Therapeutic social control of people with serious mental illness:

An empirical verification and extension of theory *

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Abstract

Mental health services and psychiatric professional values have shifted in the past several decades toward a model of client autonomy and informed consent, at least in principle. However, it is unclear how much has changed in practice, particularly in cases where client behavior poses ethical challenges for clinicians. Drawing on the case of clients' sexual behavior and contraception use, we examine whether sociological theories of "soft" coercion remain relevant (e.g., therapeutic social control; Horwitz 1982) in contemporary mental health treatment settings. Using structured interview data from 98 men and women with serious mental illness (SMI), we explore client experiences of choice, coercion, and the spaces that lie in between. Patterns in our data confirm Horwitz's (1982) theory of therapeutic social control, but also suggest directions for updating and extending it. Specifically, we identify four strategies used to influence client behavior: coercion, enabling, education, and conciliation. We find that most clients' experiences reflect elements of ambiguous or limited autonomy, wherein compliance is achieved by invoking therapeutic goals. However, women with SMI disproportionately report experiencing intense persuasion and direct use or threat of force. We argue that it is critical to consider how ostensibly non-coercive and value-free interventions nonetheless reflect the goals and norms of dominant groups.

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Sociologists have long argued that rational choice-based theories of health services utilization are largely inconsistent with the experiences of people with serious mental illness, instead emphasizing mixed elements of choice and coercion in psychiatric practice (Pescosolido, Brooks-Gardner, and Lubell 1998). In 1982, Horwitz developed a theory of therapeutic social control, distinguishing coercion from conciliatory control. The latter concept reflects soft coercion that permits limited or ambiguous agency on the part of mental health clients. In these cases, desired behavioral outcomes are often obtained by framing conformity as adherence to cooperatively developed treatment plans.

Two related goals motivate the current study. First, Horwitz's (1982) theory of therapeutic social control has arguably been underutilized in the sociology of mental health, and has rarely been empirically evaluated. We hope to revive it. However, there were significant shifts in medical ethics and professional values in subsequent decades toward greater client autonomy and informed consent (Hiday 1992; Solomon 1996; Szasz 1963, 1994, 1997; Wertheimer 1993). More recently, there has been increasing controversy and a renewed push for involuntary commitment and other forms of social control in the context of an under-resourced and failing community mental health treatment system (Miller and Hanson 2016). In light of these developments, our aim is to update and extend the theory to include additional contemporary forms of social control employed in mental health treatment settings.

Second, the sociological and mental health literatures make clear the existence of tensions between autonomy and social control in the practice of mental health treatment. However, little is known about how social control is exercised in situ in outpatient and inpatient mental health treatment settings. More importantly, how do clients experience and react to clinician control and constrained decision-making? And, do patterns of social control reflect broader status hierarchies and prevailing stigmatizing attitudes about serious mental illness?

To address these aims, we explore the use of therapeutic social control using data from structured in-depth interviews with 98 men and women receiving treatment for serious mental illness. We focus on sexual and reproductive behaviors – a case that is ideal for observing institutional practices and therapeutic interactions that reflect social control. Historically, people with SMI and others with disabilities have been subjected to extreme forms of legal and medical control in the domain of reproduction (Kevles 1985; Stern 2005). Moving away from eugenic principles, contemporary research and clinical perspectives on the sexual behavior of people with SMI have taken the form of discourses of risk (Wright, McCabe, and Kooreman 2012). However, clients' sexual behaviors often pose ethical challenges for clinicians, and the professional principles of client autonomy and beneficence are often in direct conflict (Miller and Hanson 2016). Therefore, we expect to observe elements of choice, coercion, and the ambiguous therapeutic interactions that lie in between.

Background

Social Control and Mental Illness. Like other subjugated groups, persons with serious mental disorders have long been subjected to social control. In the opinion of some advocates, psychiatry itself is a "perversion of medical power (Szasz 1997, p. 496)," and the mental illness construct and the profession of psychiatry itself are tools used by powerful groups to justify the control of deviant thought and behavior (Szasz 1963, 1994, 1997). Throughout the history of Western society, people with psychiatric problems have been detained against their will for long periods of time and forced to undergo painful and invasive procedures (Deutsch 1949; Foucault 1965; Goffman 1961). Although laws intending to protect the rights of people with mental illness have been enacted, involuntary commitment to institutions, aggressive community treatment, forced medication compliance, and coerced electroconvulsive therapy still threaten the freedom and autonomy of this population (Berg and Bonnie 1996; Burstow 2006; Lamberti et al. 2014; Miller and Hanson 2016; Solomon 1996). People with SMI are one of the few remaining groups who may be legally denied their basic human rights.

Yet, the use of social control, particularly through legal means, is widely contested both within and outside of the mental health field (Saks 2002). Most clinicians agree that preserving the autonomy of patients – or the ability to act freely without controlling interference by others – is or should be a core value in mental health practice (Varelius 2006). Moreover, professional standards of conduct require that clinicians weigh the principles of autonomy and justice in equal measure with the principles of beneficence and non-maleficence, and federal law mandates that all patients must be informed of their right to refuse treatment (Medical Professionalism Project 2002). However, some argue that exerting social control over people with SMI ultimately promotes autonomy because engagement in treatment leads to improved functioning and the ability to live independently (Lamberti et al. 2014).

Along these lines, overt use of coercion has likely been replaced by more subtle forms of social control in modern psychiatric practice. Contemporary clinical discourses conceptualize adherence to treatment plans – developed in collaboration with clients – as evidence of self-care and progress toward recovery (Coverdale et al. 1993; Torrey et al. 2001). This shift toward client-centered care prompted the development of the concept of therapeutic social control

(Horwitz 1982), or the attempt by mental health professionals to alter the behaviors or cognitions of individuals with mental illness through what are considered therapeutic means.

In his early book, *The Social Control of Mental Illness*, Horwitz (1982) described two distinct types of therapeutic social control. First, *coercion* occurs when a decision made by one individual or group is forcibly imposed on another. For example, mental health professionals may secure adherence to prescribed medication regimens by administering punishment for noncompliance. In this form of social control, the more powerful individual or group gains at the expense of the weaker one (Durkheim 1893; Horwitz 1982). Though ostensibly less common in modern mental health practice than it once was, de facto social control clearly operates in issues around involuntary commitment and mental illness in the criminal justice system (Aldige'Hiday et al. 2002; Gilburt, Rose and Slade 2008). Mental health courts, drug courts, jail diversion programs, and mandated community treatment programs, for example, use legal leverage to induce engagement in treatment, using threat of incarceration, probation, or other punishments to achieve compliance (Lamberti et al. 2014).

Second, Horwitz (1982) defined *conciliation* as a negotiation or compromise between two parties to achieve consensus, underscoring that therapeutic social control need not involve the direct use of force or coercion (see also Black 1976). Conciliation is characterized by persuasion of a person with SMI by the mental health professional to agree and comply with treatment and advice. For instance, a therapist who convinces a reluctant client to experiment with a new psychiatric medication is exercising conciliatory control. While conciliatory control differs from explicit coercion, given the premise of negotiation, conciliation often takes the form of "soft coercion." Critical in the distinction between conciliation and autonomous compromise is the unequal distribution of power between a mental health treatment provider and his or her client.

Sexuality as a Site of Social Control. Historically, social control of marginalized and powerless groups, including people with SMI, has taken the form of reproductive control (Kevles 1985; Stern 2005). This was the crux of the eugenics movement – an international effort to improve the quality of the human race, often through sterilization of individuals believed to be genetically defective (Allen 1997). Indiana, where we collected data for the current study, was the first state in the U.S. to pass a eugenics law, possibly the first of its kind in the world (Stern 2007). The 1907 legislation targeted "'confirmed criminals', 'idiots', 'imbeciles', and 'rapists'" (Stern 2007: 9). However, a second law passed in 1927 shifted the focus of eugenics in Indiana to institutionalized persons with mental illness, focusing on the "'insane', 'feeble minded' or 'epileptic'" (Stern 2007: 29). Under this law, which was repealed in 1974, approximately 2,500 sterilizations of men and women were conducted in the state without informed consent (Sterns 2005). Though it is widely assumed that eugenicists primarily targeted people with developmental disabilities, historians estimate that about 80% of sterilizations in later years of the movement were carried out on people with mental illness (Ferster 1966).

Given the longstanding preoccupation with the link between mental illness and sexuality, it is unsurprising that people with SMI were a focus of the eugenics movement (Block 2000). Inappropriate sexual behavior is an explicit diagnostic criterion of borderline personality disorder, and is widely thought to characterize manic phases of bipolar disorder (Langer 2015; Geller et al. 2002; Gunn and Potter 2014). Likewise, psychiatrists have identified disproportionately high rates of "hypersexuality" – defined as "an increased frequency and intensity of sexually motivated fantasies, arousal, urges, and enacted behavior in association with an impulsivity component (Kafka 2010: 385)” – in people with mood, impulse control, and substance use disorders (Kafka and Hennen 2002; Raymond, Coleman, and Miner 2003). More generally, with respect to sexuality, people with SMI are often either infantalized (i.e., framed as asexual and devoid of desire) or pathologized (i.e., viewed as sexually aggressive, hypersexual, and lacking self-control) by the discipline of psychiatry (Chouinard 2009; Block 2000; Collins, Unger, and Armbrister 2008).

Sexuality is often a fraught issue in the mental health field, pitting the values of patient autonomy and beneficence directly in conflict (Sy 2001). In the course of treatment, clinicians may face an ethical dilemma – namely, allow clients to make sexual or reproductive decisions that jeopardize their wellbeing, or compromise their autonomy by exerting social control (Wright et al. 2012; Coverdale et al. 1993). Research suggests that many mental health service providers believe that their clients are unable to have successful relationships or engage in appropriate expressions of sexuality (Buckley et al. 1999; Wright, McCabe, and Kooreman 2012). Moreover, both clinicians and the scientific literature on mental illness tend to emphasize risk, focusing on unsafe sexual practices and “deviant” sexual behavior within psychiatric facilities (e.g., Carey 2004; McKinnon and Rosner 2000; Lavan and Johnson 2002).

Among clinicians on the frontlines, the most persistent concerns about client sexuality are the risk of sexually transmitted infections and unintended pregnancies (Dobel and Torkelson; Hall, Steinberg and Marcus 2014; Wright et al. 2012). A large number of empirical studies have identified an increased tendency to engage in unprotected, high-risk sexual behaviors among people with SMI, including having multiple concurrent partners and irregular use of contraception (e.g., Carey et al. 2001, 2004; Levan and Johnson 2002; Tubman, Gil, Wagner, & Artigues 2003; Perry and Wright 2006). Additionally, people with SMI are more likely to have unplanned pregnancies than those without a mental illness (Hall et al. 2014; Marengo et al. 2015). This population also disproportionately makes adoption plans for their children (Seeman 2012) and experiences a loss of custody (Sands 2004), due in part to high rates of poverty among parents with SMI (Luciano, Nicholson and Meara 2014). Finally, individuals with SMI are more likely to report that raising children is stressful and to require additional support compared to the general population (Dolman, Jones, and Howard 2013; Schrank et al. 2015). In response to these risks, clinicians have often sought ways to increase contraception use among their clients with SMI (Hall et al. 2014; Wright et al. 2012).

Methods

The data used in this analysis are from the Indiana Mental Health Services and HIV Risk Study. This was an NIMH-funded study (R01 MH59717) of the impact of HIV on the mental health treatment system and the risk profile of people with SMI. The primary objective of this larger study was to determine which types of HIV and sexuality-related services mental health clients want and need, and to assess the services, if any, that were being provided. Mental health clients with serious mental disorders (i.e., major depression, bipolar disorder, schizophrenia, schizoaffective disorder, or psychosis NOS as the primary diagnosis) from two state hospitals and three community mental health centers were recruited for the study.

Respondents were systematically selected from clients who met the study’s diagnostic eligibility requirements to ensure representation of each sub-sample and roughly equal sample sizes across sites (see Wright et al. 2007 for detailed overview of the sampling procedure). All of the eligible, selected clients were contacted at their service center and asked to participate in the study. Those who chose to participate were paid $25 upon completion of the interview.

Participation was completely voluntary, and refusal in no way affected the client's access to services provided by the hospital or community mental health center. All study procedures were reviewed and approved by the Indiana University IRB. Each respondent participated in a confidential, in-depth, face-to-face interview with a trained member of the project staff. The qualitative data analyzed here are from 198 clients interviewed at two community mental health centers (CMHCs) and one state hospital. The response rate for these sites, collectively, was 77.9%.

The client interview was an extensive examination of the respondent's sexual desire, sexual practices, contraceptive use, partners/relationships, and HIV risk. The open-ended protocol used in this analysis explores the respondent's perceptions of and experiences with how mental health professionals addressed HIV risk or other sexuality-related issues. Included in this last section was a group of questions about contraceptive use. These were:

- Now I would like to ask you about your experiences with birth control. Have any staff or doctors ever spoken with you about birth control options?
- Have family members, friends, sexual partners, or any staff members or doctors ever spoken with you about the risk of pregnancy and what it might mean for you or the child?
- What recommendations about birth control have been made by family members, friends, sexual partners, doctors, or staff members here or at another facility?
- Have you ever felt pressure from anyone to use birth control methods that you weren't sure were right for you?
- Have you ever regretted any decisions you've made about birth control? If so, what do you regret doing or having done, and why?

Participants were encouraged to be thorough in their responses, and interviewers probed for detail. Open-ended sections of the interview were tape recorded when permission was granted. Responses were transcribed word-for-word to preserve the accuracy of the data.

The first author open-coded all interviews that mentioned birth control and contraceptive use, identifying key themes and emerging patterns. After open coding, a semi-structured coding scheme was developed, guided both by theory and data, in what Timmermans and Tavory (2012) refer to as abductive analysis. Qualitative researchers using abductive analysis do not use pure induction, as one would if taking a grounded theory approach. Nor do they use pure deduction, or coding and analysis driven purely by existing theory. Instead, during the iterative coding process, the first author synthesized emerging themes and relevant theory to develop a structured coding scheme (see Appendix A). The coding scheme facilitated the identification of quotations consistent with existing theory, but also permitted the emergence of themes that conflicted with existing theory or suggested ways to build upon it.

After constructing the structured coding scheme, the first author conducted a final round of coding to classify mentions of coercion, conciliation, education, and enabling relating to birth control and sterilization decisions. The first author coded all passages where clients discussed issues pertaining to contraception without regard to client gender; the experiences of both men and women regarding contraception are included in our analysis. To identify patterns relating to gender, we compared statements from men and women and analyzed gender differences in patterns of control and autonomy. This process was aided by the use of Atlas.ti, which allowed us to compare excerpts and code frequencies across gender groups and across different forms of social control or autonomy.

Results

In all, 49.5% of the mental health clients interviewed had spoken with staff, doctors, family members, or friends about birth control and/or the risks associated with pregnancy (n=98). The remaining clients either had not spoken to anyone about contraception or only spoke to sexual partners in the context of a relationship. These clients were excluded from further analyses because no additional information regarding social control of birth control use was obtained. Of those respondents who had spoken with someone other than a sexual partner about birth control, 49.0% (N=48) were women (42.9% of the full sample was women).

Therapeutic Social Control Strategies. Evidence of both social control and autonomy was present in the remaining respondents' interviews. We identified four distinct types of strategies. Together, these both verify Horwitz's (1982) theory and suggest a need for updating to accommodate recent trends in psychiatric practice. At one end of the continuum, *enabling* reflects instances of relative autonomy, in which a client is in control and is self-directed. At the other end of the continuum is *coercion*, where no agency on the part of the client is evident, and behavior is enforced via threat, force, or obfuscation. In the middle lie two additional strategies, *conciliation* and *education*, in which the client is a passive recipient of persuasion, but ultimately makes the decision. We report the number of instances of enabling, coercion, conciliation, and education mentioned in client interviews in Table 1.

In addition, gender emerged as an important factor in the deployment of social control in the sexual and reproductive behaviors of respondents with SMI. Consistent with Horwitz's (1982) claim that lower status individuals are particularly likely to be subjected to more coercive forms of social control, women disproportionately reported conciliation and coercion. Alternatively, men were provided with education about birth control at much higher rates than women. In our discussion of findings, we argue that gendered patterns of contraceptive intervention employed in the mental health treatment system reflect larger structures of patriarchy and gendered forms of sexual oppression. We explore these findings in depth in the following analysis of the qualitative data.

Enabling. Enabling is defined here as the provision of means, opportunities, or support relating to contraceptive use. Although influencing reproductive decisions or sexual health behaviors may be the goal, particularly in inpatient treatment settings, the defining feature of this strategy is that the client is in control and self-directed. The client is given the opportunity to freely choose to use birth control. Enabling clinicians and informal caregivers take a hands-off approach, or become involved when the client initiates a request for support or resources. About 19% (n=19) of respondents were enabled to change their birth control behavior by treatment providers, family members, or physicians (see Table 1).

One common example of enabling found in these data was the provision of condoms, either available upon request or put out in the open for clients to take as needed. The following description of the contraceptive options offered at one client's local community mental health center illustrates the concept of enabling: "They have condoms here for you and pamphlets you can read, and I can also talk with my therapist (1007, Female)." The supplies and the information needed to effectively use contraception were made available, but there was no explicit use of persuasion or coercion to change behavior. Many respondents discussed how they were enabled to access condoms, explaining that “[the staff] passed them out” (4003, Male). Others said, “I go up to the office and ask for a condom first” (2136, Male), and, “They have condoms that you can get if you need them, if you ask for them even though they don’t encourage sex here” (2064, Female). Another respondent expressed the importance of access to condoms:

> At another hospital I was at…they would supply rubbers…I think they should at least give rubbers to the people who are [sexually active], just in case. Even if they don’t allow it, you might have somebody that wants to do it.”

He expressed the view that hospitals should allow clients to access and use condoms, illustrating how using contraceptive measures can be a fully autonomous choice. Other respondents mirrored this perspective: “At some of the places I’ve been, they give you a starter kit….the starter kit has a condom, a swab, alcohol or some type of swab to clean up and everything” (2053, Male).

While many instances of enabling involved the provision of condoms to male clients, another respondent described how her father had enabled her contraceptive use:

> I got home and I looked for my birth control pills ... my dad was sitting there on the sofa and he said, "Are you in trouble?" and I said, "Yes, dad, I am." And he said, "What do you need?" And I said I needed some money for my birth control 'cause I couldn't find it in my purse, so I got to drive to the pharmacy and my dad gave me ten dollars (1097, Female).

One respondent sought the advice of her physician:

> I was asking for alternatives, because the pill hadn't worked for me. I had gotten pregnant on the pill. So, I was looking for options, and, um, (my doctor) suggested a tubal ligation (2010, Female).

In these cases, advice was provided at the request of the respondent, and she was in control of the decision to use a permanent form of birth control.

Men and women mentioned enabling interventions in roughly equal measure. About 19% of men and 17% of women reported experiencing enabling. Gender balance in reporting of this strategy may reflect equivalent demand for accessible resources among men and women with SMI, who may face financial barriers and other problems accessing contraception. This pattern also reflects active and healthy sexuality among a sizeable proportion of people with SMI, who are often assumed to be asexual or incapable of independently managing sexual risk and behavior.

Coercion. In stark contrast to experiences of relevant autonomy exercised through enabling, some clients also reported coercion. Consistent with Horwitz (1982), coercive social control is defined as the denial of client autonomy in decision-making through use or threat of force. In addition, clients in our sample mentioned instances of coercion through lack of informed consent or even obfuscation. Coercion was exercised both within the mental health treatment system and by family members and sexual partners. Although coercive control was the least common intervention mentioned by clients, about 11.2% of respondents (N= l1) were affected (see Table l).

Irreversible sterilization procedures were particularly traumatic for clients, and those who had been coerced into undergoing these procedures often expressed deep regret. Such was the case with the following respondent:

> My sister was my legal guardian and she had me have (my tubes) tied ... I told her I didn't want 'em and she said I had to ... She never gave me a reason why. I was upset... We tried to find out how much it would cost to have them untied ... $25,000 ... we don't have that kind of money ... She knew how I felt, that she didn't want me to make that decision…I guess she and my mother thought I would spend my entire life in a group home…So they think I can't make that decision [because of] my disability (3026, Female).

This woman had recently married and was devastated that she would be unable to have children with her new husband. Her life was irreparably affected by the deployment of coercive control. Similarly, another woman's marriage was jeopardized by her inability to have children with her new husband. She said:

> Later after I had my tubes tied, I met somebody…we got married but his issue was that we couldn't have children. He wanted them…I mean, at the time, I had three children and they were like fourteen months apart. And my mother kept pushing me, you know, to go ahead and get my tubes tied. So I did what she asked me to (3113, Female).

As this passage illustrates, family members sometimes badgered clients into accepting contraceptive services. Although some had children already, many of these women were quite young when they underwent an essentially irreversible procedure.

Some women's refusal of oral contraception was framed as medication noncompliance. This always occurred in the context of inpatient services. For example, one hospitalized woman said:

> The birth control pill at (State Hospital), I didn't think I really needed it, but, um, the staff told me I had to take it... if you miss any medication while you were there, then they usually restricted you to the unit. Of, if you refused to go to the doctor for pelvic exams, they would take my pass away (2097, Female).

While being pressured to take oral contraception is less violent and invasive than sterilization surgery, it is no less coercive, and can result in harmful side effects for some women.

Coercive social control also occurred when decisions about birth control were implemented without the knowledge or consent of the client with SMI, regardless of whether or not he or she would have objected. Long acting birth control, such as the Depo-Provera shot, was the most common form of contraception used in these cases. For example, one woman said:

> I don't know why they gave me a Depo-Provera shot... They stuck me in the butt when I came ... I think they took me off my birth control so they didn't want to have to worry about getting my birth control filled everyday ... I was upset 'cause they didn't get my permission ... I feel that I'm old enough to make my own decisions (2111, Female).

Here, the respondent did not oppose being on contraceptives, but she was upset that she was injected without her consent and treated in a dehumanizing manner. Another woman reported, “I think [the Depo-Provera shot] is required for my health…so I can sleep at night. Because I used to have real bad nightmares” (2038, Female). Since Depo-Provera is not indicated for insomnia, it is clear that this client was not fully informed about the treatment, and may have been given inaccurate information. Medical or mental health professionals providing misinformation as coercive strategy was evident in multiple interviews. One woman explained how a doctor told her “diabetics aren’t supposed to get pregnant” because “it interferes with the diabetes” (4009), and another was told that she was on Depo-Provera to stop her periods. Misinformation and withheld information precludes the client’s ability to give informed consent and reveals medical professionals’ exploitation of their position of power and clients’ trust.

Overall, 20.8% of women and only 2.0% of men reported experiencing coercion. This suggests that the deployment of coercive power is highly gendered, mirroring feminist scholars’ contention that the bodies and reproductive decisions of women are disproportionately subject to patriarchal control. Examining contraceptive coercion of individuals with SMI through the lens of gender reveals systematic inequality in family and institutional practices around birth control for people with SMI.

Education. The most interesting reported birth control experiences lie in the gray area between autonomy and coercion, and might be characterized as soft social control or limited autonomy. Along these lines, clinicians and staff at treatment facilities employed sex education in an attempt to persuade clients to practice birth control. Education, in the context of social control strategies, is the provision of information about sex and contraception. In these cases, clients are passive recipients of information that is typically preventative in nature, undirected and impersonal, and often administered in group settings. Often, such classes or group therapy sessions are compulsory. However, birth control decisions are ultimately made by the client. In all, approximately 30% (N=29) of respondents were educated about contraceptives and the advantages of using them (see Table 1).

Education about sex and birth control focused on increasing clients' biological and public health knowledge. There was no explicit application of pressure regarding specific clients' behaviors or their personal lives, more generally, and education was often perceived as useful. The following passage is exemplary of the purpose of educational intervention:

> I was glad to know about how pregnancy can be stopped ... so I can make my own decision about what to do and to have information to know what to do (2019, Female).

This statement reveals how and why education efforts facilitate clients' use of contraception. Typically, this type of intervention occurred in sex education or STD prevention classes:

> We have classes sometimes in the back room about AIDS and using condoms and having sex and even sex education sometimes. That's about it. It don't happen often, but sometimes we do have classes (2037, Male).

Other clients watched videos about birth control in groups or on the unit. One respondent discussed attending sexual education groups:

> I know that the clients have the group on safe sex and they have movies talking about how AIDS can be transmitted among other sexual diseases, too and they have several groups. Everyone has to attend at least a week, groups on HIV and sexual related diseases, they also make sure that people are aware of safe sex (2064, Male).

As this passage demonstrates, most interventions occurred in group settings and addressed risk factors for pregnancy and sexually transmitted infection.

Though education is seemingly value-neutral and potentially empowering, clients provided no evidence of sex positive messaging. By and large, clients reported that educational interventions tended to focus on risky behavior and basic biological aspects of sex to the detriment of topics like desire, communication, and emotion – a pattern that has been noted in previous research (Fields 2008; Allen 2005). In other words, medical and psychiatric discourses often frame clients with SMI as bodies at risk rather than autonomous subjects. Further, attendance at most groups in these settings was mandatory or strongly encouraged, raising questions about the extent to which education in institutional contexts constitutes soft coercion. Following Foucault, the presumed objectivity of scientific and medical knowledge is often enlisted in projects with political intent; in this case, bodies were the politicized entities within which power/knowledge was exerted (Foucault 1975). Thus, because education about sexual practice was provided by medical professionals in positions of authority, education likely contains elements of both social control and autonomy.

Substantial gender differences were evident in exposure to education. In total, 44% of men in the sample reported receiving education, compared to only 15% of women. If education was intended to provide resources and knowledge with which clients could make autonomous decisions about their sexual practices, men’s greater access to education parallels broader cultural notions of men as rational and in control. In contrast, women tend to be perceived as passive or as sex objects in the context of sexuality, and this pattern is often exacerbated among women with SMI (Collins 2001; Stern 2005; Frohmander and Ortoleva 2013). Unequal access to education across gender implies that even if education sometimes functions as a mechanism of social control, the influence exerted on men is less coercive than that experienced by women in mental health treatment contexts.

Conciliatory Social Control. Conciliation was the most frequently described type of interaction respondents reported vis-à-vis birth control. Consistent with Horwitz (1992), conciliatory control was characterized by explicit attempts to persuade clients to change their behavior. Treatment providers or family members made personal appeals to clients, drawing on arguments about risks specific to an individual's own treatment goals or life circumstances. This feature of conciliation distinguishes it from education, which is employed in a preventative and undirected way. While conciliatory control features clients as passive recipients of persuasion, a hallmark of this strategy is the absence of an explicit use or threat of force or misinformation. About 54% (n=53) of respondents experienced conciliation (see Table 1).

Two common elements of conciliatory control were appeals to safeguard the welfare of unborn children and assertions about clients' lack of fitness to be parents. The following is a prototypical example of conciliatory control:

> Dr. __ has said that she definitely thinks we should not have a child. Well, her exact words were "You can't even take care of yourselves let alone a child" ... I think she meant that it is hard enough for us to manage our own lives, let alone the life of the child who would be very hard to take care of. .. She said just to abstain is the best method (3016, Female).

The above excerpt illustrates how psychiatrists employed paternalistic and stigmatizing judgments in the course of providing medical advice. While not directly forcing the client to abstain, the psychiatrist used shame to influence the client to abstain from sex. Another respondent echoed these experiences, reflecting on why she and her partner were encouraged to use birth control: “To help us survive and get along. We are not too mature ourselves. That’s why these recommendations are being made. A lot of times you can’t support for yourself” (2084, Female). Discourses portraying clients with SMI as childlike, financially or otherwise irresponsible, and dependent were commonplace. Along these lines, a client described his therapists' insensitive reactions to his efforts to become a parent:

> We're trying to get pregnant right now, but what they have suggested is birth control like rubbers, pill, diaphragm, sponge ... They felt like I couldn't afford a kid, that I would lose self-motivation and maybe I am just not smart enough right now or got the stuff it takes to have a kid ... I'm schizophrenic and they know. Partially, that's why. They don't really know the whole story, but they do speak some truth (3040, Male).

As this passage illustrates, many clients had internalized stigmatizing attitudes about mental illness and fitness for parenthood.

Many clients reported that their mental illness was specifically cited as a reason to avoid pregnancy, while in other cases it was implied or coded (see above quotations). For example, one woman was pressured by her family to avoid pregnancy because of the heritability of mental illness:

> They advised me to use (birth control) because they didn't think it would be healthy for me to have a baby for two reasons. One, due to my mental health, although schizophrenia has been known to skip a generation. My family members didn't want to take the risk of me bearing a child I couldn't take care of since I couldn't take care of myself. Also, I had surgery on my uterus. I didn't have it removed. I had a tumor removed one time and had some blood transfusions. They said it would be a very difficult pregnancy for me if I were to carry a child. A lot of things could go wrong (3142, Female).

As seen in this passage, people in positions of authority often used discourses of risk, capitalizing on anxieties about worst possible outcomes. Conciliatory control may appear to offer a measure of autonomy, since clients are the ultimate decision-makers. However, the authoritative positions of health professionals and often family caregivers removes much of the agency from clients with SMI. Due to the subjugated and stigmatized position of the client, portrayed as dependent and incapable, substantial pressure is exerted on those making birth control decisions.

The data in Table 1 suggest that women were particularly vulnerable to conciliatory social control. Specifically, 63% of women reported experiencing conciliatory social control, compared to only 46% of men. Moreover, the types of interventions commonly recommended to women – such as tubal ligations and long-acting birth control – were potentially permanent and more invasive than those which men were persuaded to use (e.g., condoms). Thus, the burden of conciliatory social control disproportionately affected women and women's bodies.

Discussion

Consistent with Horwitz's (1982) theory, our data suggest that mental health treatment providers commonly exercise various forms of therapeutic social control to alter the contraceptive behavior of individuals with serious mental illness. Coercion made up only a minority of clients' experiences. Rather, conciliation and education, which combine elements of autonomy and control to varying degrees, were the most common types of interactions reported by respondents. These patterns may reflect a broader shift in the mental health treatment system toward a service-oriented approach with a culture of clients' rights. Consequently, the social control of individuals with SMI in contemporary practice is often obscured by discourses of self-determination, in which compliance is reframed as evidence of self-care and progress toward recovery rather than obedience (Coverdale et al. 1993; Torrey et al. 2001; Clarke et al. 2003). Consequently, mental health professionals and family members may influence the behavior and decision-making of individuals with SMI by invoking therapeutic goals rather than acting through legal channels. That said, it is worth noting that many of the arguments leveled by treatment providers and family members about clients' inability to effectively parent or be financially independent are direct reflections of pervasive stigmatizing attitudes toward people with SMI. In short, research that looks beneath the veil of humanistic clinical ideology is likely to reveal practices that create and reproduce traditional social hierarchies, as Horwitz originally argued (1982).

While these findings on limited or ambiguous autonomy are largely consistent with the work of Horwitz (1982) and Pescosolido and colleagues (1997), they build on existing theory in two ways. First, the strategies of enabling and education suggest a need to rethink and expand how sociologists conceptualize therapeutic influence and soft control in current psychiatric practice. Specifically, it is critical to consider how ostensibly non-coercive and value-free interventions nonetheless reflect the goals and norms of dominant groups. For example, respondents indicated that sex education provided in the context of inpatient psychiatric treatment was often compulsory, and pushed a discourse of risk and abstinence rather than emphasizing skills like communication that clients might use to establish more satisfying, reciprocal, and safe sexual relationships. As Foucault notes, power and knowledge are inextricably linked (1980). Providing education may constitute a form of paternalistic social control, even if medical advice is ostensibly scientific, value-free, and in the best interest of the client (Breeze 1997). Similarly, though enabling allows clients to make self-directed decisions about birth control, this strategy often ultimately guides them toward a limited set of choices through the selective provision of some kinds of resources and support and not others.

Second, our findings expand existing theories of therapeutic social control by revealing how gender structures the strategies used by clinicians and family members, as well as the birth control experiences of clients. Our data suggest that when therapeutic control is exercised, men disproportionately report softer and more impersonal forms of social control, while women disproportionately experience intense persuasion and direct coercion. These findings likely reflect distinct gendered approaches to therapeutic social control in mental health treatment settings. Moreover, when clinicians do approach the sexuality and reproduction of clients who are men and women differently, these interactions and interventions mirror traditional gender ideologies (Keskiner et al. 1973). This pattern is broadly consistent with feminist research on the exercise of patriarchal control over women and their bodies by the medical and mental health treatment systems (Barker 1998; Riska 2003; Metzl and Angel 2004; LaFrance 2007). However, our society views women with SMI, in particular, as simultaneously vulnerable and promiscuous (Collins 2001; Stern 2005; Frohmander and Ortoleva 2013), singling them out for paternalistic interventions and threatening their autonomy. Therefore, it is likely that women with SMI occupy a unique position of double disadvantage at the intersection of gender and psychiatric disorder.

Alternatively, the observed gender differences may reflect the types of contraception available for men and women. Aside from sterilization, condoms are currently the only birth control option for men. Unless the agent of social control is present, it is difficult to coerce someone into using contraception that is applied just prior to intercourse. In contrast, birth control methods for women include Depo-Provera, Norplant, the IUD, and the pill, all of which are effective over longer periods of time. Additionally, the consequences of pregnancy – including childcare, financial responsibility, and related stressors – fall primarily on women, especially if partner support is lacking. Clinicians and family members may employ more overt forms of social control in interactions with women with SMI compared to men because an unplanned pregnancy would disproportionately affect them.

This study has important limitations. First, insights about therapeutic social control strategies are viewed through the lens of clients in inpatient and outpatient treatment settings. We did not talk to clinicians or family members to obtain their perspectives, and therefore the reader should interpret with caution any attribution of motivation or intent on the part of these individuals. Second, data were collected prior to the passage of the Affordable Care Act and the associated infusion of resources into wrap-around mental health services. It is possible that institutional practices around social control have changed as a result of this shift in policy. Some of the evidence-based practices advocated by the ACA – including assertive community treatment and mental health courts – are coercive and/or conciliatory by definition. Future research should examine how national policy shifts influence the practice of therapeutic social control in localized treatment settings and clinician-client interactions.

With respect to clinical implications, our findings point to the need for a shift in discourse and clinician attitudes away from a risk avoidance narrative. Our interview data suggest that many clinicians approach their clients' sexual behavior as a symptom to be treated, or as a barrier to recovery. These views may drive use of therapeutic social control, pitting the values of autonomy and beneficence against one another. To achieve true autonomy in mental health practice, it is critical to foster open, sex-positive communication about clients' sexual and romantic goals and desires, and to make these a priority in treatment plans.

In sum, our findings provide empirical evidence for Horwitz's theory of therapeutic social control, underscoring the continued relevance of the distinctions between conciliation and overt coercion. However, we also identified new forms of ambiguous autonomy and soft control – education and enabling – in the 21st century experiences of clients in inpatient psychiatric hospitals and community mental health centers. Additionally, our data indicate that the use of social control is not consistent across clients within these treatment facilities and within families. Rather, on a continuum of control, men enjoy greater reproductive freedom. In contrast, women more frequently report unwanted intrusion into reproductive decisions that are sometimes irreversible, reflecting and reifying broader patriarchal systems of social control.

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Table 1. Distribution of contraception experiences among people with serious mental illness, IMHSHRS.

	All (n=98)		**Men (n=50)**		**Women (n=48)**	
Intervention	n	%	n	%	n	%
Enabling	19	19.4	11	22.0	8	16.7
Education	29	29.6	22	44.0	7	14.6
Conciliation	53	54.1	23	46.0	30	62.5
Coercion	11	11.2	1	2.0	10	20.8

Appendix A

Table A1. Structured coding scheme for abductive analysis

1	2	3	4	Theme
1.000				Mention of birth control, unwanted pregnancy, STIs
	1.100			Clear social control; Client has no agency; Birth control applied without choice
		1.110		**Coercion = Client is denied agency through use or threat of force or lack of informed consent**
			1.111	Threat of medication noncompliance
			1.112	Forced/coerced sterilization
			1.113	Deliberate misinformation
			1.114	Birth control given without informed consent
	1.200			Autonomy; Client is in control and self-directed; Client is agent
		1.210		**Enabling = Client given opportunity to make self-directed choice**
			1.211	Birth control openly accessible (e.g. condoms, spermicide)
			1.212	Client-initiated requests for birth control
	1.300			Soft social control; Client is a passive recipient, but ultimately makes decision
		1.310		**Education = Providing information, whether requested or not; Undirected and impersonal; Preventative in nature**
			1.311	Safe sex classes/sex education (voluntary/unspecified)
			1.312	Safe sex classes/sex education (compulsory)
			1.313	Education with focus on risk of STIs or pregnancy
		1.320		**Conciliatory control = Directed and individualized attempt to persuade toward some goal; Often paternalistic and reactionary**
			1.321	Advised s/he is not fit parent
			1.322	Sex/pregnancy is threat to physical/mental health
			1.323	Advised parenthood would disrupt recovery
			1.324	Advised s/he is not financially independent enough to parent