how one of the residents was «reborn» thanks to the doll therapy. Then, I ask why there have not been used the doll for a long time. She answers to me that the doll is a big burden for the operators «also because it is not that you can give the doll and leave it there, you have to monitor, to observe». (Ethnographic field notes, Blue Residence)

The script, included in the protocol provided with the doll, guides the use of doll therapy, establishing the following steps: *i*) the emerging challenging behaviors are observed by care aides and discussed with the nurse and, in turn, with the psychologist; *ii*) if the psychologist decides that the patient can be considered for the doll therapy, the doll must be provided to the patient for at least 15 days, until 4 times per day; *iii*) each therapeutic session must be closely supervised by a care aide that has previously attended specific training courses and that must fill a long form; *iv*) the results of the therapy must be constantly discussed with the psychologist. The over-specification of the script is typical of the protocols that circulate, with the aim of rendering the professional practice «more scientific» (Berg 1997, 1086). Doll therapy has previously been widely tested, and the sequence of planned actions has been strictly defined, cultivating «the illusion of the single answer» for which there is one optimal way of facing every medical problem (*ivi*, 1083). The considered script is characterized by a number of prescriptions

hardly applicable to the considered long-term care facilities: First, the low number of care aides and high-skilled personnel compared with the number of patients make the continuous supervision of the resident from the care aides and of these latter from the psychologists difficult; second, the unwillingness of the facilities to give continuity to training courses and of the care aides (low paid and with a low level of job satisfaction) to attend them obstruct the transformation in the protocol in daily care practices. This over-specification has indirectly favored the reproduction of coercive practices, also in the case of residents who potentially could have benefitted from the doll therapy.

5.2. *Physical spaces*

(At the beginning of the New Path project) we also wanted to give the *right environment*. So, the painter painted the cabinets that were already there. We didn't buy anything new. To paint the rooms, we had identified two colors, yellow and orange, which are the colors that people with dementia see without troubles. (Medical director and creator of the New Path project, female, 50 years old)

While we are having lunch, I can say to my senior colleague, «In my opinion, it is better to put Mrs. Federica next to Martina, who is capable of talking (more than other residents), otherwise she already gets nervous». (Care aide, male, 27 years old, Red Residence)

The staff is engaged daily in the production of the physical space, with the aim of shaping the behaviors of people with dementia, obstructing the conducts considered dangerous for residents' health (e.g., the knives are permitted only if with the rounded tip), or allowing the ones judged as positive for it (e.g., pictures with famous old actors are hanged up to slow down wandering, attracting the attention of residents and avoiding that they become overtired). The production of physical spaces takes place through a set of practices that mobilize professional knowledge concerning what challenging behaviors are and how they can be reduced, redesigning the environment in which people with dementia live. As described in the first reported excerpt, managers, psychologists, care aides, artisans, and other professional figures get in relation to spaces and objects, producing physical spaces, with the aim of limiting challenging behaviors without the use of constraints. Other times, the transformation of the physi-

cal space is deeply interwoven with the daily working practices enacted by the staff and by the care aides. An effective example is provided by the second excerpt concerning the re-assignment of seats at the table. In this case, the replacement of bodies in a physical space can be framed as a working practice aimed at preventing the episodes of aggression and, at the same time, at allowing the smooth execution of another working practice (i.e., the nutrition of the residents).

However, the physical spaces are not produced only by the practices enacted by the staff that directly interact with the residents but also by budgeting practices that, in turn, are related to the setting of an organizational goal. In line with the neoliberal era, characterized by a chronic underfunding of public policies and by the spreading of managerial models in healthcare (Giarelli, Neri 2020) and social care sectors (Pavolini, Ranci 2008), the management of long-term care organizations sets and follows the goals of economic efficiency and productivity, using the budget for opening new structures rather than improving the quality of the existing ones (see Fine, Davidson 2018). The low budget made available by the management for reshaping the physical spaces, in line with the purposes of the New Path project, seems to allow the persistence of coercive practices:

Restraints such as the anti-fall sheet (that reduces the movements of the edlerlies and prevents them to get out of the bed) or the sanitary pajamas (that can be marched only from care aides) are for protecting the residents [...]. Care aides cannot be in every guest's room, and at the moment there are not cameras (they are present but do not work). (First operator, 65 years old, Red Residence)

3:00 PM. A care aide passes the card. The automatic sliding door opens. Teresa (a patient who is walking around the facility) tries to get out. The care aide takes her by the arm and carries her inside her. The door closes, and Teresa reacts violently, biting the care aide. Then, Theresa is brought away by another aide. (Ethnographic field notes, Blue Residence)

In these excerpts, the thematized challenging behavior is the so-called *wandering*, a kind of walking typical of people with dementia judged as dangerous by caregivers, given that it is aimless and uncontrolled. Care approaches ascribable to the cultural change movement have criticized the stigmatization of wandering for two main reasons. As anticipated at the beginning of the paper, from the perspective promoted by the cultural

change movement, Western societies would be dominated by a hyper-cognitivist conception of the self for which losing cognitive capabilities means losing identity; consequently, «walking without thinking» automatically becomes pathological and wrong (Edensor 2010). Moreover, critical authors have underlined how wandering can have positive consequences for people with dementia, giving them the possibility to explore places attractive to them and to experience pleasant corporeal feelings. From this point of view, a careful design of the physical context could allow people with dementia to wander, reducing potential dangers for their health. In the considered facilities, the rigidity of the physical spaces seems to obstruct the «liberation of the wonders» (Wigg 2010). In the Red Residence, the cameras, a technology that would support control over the residents without limiting their physical movements, are broken; in the Blue Residence, there is a sliding door that can be open both by inside and outside with a card, requesting the intervention of care aides to stop the «wanderer». Therefore, the emerging spatial arrangements are judged as far from the principles carried out by the cultural change movement, being evaluated by the supervisors of the New Path project as «unsuitable» and «defective» (using the words of the Psychologist of Blue Residence).

5.3. *Discursive practices*

New Path is a systemic intervention aimed at understanding and valorizing the residual capacities of people with cognitive impairment, their biography, and their desires, with the aim of improving their wellbeing. (Presentation document of New Path project)

The coercive practices considered are reproduced within facilities in which the overall care approach is based on the personalization of care paths and on the strong criticism of the cultural assumptions that have sustained coercion for a long time (i.e., *depoliticization* and *hypercognitivism*). How do discourses on coercive practices still make them justifiable and acceptable in this frame? The answer to this question is particularly important given the growth delegitimization of restraints in both scientific and clinical communities and the widespread attempt to replace them with alternative practices.

In this section, discourses about coercion enacted by the staff are defined as «neutralizing discourses». The concept of «neutralization», introduced by Sykes and Matza⁶ (1957), has recently been re-elaborated by Gariglio (2021) to analyze the discourses reproduced by care workers and parole officers to make the coercive practices adopted in Italian psychiatric hospitals against inmates justifiable, alleviating the emotional discomfort that arises from the reproduction of these ways of doing. In this case, the object «neutralized» by the discourses enacted by the facilities' staff is the gap between the cultural background typical of the organizational and historical reference contexts and the coercive practices enacted by the interviewees. Through discourses of neutralization, staff try to renegotiate the meanings given to coercive practices, laying the basis for their persistence, even in an organizational and historical context increasingly hostile to them.

Taking inspiration from the typology provided by Gariglio, the discourses of neutralization reproduced by the staff can be subdivided into three types: *i*) minimizing the injury, in which the staff represents restraints as without negative consequences for the health of the patient or that produce better than harm; *ii*) denying of responsibility, in which workers describe themselves as mere executors of orders carried out by superiors; *iii*) (re)inventing the function, in which constraints are described as consistent with the overall approach of the facility.

Well, let's say that I would say that the first approach is always a non-pharmacological approach [...]. If this person has a «recidivist» behavior disorder (i.e., that does not respond to non-pharmaceutical therapies), I have to intervene with drugs. (Doctor, female, 50 years old)

The «minimization of the injury» is a discourse of neutralization transversal to all professional figures. It underlines how coercion is rarely used when it is not possible to do anything else and/or when much greater damage must be avoided. This

⁶ The concept of neutralization was proposed by the two authors to provide an alternative explanation for juvenile delinquency to that previously formulated by Cohen (1955), for which young people commit crimes with the aim of adhering to specific sub-cultures. According to Sykes and Matza, «deviant» young people are most of the time compliant with the prevailing social norms, feeling remorse after the commission of the crime. In this context, the discourses of neutralization would be enacted by «deviant» people to reduce the individual sense of guilt for criminal acts, deriving from the discrepancy between their behaviours and the dominant norms.

discourse is also empowered by the wide use of lexical labels. In facilities, mechanical restraints are often renamed using terms of endearment. For example, the gait belt for limiting residents' movements is called *cinturina*, a term that can be translated in English as «little belt». Similarly, the containment jumpsuit is called *tutina*, an equivalent English term could be «onesie». These lexical labels are probably used to minimize the dangerousness of the considered devices, both in the eyes of the practitioners and of the other people (i.e., the interviewer), reducing the discomfort associated with their usage (in several interviews, care aides described the experience of seeing the residents with mechanical restraints as painful).

The second discursive practice aims at the «denying of responsibility» through which the members of the staff, mostly care aides, describe the coercive practices as something that is decided by others (with particular reference to general practitioners):

Okay, however, the decision is not up to us (the care aides). But what gives me food for thought is when we put on a wheelchair a person that can walk with the aim of avoiding potential falls. After a year (*lowering the tone of voice*), this person no longer walks. (Operator, male, 37 years old, Blue Residence)

9:30 A.M. I'm in the room of a resident named Raffaele, two care aides are bathing him. At one point, one of them tells me «You should have seen Raffaele some time ago, in August he had a bad period (with a high intensity of challenging behaviors). Now he is practically dead (he alludes to the alleged excessive use of drugs), I don't know why, I make no comment, I'm not a doctor». (Ethnographic notes, Red Residence)

In both excerpts, care aides underline that they have nothing to do with the decision-making process through which constraints are applied to the residents, criticizing them. In the first excerpt, the interviewee focuses on the debilitating consequences of using the wheelchair to prevent the resident from falling; in the second excerpt, the care aide, in the face of a strong attachment to the guest and the discomfort of seeing him lacking in energy, points out that he is not a doctor and therefore does not have word power about the administration of drugs.

The third and final discourse of neutralization can be traced back to the so-called «(re)invention of the function», in which, faced with a practice hardly acceptable in a certain organiza-

tional and historical context, the practitioner changes the overall meaning of the practice.

The natural trend today is to take in consideration, first of all, the alternative options before the use of medications or of the body restraints. However, we must assure the safety of the patient. We talk a lot about this and I like a lot to use the term «prosthetic environment». If you don't secure a person with all the devices they need, it's a big problem. So you have to use them. (Doctor, 56 years old)

In the excerpt above, the doctor first claims that today, the reduction of mechanical constraints illustrates the problematic nature of the mechanical constraints whose reduction is nowadays portrayed as «natural,» after which she indicates the solution (emerged within working groups with other colleagues): the constraints are reframed as part of a «prosthetic environment». The use of this concept appears particularly interesting, as it was originally adopted by some exponents of the *culture change movement* to indicate a set of spaces, activities, and relationships that should help the person with dementia in the face of the loss of physical and cognitive abilities (see the gentle care approach in Jones, 1996). The concept of a «prosthetic environment» was therefore originally born in opposition to coercive practices, coherently with the cultural assumption for which challenging behaviors emerge from the unsuitability of the physical and relational environment to the needs and abilities of people with dementia. The interviewee, in contrast, seemed to use this concept to radically renegotiate the meaning given to the coercive practices still used in the considered facilities. Through the discourses of neutralization aimed at «reinventing the function», the use of mechanical restraints is no longer a coercive practice, becoming a way of modifying the spatial arrangements around the specific needs of people with dementia.

6. *Conclusive remarks*

Adopting a practice-based approach grounded mainly on the studies that have used the practice concept to understand organizational dynamics, in this paper, I have explored the role of plans of action, physical spaces, and discourses in supporting the persistence of mechanical and anesthesiological restraints. Lastly,

it is important to report three conclusive remarks concerning the persistence of coercive practices in contemporary organizations dedicated to people labeled as «mad,» taking into consideration the case of people with dementia.

The first remark concerns the emerging texture of practices⁷ (Gherardi 2006) characterized by a constant flux of tensions and contradictions produced by the co-existence between coercive practices and practices consistent with the principles of the cultural change movement. In the considered facilities, the execution of coercive practices is often interwoven with the implementation of interventions alternative to them (e.g., in the same facility, wandering can be slowed down with the help of pictures that attract the attention of residents and, especially at night, stop using mechanical restraints). Other times, the enactment of coercive practices is favored by the interruption of practices born in opposition to them (see, for example, the difficulties encountered by the staff in reproducing overspecified scripts that should support the treatment of anxiety symptoms and delirium without the use of sedatives). In any case, the staff feels a constant tension between these two groups of practices that, while sharing the same end (i.e., the treatment of challenging behaviors), start from cultural backgrounds and develop courses of action that are completely different. This tension is alleviated by discourses of «neutralization» that cross the emerging texture of practices, justifying the permanence of restraints with explanations aimed at absolving the organization or, at least, the individuals employed within it.

The second remark concerns the interplay between persistence and flexibility. From the discussed cases, it emerges how coercive practices persist, despite their growing delegitimation, both in scientific and clinical communities, because they are continuously readapted to the changeable social and material context. This regards both the ways in which coercion is executed and the meanings associated with it. First, the facilities are composed of people, bodies, artifacts, and spaces that can change in their features and behaviors during the time, with a consequent readjustment of coercive practices. Second, the organizational and historical context can be interested in important changes (e.g.,

⁷ This term underlines how practices exist in configurations, being bound together in harmonious or conflicting relationships.

in assumptions and beliefs concerning dementia) and, in parallel, the staff is engaged in a continuous sense-making process aimed at renegotiating the meanings of the coercive practices. In this sense, the presented results show once again that something that is adjustable and polymorphic proves more durable than something that is inflexible and robust (see de Laet, Mol 2000).

A final remark regards the influence of the neoliberal era, characterized by a chronic underfunding of public policies and by the spreading of managerial models in healthcare organizations, on the persistence of coercive practices. As previously observed by Cardano and Gariglio (2020, 166) for psychiatric wards, the organizational life of long-term care facilities is strongly influenced by the broader socioeconomic milieu of which these organizations are part. In line with the neoliberal politics that have affected Italian long-term care for a long time, management allocates the budget and sets organizational goals, following the goals of economic efficiency and productivity, and overlooks the improvement of the quality of care. Management practices are an integral part of the texture of practices daily enacted in facilities, being constantly connected with the other activities that characterize the daily life of these organizations and, thus, influencing the ways in which the challenging behaviors associated with dementia are treated. As shown in the empirical section, the staff often struggles in adapting their daily work to the principles of cultural change movement: On the one hand, the spaces seem to make inevitable the use of mechanical and anesthesiologic restraints for reducing the disruptive consequences of challenging behaviors; on the other hand, the detailed scripts that should guide the use of doll therapy request a quality and a number of professionals that can rarely be guaranteed by the management.

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On the persistence of coercive practices in dementia treatment. When plans, spaces, and discourses matter

Over the last three decades, the enactment of coercive practices to contain the so-called «challenging behaviors» associated with dementia (e.g., wandering, biting, agitation, and physical attacks) has been widely delegitimized by public opinion and the scientific community in favor of practices and principles promoted by the so-called *culture change movement*. Nevertheless, *mechanical* and *anesthesiological* restraints continue to persist widely in nursing homes

dedicated to people with dementia. This paper explores the reasons behind this persistence, drawing upon a two-year ethnography in two nursing homes in Northeast Italy. Adopting a practice-based approach, grounded mainly on studies that have used the practice concept to understand organizational dynamics, this paper explores the role of plans of action, physical spaces, and discourses in supporting the reiteration of coercive practices. In doing so, the work also pays attention to the struggles encountered by workers in enacting the practices born in opposition to the use of coercion (e.g., non-pharmacological therapies and the adaptation of physical spaces to the needs of people that live with dementia) and that should replace body restraints and sedation in the management of disruptive behaviors.

Keywords: practice-based studies, coercive practices, long-term care organizations, madness, dementia, ethnography.