

Fear and Power in Forensic Psychiatry:
Nurse-Patient Interactions in a Secure Environment

by

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Thesis submitted to
The Faculty of Graduate and Postdoctoral Studies
in partial fulfillment of the requirements for the
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School of Nursing
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SUMMARY

This research project was situated at the crossroads of two distinct disciplinary fields: nursing and criminology. It sought not only to situate nursing practice in an extreme environment, but also to explore a professional practice in a context where the probability of nurses becoming victims of interpersonal violence is considered to be high, and where fear becomes a perceptible variable that shapes nurse-patient interactions. The goal was to describe and comprehend how fear as a dynamic process influences nursing interactions with patients. This understanding of the relationship between nurses and patients required that fear, the central concept in this project, be examined within the context of the total institution where nurses are both objects and subjects of power. To accomplish this, a qualitative design, which incorporates explorative and descriptive attributes, was thought to be an appropriate choice for this research project. Given the embryonic state of research regarding fear in forensic psychiatric nursing, and given the nature of the research question, grounded theory was considered to be the research method of choice for this project. Once the methodological groundwork was completed, introduction into the research setting permitted the direct observation of nursing routines as well as the completion of eighteen (18) semi-structured interviews. In keeping with an inductive methodological framework, the analysis of the data produced four mutually exclusive categories: 1.) Context, 2.) Nursing Care, 3.) Fear, and 4.) Othering. The fourth category (Othering) that emerged from the data analysis is the core category, because it is the site of a basic social process, and represents the site where all other categories converge. In brief, the results from this research indicate that the environment in which nurses practice is extremely constraining. Within this highly regimented context, nurses are socialized to incorporate representations of the patient population as being potentially dangerous, and, as a result, distance themselves from idealistic conceptions of care. In effect, the heightened awareness and suspicion that a few patients may evoke creates an environment in which trust is difficult to develop. Moreover, the research results emphasize the implication of fear in nurse-patient interactions and particularly how fear reinforces nurses' need to create a safe environment in order to practice. A constant negotiation between space, bodies and security takes place where nurses are forced to scrutinize their actions (self-discipline) in order to avoid becoming a victim of violence. As a result, security is a factor that needs to be present in order for care to be provided. If the environment is considered to be unsafe, then interventions to secure the space are inevitable. In parallel, participants also described how being able to identify with patients enabled positive (read "therapeutic") interventions to take place. Casting the patient in the role of the other (sick and/or vulnerable) enabled the nurse to create a rapport with the patient and to use the relationship in a transformative way (self-governance). However, exposure to the patient's criminal history, as well as the inability to rationalize the patient's behaviours within a sickness model, fostered a negative differentiation process wherein nurse-patient interactions became difficult. Along these lines, demonstrating "potential" was also described as an essential motivator for nurses to invest themselves in therapeutic relationships. The tension generated by (a)potential individuals disrupts the normal nursing process, because nurses experience difficulty in finding meaning in nursing care. Finally, participants also highlighted the presence of gender dynamics and social norms that implicitly and explicitly governed work divisions and the presentation of the self in the forensic psychiatric units. Incorporating the masculine standards (being fearless) was seen as a socially desirable attribute. Overall, this research project suggests that the need for safety (both at the individual and collective levels) will always cast a dark shadow over the ideals of care. When nurses feel threatened, security will take precedent over care.

CHAPTER 1

INTRODUCTION

"...if Charlie Manson had been picked up for breaking windows and kept forever, history would maybe be a little different." (Dustin: lines 654-656)

Historically, the development of a "scientific criminology" corresponds to a shift in emphasis away from the deviant act and towards the deviant individual (Mercer & Mason, 1998). Since the nineteenth century, criminal law has been highly influenced by the emergence of *the criminal* as an object of investigation and a focal point in the determination of punishments (Foucault, 1978). Somehow, this movement from the crime to the criminal has generated a conceptual gap—that is, establishing "the criminal as existing before the crime and even outside of it" (Foucault, 1978, p. 252)—a gap with which experts in the field of law continue to struggle. Precisely at the moment when the criminal's actions cannot be explained or understood rationally, the judicial machine ceases to function and the penal system must turn to psychiatry for answers (Chauvaud, 2009). In a complex analysis of what transpires between the act of reasoning (or lack of) and the action itself, the medico-legal expertise has developed a technical-knowledge system considered to be scientifically accurate in the identification of mad or bad individuals (Federman, Holmes & Jacob, 2009). In other words, criminal acts have become the responsibility of experts (such as psychiatrists and nurses) who can determine the sense beneath the act, measure the danger of an individual and establish the necessary intervention (i.e., indefinite hospitalization) to counter potential dangers (Foucault, 1978). The work of Rose (1998), who problematizes the new associations established between public risk and the priority of public safety, echoes the introduction of psychiatry into the field of law. Forensic psychiatry now holds the authority to evaluate "those who are thought to pose a risk to society on the basis not so much of what they have done, but of what they might do" (p. 184). As the introductory quote would suggest, if Charles Manson (the leader

of a U.S. cult responsible for serial murders, including that of actress Sharon Tate) had been identified as an "at risk individual," and had been indefinitely hospitalized under the potential risk that he embodied, history might have been different.

As early as the 1800s in the UK, the belief that certain individuals could not be held responsible due to mental illness led to the construction of special institutions designed to contain and treat those detained under medico-legal jurisdiction (Kettles & Woods, 2006). Within these institutions, a highly specialized field of nursing practice was created. Today, the complexity of care not only revolves around the difficult articulation of therapy and security imperatives (Burrow, 1998; Holmes, 2001a, 2001b, 2005; Mason, 2002; Peternelj-Taylor, 2004), but also includes the daily management of potential dangers (perceived or real) embodied by the inpatient population, since fear is considered to be evocative of caregivers' self-protective interventions (Whittington & Balsamo, 1998). As recent research demonstrates, working under threat compels nurses to redefine their interactions and choice of interventions with patients (Arnetz & Arnetz, 2001; Duxbury & Whittington, 2005; Foster, Bowers & Nijman, 2007; Kindy, Petersen & Pakhurst, 2005; Morrison, 1990; Needham, 2006). However, fear is not a topic that has been openly discussed in forensic psychiatry, and remains under-theorized (Morrison, 1990). It is important to explore and comprehend how fear, the central concern of this project, influences the exercise of nursing care in an environment, specifically, in a forensic psychiatric unit, where the potential for violence is considered to be high.

1.1 RESEARCH PROBLEM

"Neither a man nor a crowd nor a nation can be trusted to act humanely or to think sanely under the influence of great fear." (Russell, 1943, p. 121)

The topic of workplace violence often evokes graphic images of rare but high profile cases. "However, the most frequent and costly category of violent behaviours observed in work places are verbal coercion and physical assaults resulting, not in death, but in significant

time-loss injuries" (Love & Morrison, 2003, p. 600). It is well known that anyone exposed to manifestations of violence and/or aggression is confronted with two different choices: face the aggressor or avoid the confrontation (Mason & Chandley, 1999). The response to these types of experiences will vary depending on the person, while the process in which the victim is implicated is extremely complex. Other than physical repercussions, violence can have detrimental effects on the psychological processes of victims (including post-traumatic stress disorder, insomnia, agoraphobia, depression and fearfulness), as well as affect the dynamics of the work environment (sick leave, poor morale, higher staff turnover) (Atawneh, Zahid, Al-Sahlawi, Shahid & Al-Farrah, 2003; Lam, 2002; Zimmer & Cabelus, 2003). Although it remains difficult to capture the actual extent and cost of workplace violence (Love & Morrison, 2003), its negative social effects, both in terms of injured workforce and impact on interpersonal relationships, are evident and require further exploration (Needham, 2006).

Over the last two decades, workplace violence has gained worldwide attention, demonstrating both a growing concern about the issue and a conscious realization regarding the complexity of its manifestations and repercussions (Leather, 2001; Waddington, Badger & Bull, 2005b; Wells & Bowers, 2002). As publications about violence proliferate, similar attention is being directed towards the identification of specific workplaces and populations that are affected by this problem. Workplace violence in the healthcare sector is well-documented and has been described as having reached "epidemic" proportions (Lanza, 2006). In fact, "more assaults occur in health care and social service industries than any other, including law enforcement" (Love & Morrison, 2003, p. 599). Physical and verbal aggressions are a common occurrence in hospitals (Jansen, Dassen & Jebbink, 2005; Spector, Coulter, Stockwell & Matz, 2007), and nurses are believed to be 16 times more likely to experience these types of violence than any other worker (Elliot, 1997). Reported rates of exposure to violence against nurses vary in

the literature, but remain high (Rippon, 2000). Verbal abuse is the most common type of violence experienced by nurses (Duxbury, 2002; Maguire & Ryan, 2007; Atawneh et al., 2003; Farrell, Bobrowski & Bobrowski, 2006; Foster, Bowers & Nijman, 2007). However, reported rates of both verbal and physical violence indicate that most nurses, regardless of their area of practice, will face violent experiences in their careers (Fédération des infirmières et infirmiers du Québec (FIIQ), 1995; Hesketh, Duncan, Estabrooks, Reimer, Giovannetti, Hyndman and Acorn, 2002; Landy, 2005; Rippon, 2000). Alarming statistics demonstrate that, even in the short term (12 month period), up to 95% of nurses reported being victims of verbal violence, 85% reported being victims of physical violence, and 30% of nurses reported being victims of violence on a daily basis (Jansen, Dassen & Jebbink, 2005). Overall, the literature on workplace violence and health-care settings strongly attests that working environments can pose a threat to the physical and psychological integrity of nurses. Yet, it is believed that, due to the normalization of violence in our culture and the lack of standardized measuring and reporting mechanisms, violence in the workplace continues to be under-reported, and available statistics only represent the tip of the iceberg (Lanza, 2006; Morrison & Love, 2003). By some estimates, approximately 80% of violent incidents go unreported (Farrell, Bobrowski & Bobrowski, 2006; Owen, Tarantello, Jones & Tenant, 1998).

According to U.S. occupational health and safety agencies, workplace violence may be perpetrated by strangers, co-workers, or service recipients (ASIS, 2005). Despite a growing body of literature addressing co-worker violence in healthcare settings, service recipients (patients), whose primary target is often nurses, account for an important proportion of violent acts (Spector et al., 2007; Love & Morrison, 2003). Nurses are much more likely to fall victim to violence because of the situations in which they work, rather than because of their socio-professional status. Due to the proximity of caregivers to patients, nursing is one of the professions most apt to be the target of violent acts

(Anderson, 2002; Holmes, Kennedy & Perron, 2004; Lawoko, Soares & Nolan, 2004; Rotin, 2005).

The nature of violence may vary depending on the patient population being cared for and the units in which nursing care is being provided. The perceived risk of victimization is greater in some environments than others (Landy, 2005). In psychiatry, the risk of being exposed to a violent act from the patient population is considered to be high (Duxbury, 2002; Lawoko, Soars, & Nolan 2004, Morrison, 1990; Love & Morrison, 2003). According to Bilgin and Buzlu (2006), psychiatry remains one of the most at-risk areas of practice; their conclusion is substantiated by the U. S. Bureau of Justice Statistics' (2001) estimate that persons working in mental health settings become victims of workplace violence at a rate that is three times higher than that of those working in general medical fields. Not surprisingly, the issue of violence is well-known to healthcare professionals working in psychiatry.

Given the well-documented vulnerability of workers in such environments, healthcare providers are often confronted with the clinical decision to exercise restrictive measures. To this day, means of containment such as seclusion and restraints (chemical and physical) are commonly used in psychiatric settings to deal with violence and aggression (Bush & Shore, 2000; Duxbury, 2002; Duxbury & Whittington, 2005; Mason & Chandley, 1999). However, the humanitarian, ethical, and legal issues associated with the use of these restrictive interventions make them highly controversial management strategies (Holmes, Perron & Guimond 2007; Sailas & Wahlbeck, 2005). Despite prominent international recommendations to diminish such approaches (Sailas & Wahlbeck, 2005), and despite a common belief that nurses should be able to verbally diffuse threatening encounters (Fisher, 2003), current research continues to show that healthcare professionals' attitudes towards restrictive interventions have changed very little; the management of violence and aggression continues to be reactive and controlling

(Duxbury, 2002; Sailas & Wahlbeck, 2005). Apprehension about being victimized may motivate staff to manage aggressive incidents on a frequent basis, using physical methods such as seclusion and restraints (Foster, Bowers & Nijman, 2007).

Institutional culture has proven to be most influential in the decision-making process involved in the use of restrictive practices. This is true even when structural variables, such as peer pressure, are in opposition to the legal and ethical obligations of nurses (Holmes, Perron & Guimond 2007). While it is agreed that restrictive measures should only be used in extreme situations, empirical data demonstrates that healthcare professionals do not always respect this recommendation when confronted with the reality of the clinical field. In fact, more often than not, the most restrictive option to deal with violent behaviours is the most attractive, as it minimizes the potential blame of administrators and co-workers (Benson, Secker, Balfe, Lipsedge, Robinson and Walker, 2003; Hinsby & Baker, 2004). Because of the predictive connotation of violence, nurses are more likely to try to minimize blame from peers (Deans, 2004). As Deans (2004) suggests, it is very unlikely that we will be able to completely eliminate work-related violence, and, therefore, it is imperative that individual nurses and the entire nursing profession become increasingly aware of this phenomenon and how it affects nursing care.

Unlike traditional treatment settings, "the interpersonal climate, organizational culture, and social context of forensic settings result in forensic environments being identified among the most severe and extreme environments known to society" (Peternelj-Taylor, 2008, p. 800). The intricate combination of the hospital and the prison requires hospital-based forensic psychiatric nurses to work with individuals who have violated the law in some way or another; this includes individuals who have been diverted from custody for a psychiatric evaluation and those who are unfit to stand trial or are not criminally responsible on account of mental disorder (Peternelj-Taylor, 2008). In the nineteenth

century, forensic psychiatry was proclaimed as being "first and foremost a pathology of the monstrous" (Mason, 2006, p. 2), and great criminal events of the most violent and rarest sorts were its founding pillars; this is a representation that forensic psychiatry has yet to distance itself from (Federman, Holmes & Jacob, 2009). In the field today, the patient population is considered to pose a perpetual risk to the physical and psychological integrity of nurses (Holmes & Federman, 2003; Whittington & Balsamo, 1998). If the violence associated with this patient population is not always evident, there is, nevertheless, a perceived risk (Mason, Coyle & Lovell, 2008). Despite being periodic, violence in these environments produces a constant feeling of threat that inevitably affects nurses and their interactions with patients. Fear and the need for personal safety become integral parts of nurses' interactions and interventions with patients (Whittington & Balsamo, 1998).

Nursing practice in forensic psychiatric environments proves to be particularly complex, as "[...] nursing personnel must assume functions with regard to social control and psychiatric care in a hybrid work environment in which hospitals and prisons merge" (Holmes, 2005, p. 3). Some authors have described the difficulties associated with nursing care in forensic psychiatric settings (Burrow, 1998; Holmes, 2001a; Holmes & Federman, 2003; Mason, 2002; Peternej-Taylor, 2004). As many of these authors suggest, the articulation of therapy and security imperatives proves to be a challenge for these nurses. More precisely, the difficulty within the field of forensic psychiatric nursing lies in marrying two contradictory professional mandates: providing care and ensuring social control (Holmes, 2005). Psychiatric nurses are constantly torn between the ideal of care—to establish a reciprocal and trusting relationship (Peplau, 1992)—and confronting the realities of a security discourse, one that seeks to discipline deviant behaviour. Moreover, recent publications suggest that within disciplinary/total institutions such as correctional or forensic psychiatric settings, nurses tend to cast off the therapeutic ideal of care, and adopt authoritarian behaviours that are more characteristic of carceral ideology (Holmes,

2005; Holmes & Federman, 2003; Perron, Holmes & Hamonet, 2004). Within the forensic milieu, nurses undergo an indoctrination process as described by Holmes (2005), whereby the totalitarian regime imposes a modification of nurses' roles and redefines the representation of the persons for whom they care.

In addition to this complex professional role, nurses working in forensic psychiatric settings are confronted with yet another duality: the role of carer in which maintaining one's own right to safety is in opposition to offering the best quality of care (Needham, 2006). Such a paradox may very well lead to an ethical dilemma: nurses are caught between their best intentions to fulfil the profession's moral standards while concurrently attempting to safeguard and maintain their own rights to personal safety (Needham, 2006). Needless to say, the difficult position of professionals working in violent environments is creating concern regarding the effects of these conflicts on patient care (Anertz & Anertz, 2001).

According to Whittington and Balsamo (1998), nurse-patient interactions in forensic psychiatry are far from being similar to traditional hospital settings (i.e., medical-surgical). What makes forensic psychiatric environments so different is the perceived risk of violence and the need for personal safety that is involved. Because of the perceived risk of violence that the patient population embodies, the need for self-preservation on the part of nurses becomes a perceptible variable that influences nurse-patient interactions (Arnetz & Arnetz, 2001; Duxbury & Whittington, 2005; Foster, Bowers & Nijman, 2007; Kindy, Petersen & Pakhurst, 2005; Morrison, 1990; Needham, 2006; Whittington & Balsamo, 1998). The negative effects of fear (one of the most reported effects of violence) on patient care have been described by various authors. The apprehension about being victimized may lead fearful healthcare staff to adopt more controlling and less responsive services (Foster, Bowers & Nijman, 2007), to dissociate themselves from patients (Farrell, Bobrowski & Bobrowski, 2006; Hellzén, Asplund, Sandman & Norberg, 2004; Holmes, Perron &

O'Byrne, 2006; Kindy, Petersen & Pakhurst, 2005) and to become passive carers. Other authors have suggested that further investigation should be conducted on the "dark side of care," when those who pose a risk to the staff's integrity are more likely to be treated with less trust and less commitment, or neglected altogether (Hellzén et al., 2004). In this case, fear as a principal emotion in response to a perceived threat plays an important role that considerably affects how nurses view patients and interact with them (Farrell, Bobrowski & Bobrowski, 2006; Hellzén et al., 2004; Holmes, Perron & O'Byrne, 2006; Kindy, Petersen & Pakhurst, 2005;).

The notion of security is an important aspect of psychiatric ward environments (forensics and others) (Cleary & Edwards, 1999; Kindy, Petersen & Pakhurst, 2005,). Nurses in psychiatry tend to strive for a common goal of safety to create a therapeutic milieu. If nurses cannot create safe environments, however, there is a good chance that interactions will become custodial in nature (Kindy, Petersen & Pakhurst, 2005). In response to the threat of violence, when apprehensions about danger and fears prevail, "keeping the unit safe" through the use of surveillance technologies (spatial organization, increased visibility, etc.) and safety fortifications (use of cameras, seclusion rooms, etc.) represents the new ideals of psychiatric ward management (Johnson & Delaney, 2006; Kindy, Petersen & Pakhurst, 2005) and redefines the boundaries of nurse-patient relationships (Holmes, 2001b).

In forensic psychiatric settings, creating a tangible protective barrier between the staff ("us") and the patient population ("them") goes beyond the use of technologies to include psychological defence mechanisms. In effect, patients are distanced from carers because they may evoke feelings of disgust and fear (Holmes, Perron & O'Byrne, 2006). Consequently, "nurses face the difficult task of confronting challenges contained in the interpersonal care they are required to render, and in their own psychic make-up defence systems" (Müller & Poggenpoel, 1996, p. 143). When the discrepancy between

interpersonal care and the use of a defence mechanism is too great, the nurse can no longer relate to the patient in a professional/ethical manner, because a safe zone cannot be established. In such cases, breakdowns in the nurse-patient relationship are inevitable, and constitute a fertile ground for interactions based on custodial practices (Müller & Poggenpoel, 1996). In order to understand how these negative emotions operate, we must ask what mechanisms are implicated in producing these responses. Moreover, it is imperative to understand how fear operates when one is confronted with repulsive/dangerous groups of patients, such as mentally ill offenders.

This research project is thus situated at the crossroads of two distinct disciplinary fields: nursing and criminology. It seeks not only to situate nursing practice in an extreme environment, but also to explore a professional practice in a context where the probability of nurses becoming victims of interpersonal violence is considered to be high, and where fear becomes a perceptible variable that shapes nurse-patient interactions (Whittington & Balsamo, 1998). According to some authors (Holmes, 2005; Holmes & Federman, 2003), nursing practice cannot adhere to nursing ideals in an environment where security prevails and where the population being cared for is understood as being "at risk" of violence. However, the process of the nurse-patient interaction in a secure, potentially violent environment has not been clearly defined in contemporary nursing theorization, as political and institutional elements have previously been excluded (see Whittington & Balsamo, 1998). Nursing practice has not been sufficiently conceptualized in accordance with the nature of the environment in which the nursing practice takes place. Similarly, the topic of fear has not been openly discussed in forensic psychiatry, and it remains under-theorized (Morrison, 1990).

It is important to explore and comprehend how fear influences the exercise of nursing care in an environment where the potential for violence is considered to be high (forensic psychiatric unit). This understanding of the relationship between nurses and

patients requires that fear, the central concept in this project, be examined within the context of the total institution (see Goffman, 1990) where nurses are both objects and subjects of power (Holmes, 2005; Holmes & Federman, 2003; Whittington & Balsamo, 1998).

1.2 RESEARCH OBJECTIVES

1. Critically analyse nursing interactions in light of political realities at play in a total institution.
2. Describe and comprehend how fear, as a dynamic process, influences nursing interactions with patients in forensic psychiatry.

1.3 RESEARCH QUESTIONS

1. How does fear influence the nurse-patient interaction in forensic psychiatry?
 - a. How do nurses organize their care when dealing with potentially violent populations?
 - b. How do nurses' mental representations of forensic psychiatric patients shape nursing care in forensic psychiatry?
 - c. How do nurses engage with patients?
 - d. How do nurses view their therapeutic roles in hospital-based forensic psychiatric settings where fear is omnipresent?

1.4 PHILOSOPHICAL STANCE

This project will address the above research questions and objectives within the paradigm of critical theory as defined by Guba and Lincoln (1994, 2005), and more precisely, from a postmodern perspective. The main aspect of this paradigm is that reality (ontology) is a product of social, political, cultural, economic, ethnic, and gender factors (Guba & Lincoln, 1994). This constructed "reality" is incorporated into various discourses (theoretical, ideological, scientific, etc.), but is also imbedded into social institutions, including the psychiatric hospital and the prison. Therefore, as a social construction and historical

product, this reality (the researched phenomenon) must be located within a specific time/space context to reveal how it came to be, what it has become and which factors have influenced its evolution. From an epistemological perspective, the researcher is considered to be interactively linked to the participants and the context in which they are situated (Guba & Lincoln, 1994). In effect, the values of both the inquirer and participants are considered to be inextricable factors with the production of knowledge and the type of knowledge produced (Guba and Lincoln, 1994). As a result of the researcher's position within the research process, it is inevitable that "issues of class, gender, race, power and the like" (Annell, 1996, p. 390) will be introduced and will reflect the values brought to the research by the researcher.

Postmodern perspective

According to Cheek (2000), "all postmodern approaches emerge from a critique of the assumptions that underpin modernist thought" (p. 18). Indeed, "postmodern thought discards the organic notion of all parts of society working together in an orderly way, and in so doing it rejects modern assumptions of social coherence and notions of causality in favour of multiplicity, plurality, fragmentation, and indeterminacy" (Cheek, 2000 p. 18). As a component of critical theory, a postmodern position enables one to adopt a different viewpoint of the rules and regulations that govern specific phenomena by questioning the status quo and taken-for-granted narratives of truth (Cheek, 2000). In the discipline of nursing, the influence of modern thought has generated a number of grand theories, which attempt to describe, present and orient nursing care (Fawcett, 1995). Despite incorporating the notion of environment into most of their work, nursing theorists have generally described nursing care without contextual considerations; that is, nursing care is regarded as a fixed entity that will not be affected by the powers at play within particular contexts.

To answer the aforementioned research questions, therefore, the researcher has sought to create a distance from such conceptions of nursing care, and to adopt a position

that allows a different way of thinking. This permits an exploration of the power relations existing within particular contexts of care in which the environment/population being cared for redefines nurse-patient interactions.

CHAPTER 2

LITERATURE REVIEW

The inductive properties of a grounded theory method suggest that themes and explanations progressively emerge from the data as the research project evolves. As such, the elaboration and adoption of a theoretical framework prior to conducting the research project is not suggested (Strauss & Corbin, 1998b). However, an overview of the literature seems unavoidable in order to formulate a research problem and accentuate the researcher's theoretical sensitivity. According to Strauss and Corbin (1998b),

[...] there is no need to review all of the literature in the field beforehand, as is frequently done by analysts using other research approaches. It is impossible to know prior to the investigation what the salient problems will be or what theoretical concepts will emerge. Also, the researcher does not want to be so steeped in the literature that he or she is constrained and even stifled by it (p. 49).

Following grounded theory principles, the literature review evolves as the concepts (categories) emerge from the data. Initially, three databases were reviewed (CINAHL, Medline and PsycINFO) to delineate the research problem. As the research progressed, additional theoretical works were sourced out. As such, the following literature review synthesizes the body of work that was used as a source of comparison to specify and delineate emergent concepts.

2.1 WORKPLACE VIOLENCE

The topic of workplace violence often evokes graphic images of rare but high-profile cases. "However, the most frequent and costly category of violent behaviours observed in work places are verbal coercion and physical assaults resulting, not in death, but in significant time-loss injuries" (Love & Morrison, 2003, p. 600). Although it remains difficult to capture the extent and cost of workplace violence (Love & Morrison, 2003), its negative social effects, both in terms of injured workforce and impact on interpersonal relationships, are evident and require further exploration (Needham, 2006).

2.1.1 Defining Workplace Violence

Over the last two decades, workplace violence has gained worldwide attention, demonstrating both a growing concern about the issue and a conscious realization regarding the complexity of its manifestations and repercussions (Leather, 2001; Waddington, Badger & Bull, 2005b; Wells & Bowers, 2002). Underpinned by a growing realization that violence represents a common reality for workers, both researchers and clinicians are exploring the many facets of workplace violence and trying to promote safer work environments (Leather, 2001). Although workplace violence is a problem that calls for unifying efforts from individuals and institutions the world over, there remain major difficulties in addressing the problem in a consistent manner.

Without a doubt, violence is a universal phenomenon that occurs in all cultures (Mason & Chandley, 1999). However, between cultures significant differences exist regarding the attention or importance given to this problem. In effect, different conceptions regarding the nature and character of violence will inevitably direct the ways of addressing it in the workplace (Poster, 1996). How violence is defined will make it possible to target unwanted behaviours and develop ways to avoid its occurrence. More importantly, violence needs to be understood as a term that has political connotations, implicitly undermining a moral imperative to take action against its sources (Waddington, Badger & Bull, 2005a). Indeed, the proliferation of the term "violence" may actually represent a strategy used by various parties to give weight and to attract attention towards specific social situations (Rippon, 2000). For example, publicly stating that nurses are victims of violence rather than aggression immediately heightens the sense of urgency and the need to find solutions to this problem in the near future. Despite having a certain use in the political arena, this substitution has created a situation wherein the term violence has lost its defining attributes. In other words, violence means everything and nothing at the same time.

Part of this expansive definition of violence is also the result of a growing dissatisfaction with its traditional definition (i.e., physical violence). In effect, the personal meaning attributed with victimization has influenced researchers to describe violence according to a wider spectrum of interpersonal experiences (Waddington, Badger & Bull, 2005a, 2005b), thus permitting them to penetrate the subjective meanings of "violence" as defined by victims (Leather, 2001). Violence is, therefore, considered to be part of a subjective experience in which the victim's appraisal, as well as the impact of the situation, (i.e., verbal and/or physical attack) will vary from one person to another (Waddington, Badger & Bull, 2005a). As such, in the research at hand, any definition of violence must be broad enough to cover the full range of circumstances in which workplace violence may occur (Leather, 2001), including "behaviours that can cause injury, damage property, impede the normal course of work, or make workers, managers, and customers fear for their safety" (ASIS, 2005, p. 8). Some common definitions of workplace violence include "incidents where employees are abused, threatened, assaulted or subjected to other offensive behaviour in circumstances related to their work" (di Martino, 2003, p. 1) and "a broad range of behaviours falling along a spectrum that, due to their nature and/or severity, significantly affect the workplace, generate a concern for personal safety, or result in physical injury or death" (ASIS, 2005, p. 8).

Clearly then, defining violence as broadly as possible is important to the research project whose objective is to capture the subjective meanings of participants regarding this issue. However, it must be noted that the subjective meanings attributed to a violent event/situation have also led to a difficulty in defining this concept, or, at least, to creating conceptual boundaries. According to many authors, this difficulty is considered to be a major conceptual and methodological issue in the research on violence (Duxbury, 2002; Leather, 2001; Rippon, 2000; Waddington, Badger & Bull, 2005a, 2005b), not only leading to inconsistencies in reporting incidence and prevalence rates, but also making it difficult to

compare data found in the literature. In effect, if it is extremely important to recognize violence as an amalgamation of personal experiences, it is equally important to define what violence actually is (Waddington, Badger & Bull, 2005a, 2005b). The term violence has come to encompass so much that it means nothing more specific than a negative experience.

2.1.2 Extent of Workplace Violence

“... in almost any location where people gather together there is the prospect of violence and aggression.” (Waddington, Badger & Bull, 2005b, p. 1)

As publications on violence proliferate, similar attention is being directed towards the identification of specific workplaces and populations that are affected by this problem. Workplace violence in the healthcare sector is well-documented, where this occupational hazard has been described as having reached “epidemic” proportions (Lanza, 2006). “In fact, more assaults occur in health care and social service industries than any other, including law enforcement” (Love & Morrison, 2003, p. 599). Physical and verbal aggressions are a common occurrence in hospitals (Jansen, Dassen & Jebbink, 2005; Spector et al., 2007), and nurses are believed to be 16 times more likely to experience violence than any other worker (Elliot, 1997). In the literature, reported rates of exposure to violence against nurses vary, but remain high (Rippon, 2000). Verbal abuse is the most common type of violence experienced by nurses (Atawneh et al., 2003; Duxbury, 2002; Farrell, Bobrowski & Bobrowski, 2006; Foster, Bowers & Nijman, 2006; Maguire & Ryan, 2007), and reported rates of both verbal and physical violence indicate that most nurses, regardless of area of practice, will face violent experiences in their careers (FIIQ, 1995). Alarming statistics demonstrate that, even in the short term (12 month period), up to 95% of nurses reported being victims of verbal violence, 85% reported being victims of physical violence, and 30% of nurses reported being victims of violence on a daily basis (Jansen, Dassen & Jebbink, 2005). The literature on workplace violence and health care settings

attests that present working environments can pose a threat to the physical and psychological integrity of nurses. However, it is believed that, due to the normalization of violence in our culture and the lack of standardized measuring and reporting mechanisms, violence in the workplace continues to be under-reported, and available statistics only represent the tip of the iceberg (Lanza, 2006; Morrison & Love, 2003). By some estimates, approximately 80% of violent incidents go unreported (Farrell, Bobrowski & Bobrowski, 2006; Owen, Tarantello, Jones & Tenant, 1998).

According to U.S. occupational health and safety agencies, violence in the workplace may originate with strangers, co-workers, or service recipients (ASIS, 2005). Despite a growing body of literature addressing co-worker violence in healthcare settings, service recipients (patients), whose primary target is often nurses, account for an important proportion of violent acts (Love & Morrison, 2003; Spector et al., 2007). Nurses are more likely to fall victim to violence because of the situations in which they work, rather than because of their socio-professional status. Due to the carers' proximity to patients, nursing is one of the professions most likely to be the target of violent acts (2004; Anderson, 2002; Holmes, Kennedy & Perron, Lawoko, Soares & Nolan, 2004; Rotin, 2005).

The nature of violence may vary depending on the patient population being cared for and the units in which nursing care is being provided. The perceived risk of victimization is greater in some environments than others (Landy, 2005). In psychiatry, the risk of being exposed to a violent act from the patient population is considered to be high (Duxbury, 2002; Lawoko, Soars, & Nolan 2004; Love & Morrison, 2003; Morrison, 1990). According to Bilgin and Buzlu (2006), psychiatry remains one of the most at-risk areas of practice; their conclusion is substantiated by the U.S. Bureau of Justice Statistics' (2001) estimate that persons working in mental health settings become victims of workplace violence at a rate that is three times higher than that of those working in general medical

fields. Hence, the issue of violence is well-known to healthcare professionals working in psychiatry.

Despite being secure facilities, forensic psychiatric settings are environments in which violence is a problem (Daffern, Ogloff & Howells, 2003; Linhorst & Parker Scott, 2004; McKenzie & Curr, 2005; Morrison, Morman, Bonner, Taylor, Abraham & Lathan, 2002; Rasmussen & Lavender, 1996). According to Peternelj-Taylor (2008), "the interpersonal climate, organizational culture, and social context of forensic settings result in forensic environments being identified among the most severe and extreme environments known to society" (p. 800). Nurses who work in these environments often must deal with populations that have patterns of violence in their histories (McKenzie & Curr, 2005). A recent study conducted by Daffern, Ogloff and Howells (2003) in an Australian forensic psychiatric hospital indicated that 44.14% of patients admitted to the hospital during the study period (6 months) were aggressive. Eighty-eight patients (60.7%) were aggressive on more than one occasion, and eight patients (5.52%) were responsible for more than ten incidents, including two who were aggressive on twenty-five occasions. That is, 8 patients accounted for 142 (42.9%) of aggressive incidents. The most common type of aggression was "the most severe form of verbal aggression" (Daffern, Ogloff & Howells, 2003, p. 22) such as cursing viciously and making moderate threats to others or the self. Rasmussen and Lavender (1996), who conducted a study in a European secure ward, presented similar results. In this case, violent attacks upon staff were committed by 55% of in-patients, and a small number of patients were responsible for a large share of the total number of violent incidents.

Interestingly, in a secondary analysis of data collected from a statewide, annual, cross-sectional survey of all patients (N=853) residing in four long-term public psychiatric hospitals for adults, Linhorst and Parker Scott (2004) suggest that forensic patients are less likely to commit assaults than nonforensic patients. Nevertheless, these authors

reveal, "some people may still believe that forensic patients commit more serious assaults than non-forensic patients, even though forensic patients commit fewer total of assaults" (Linhorst & Parker Scott, 2004, p. 868).

In effect, the issue may not necessarily revolve around actual violence but rather the perceived risk that a population poses to nurses. If a higher risk of violence in forensic psychiatry is not evident, it is nonetheless perceived as so (Mason, Coyle & Lovell, 2008). According to Mason, Lovell and Coyle (2008), the condition of working in a potentially violent environment induces somewhat of a chronic fear, even if stressful situations only periodically spill into acute states of actual violence. This perception of threat or fear is what differentiates the forensic psychiatric environment from traditional hospital settings (medical or surgical units). In this area of practice, where the patient population is believed to be dangerous and is kept at a distance, the perceived risk of violence and the need for personal safety reconfigure nurse-patient interactions (Whittington & Balsamo, 1998). Much work needs to be done in order to explore how nurses perceive their patients and how these perceptions affect care (Holmes & Federman, 2003).

In most healthcare settings, patients' behaviours do not represent an imminent threat to the nurses' psychological and physical integrity. Therefore, nursing interventions can be viewed as altruistic, and their actions are driven towards the patient's needs without fear of being victimized. In forensic psychiatry, nurses must evaluate the patient's behaviours according to two distinct axes: (1) What does the behaviour tell me about the patient's well-being? and (2) What does this behaviour tell me about my own personal safety (Whittington & Balsamo, 1998)? The question then becomes, how can nurses balance the need for security (personal and collective) while maintaining a therapeutic environment congruent with nursing ideals of care? Thus, it is imperative for nurses to understand the nature of their interactions with patients and identify how their need for self-preservation affects how care is being delivered in a violent and threatening

environment. As a part of a reflexive practice, nurses must begin to examine their own behaviour and responses to violence in order to optimize care (Harris & Morrison, 1995).

2.1.3 Impact of Violence on Service Delivery

The effects of violence vary greatly depending on the severity and frequency of episodes, as well as the subjective experience of the victim (Atawneh et al., 2003). It is now understood that, other than its physical repercussions, violence can have detrimental effects on the psychological processes of nurses. Nurses who are victims of violence may experience a number of adverse psychological repercussions, including a variety of post-traumatic stress responses: post-traumatic stress disorder, insomnia, agoraphobia, depression and fearfulness. Evidently, these effects are personal, but they may also have a negative impact on work environments (sick leave, poor morale, higher staff turnover) (Atawneh et al., 2003; Lam, 2002; Zimmer & Cabelus, 2003).

Additionally, there is growing concern regarding violence and its detrimental effects on patient care (Anertz & Anertz, 2001). The negative effects of fear (one of the most reported effects of violence) on patient care have been described by various authors. Apprehension about being victimized may bring fearful healthcare staff to adopt more controlling and less responsive services (Foster, Bowers & Nijman, 2007). The apprehension about being victimized may motivate staff to manage aggressive incidents with physical methods, such as seclusion and restraints, on a frequent basis (Foster, Bowers & Nijman, 2007). In violent situations, nurses may also try to dissociate themselves from patients (Farrell, Bobrowski & Bobrowski, 2006; Hellzén et al., 2004; Holmes, Perron & O'Byrne, 2006; Kindy, Petersen & Pakhurst, 2005) to the point of becoming passive caregivers. Other authors have suggested that further investigation about the "dark side of care" should be conducted, examining how those who pose a risk to the staff's integrity are more likely to be treated with less trust and less commitment, or to be neglected altogether (Hellzén et al. 2004). In this case, fear as a principal emotion in

response to a perceived threat plays an important role in how nurses view patients and interact with them (Farrell, Bobrowski & Bobrowski, 2006; Hellzén et al., 2004; Holmes, Perron & O'Byrne, 2006; Kindy, Petersen & Pakhurst, 2005).

In addition to this complex professional role, nurses working in forensic psychiatric settings are confronted with yet another challenge: fulfilling the role of carer in which maintaining one's own right to safety is in opposition to offering the best quality of care (Needham, 2006). This may very well lead to an ethical dilemma; nurses are caught between their best intentions to fulfil the profession's moral standards while concurrently attempting to safeguard and maintain their own right to personal safety (Needham, 2006). Needless to say, the difficult position inflicted on professionals working in violent environments is creating concern regarding the effects on patient care (Anertz & Anertz, 2001).

2.1.4 Culture of Violence in Psychiatry

The management of disruptive individuals within psychiatric institutions is very much a question of culture, a culture that is located at the nexus between therapy and control (Duxbury, 2002; Duxbury & Whittington, 2005; Morrison, 1998). This culture must be understood as the result of locally constructed knowledge. In effect, psychiatric institutions can be defined as microcosms, or small societies (Goffman, 1990), that function according to a set of basic assumptions, values and beliefs that are shared by its members and enacted through specific procedures and practices (Johnson & Morrison, 1993), procedures and practices that are then taught to new members as the proper way to conduct themselves within these institutions (Schein, 2004).

As a result, the practices that are favoured and that become part of institutional routines in the management of violence are profoundly shaped by the psychiatric culture, which exists across three main levels: "artefacts, e.g., organizational rules, procedures, and observable behaviours of employees, espoused values (which serve to determine

employee beliefs about how things ought to be and what is important in the organization), and basic assumptions (unconscious assumptions about appropriate behaviours and reactions in any given situation" (Schein, 1992 in Duxbury, Bjorkdhal & Johnson, 2006 p. 275). As such, the violence management and the conditions under which controlling practices are deployed are profoundly influenced by the "sociofacts" (specific social relations between health care professionals and patient) and "mentifacts" (particular ideas) that make up the psychiatric culture (Duxbury, Bjorkdhal & Johnson, 2006, p. 280).

However, it is important to also understand that these micro-societies are situated within a much larger socio-political and economical reality that may affect this culture. A great deal of pressure is being exercised over nurses due to shorter lengths of stay in hospitals and lack of staffing resources in the nursing profession (Morin & Michaud, 2003). In this case, the utilization of control measures to maintain safety in psychiatric settings is imbedded in a climate of insecurity (Morin & Michaud, 2003) where therapeutic environments may be difficultly maintained (Kindy, Petersen & Pakhurst, 2005). Hinsby and Baker (2004) further believe that therapeutic environments in psychiatry are strongly imbedded in a culture of violence, where this construct is believed to be part of the job and is tolerated (Farrell, Bobrowski & Bobrowski, 2006; McPhaul & Lipscomb, 2004; Morrison & Love, 2003). As a result, suggest some researchers (Farrell, Bobrowski & Bobrowski, 2006), this tolerance to violence creates desensitization to the issue. Thus, it is not surprising that patterns of toughness may be observed in psychiatric settings, where the ability to manage violent behaviours is considered to be a valued and socialized psychiatric skill (Morrison, 1990).

As Morrison (1990) points out, a tradition of toughness exists in psychiatry. Nurses are socialized (through coercive manipulations) to adopt certain behaviours in potentially violent situations. More importantly, Morrison (1990) also notes that certain individuals may take on the role of security as their psychiatric expertise (supermanning).

The enforcers, or the police force (staff), are the ones who see themselves as expert in crisis management. The culture of toughness is based on the ideals of machismo; then, what you have is an increase in confrontation. When the value is placed on being tough, then you handle situations when things get out of hand. [...] When a unit operates from the culture of toughness, then staff are valued for their ability to physically manage assaultive patients (Morrison, 1990, p. 35).

2.1.5 Management of Violence in Psychiatry

The management of individuals manifesting violent or aggressive behaviours will vary depending on the medicalization (or not) of these behaviours (Mason & Chandley, 1999). It is understood that cultural settings that have positioned violence and aggression under the realm of medicine will "treat" these behaviours in similar ways. Individuals responsible for violent and aggressive acts will be institutionalized, classified as sick and treated as such. Therefore, under organizational ideology based on the medical model, the behaviours of individuals will be viewed as symptoms of an illness for which hospitalization is designed to provide a controlling treatment environment (Morrison, 1990). On the other hand, those who have identified violence and aggression as anti-social behaviours will most likely label the perpetrator as a delinquent and use punitive measures of control (i.e., imprisonment) to discipline unwanted behaviours (Mason & Chandley, 1999). Whether violence and aggression are viewed as symptoms of an illness or the product of a malevolent mind, a common object is shared between both perspectives: violence and aggression represent negative social behaviours and need to be controlled.

To this day, means of containment such as seclusion and restraints (chemical and physical) are commonly used in psychiatric settings to deal with violence and aggression (Bush & Shore, 2000; Duxbury, 2002; Duxbury & Whittington, 2005; Mason & Chandley, 1999). Healthcare providers are often confronted with the clinical decision to exercise restrictive measures. However, the humanitarian, ethical, and legal issues associated with the use of these restrictive interventions makes them highly controversial management strategies (Holmes, Perron & Guimond, 2007; Sailas & Wahlbeck, 2005). Despite

prominent international recommendations to diminish these approaches (Sailas & Wahlbeck, 2005) and a common belief that nurses should be able to verbally diffuse threatening encounters (Fisher, 2003) current research continues to state that healthcare professionals' attitudes towards restrictive interventions have changed very little, and that the management of violence and aggression continues to be reactive and controlling (Duxbury, 2002; Sailas & Wahlbeck, 2005). Apprehension about being victimized may motivate staff to manage aggressive incidents on a frequent basis, using physical methods such as seclusion and restraints (Foster, Bowers & Nijman, 2007).

More importantly, culture has proven to be most influential in the decision-making process involved in the use of restrictive practices (Holmes, Perron & Guimond, 2007). According to some authors (Benson, Secker, Balfe, Lipsedge, Robinson and Walker, 2003; Hinsby & Baker, 2004), the most restrictive option for dealing with violent behaviours is often the most attractive as it minimizes the potential blame of administrators and co-workers. That is, nurses are more likely to try to minimize blame from peers that occurs because of the predictive connotation of violence (Deans, 2004). As Deans (2004) suggests, it is very unlikely that work-related violence will ever completely be eliminated and, therefore, it is imperative that nurses and the entire nursing profession become increasingly aware of this phenomenon and how it affects nursing care.

The issue of security is an important aspect of psychiatric ward environments (forensics and others) (Cleary & Edwards, 1999; Kindy, Petersen & Pakhurst, 2005). Nurses in psychiatry desire a common goal of safety to create a therapeutic milieu. If they cannot create safe environments, there is a good chance that interactions will become custodial in nature (Kindy, Petersen & Pakhurst, 2005). In response to the threat of violence, which elicits fear and apprehension about dangers, "keeping the unit safe" through the use of surveillance technologies (spatial organization, increased visibility, etc.) and safety fortifications (use of cameras, seclusion rooms, etc.) represents the new ideals

of psychiatric ward management (Kindy, Petersen & Pakhurst, 2005; Johnson & Delaney, 2006) and redefines the boundaries of nurse-patient relationships (Holmes, 2001b).

2.1.6 Explaining Violence in Health Care

According to Leather (2001, p. 13), a "...consistent theme in the literature on violence is that the key to prevention lies in the validity of the underpinning explanatory model" Presently, three different explanatory frameworks exist in the literature regarding violence and its causes (Duxbury, 2002; Duxbury & Whittington, 2005): the internal model, the external model and the situational/interactional model.

Internal model

The internal model focuses on patient variables to explain violent behaviour. Historically, much of the research on violence has been done within this model (Johnson, 2004). However, this view has been criticized due to its reductive nature (Duxbury, 2002). "Whilst features of the internal model are attractive because of the relatively fixed nature of the variables, external and interactional factors are also clearly influential" (Duxbury & Whittington, 2005, p. 114).

While each variable (sex, age, history of violence, etc.) or their combination may very well lead to the occurrence of violent behaviour, the fact remains that, more often than not, violence does not occur without contextual stimulation (Leather, 2001). "Spontaneous human aggression, like spontaneous human combustion, is a rare and probably mythical phenomenon" (Whittington & Balsamo, 1998, p. 68). Certainly, individual variables make it possible for researchers and clinicians alike to capture some of the antecedents of violent behaviour, and to find common characteristics that partially explain its occurrence. However, this remains only part of the whole picture

One needs to be extremely cautious when trying to address individual characteristics and attempting to correlate them with violent behaviour. According to Pilgrim and Rogers (2003), the tentative links between mental illness and violence are not

built solely on the medical management of mental illness, but, rather, serve a distinct political tool. In fact, Pilgrim and Rogers (2003) clearly outline, mental illness is a poor predictor of violence compared to other factors such as substance abuse or a past history of violence. Pilgrim and Rogers (2003) prefer describing the phenomena of violence as a "ball of wax" wherein confounding variables make it difficult to determine why some patients are violent and others not, in much the same way that some "normal people" are violent and others not. In light of the weak empirical bases to construct policy about safety, Pilgrim and Rogers (2003) believe a set of political and sociological factors might explain the recurring pre-occupations that agencies have with psychiatric patients as sources of violence.

External model

According to Duxbury and Whittington (2005), the external model explores how environmental factors may affect the occurrence of aggression. This perspective takes into account the structure of the environment, its restrictions on individuals, staff variables, access to privacy, etc. as being influential factors in the occurrence of violence. As Whittington and Balsamo (1998) explain, the external model probably represents the opposite perspective to the internal model. From the perspective of medicine, the patient is the site of pathological inscription where all actions become possible interpretations of pathological behaviour (internal model). Alternatively, critical sociology defines the patient as a victim of the institution where violence is a way to resist the institution (external model).

"While most commentators recognize the complexity of aggressive behaviours and the likely role of multiple causative factors, much of the evidence-based debate has drawn on the epidemiological approach examining associations between demographic, clinical, and aggression variables 'within' the patient to develop actuarial models of risk" (Whittington & Richter, 2006, p. 48). Whittington and Richter (2006) further suggest that

this focus on individual variables (for example, patient symptoms) to predict violence reveals high rates of false positives. As these authors conclude, if one wishes to truly understand the origins of violence, it is sometimes important to look at violent behaviours outside their pathological framework, and normalize the behaviours according to specific circumstances.

Situational/interactional model

Unlike the previous models, the situational/interactional model explores the relationship between staff and patients as a potential variable in the productions of violent behaviours. "When the explanatory focus shifts from the individual to the situation, it is clear to see how organizational and socio-political factors come to be related to incidents of violence and aggression" (Leather, 2001, p. 17). In psychiatry, a good example of this model is how limit setting often leads to violent reactions from patients (Duxbury & Whittington, 2005; Johnson, 2004; Leather, 2001). Morrison (1994) highlights the importance of the interactional nature of aggressive behaviours in persons living with mental illness. According to this author, individuals who live with mental illness may be violent for the same reasons as persons who do not. In this particular study, 55% of aggression and violence was accounted for by only three variables: coercion, history of violence, and length of hospital stay.

In brief, explanatory models of violence in psychiatry cannot be reduced to patient psychopathology. There is a need to acknowledge the interaction between a number of factors, such as the staff, the patients and the environment. Yet, despite the growing amount of literature that demonstrates the importance of the interaction between personal and environmental factors in predicting violent behaviours, this connection has been largely neglected in clinical evaluations of dangerousness (Leather, 2001; Whittington & Richter, 2006). The challenge now is to undertake research on violence according to

external and situational models, rather than focussing only on patient variables to explain the problem of violence in psychiatry.

2.2 VIOLENCE: POWER & FEAR

Keeping in mind the situational/interaction model of violence described above, it is then possible to address the way violence is conceptualized in forensic psychiatric settings. According to Whittington and Balsamo (1998), "when nurse and patient confront each other in a conflict, strong feelings of fear and power or powerlessness are frequently generated in both participants..." (p. 65). However, the concept of fear and power remain neglected in the understanding of violence in psychiatry, in that the fear has been relatively unexplored (Masson, 2002), and power generally has been conceptualized around its extreme lack of balance between nurses and patients.

2.2.1 Power

The concept of power has been studied from various perspectives and has traditionally been conceived as a negative and repressive force (Holmes & Gastaldo, 2002). "Contrary to the traditional representations in the works of Marx (1946) and Weber (1986), power neither belongs to a privileged class of wealthy individuals who exercise it on classes of lower socioeconomic status (Marx), nor does it belong to a small group of people who occupy a position of legitimate authority at the heart of an organization, and impose their decisions upon others (Weber)" (Perron, Fluet & Holmes, 2005, p. 537). According to Foucault (1995), power is a fluid entity that is always present and exercised upon individuals. "Power is employed and exercised through a net-like organization; it is not the property of someone or a group. Power acts upon individuals as they, in turn, act upon others. Therefore, power is relational" (Holmes & Gastaldo, 2002).

In psychiatry, patients are rarely viewed as exercising power over nurses. That is, power relations are often portrayed as uni-directional, from the nurse to the patient. This perception lies in the culture of control and safety that is present in these settings. That is,

the organization and the structure of the unit (Johnson & Delaney, 2006), as well as therapeutic interventions (i.e., medication), serve as the mechanism to contain and control patients. Risk of violence is reduced by the effective use of space (enhancing visibility and enforcing boundaries between private and public), by the regulation of time and by therapeutic interventions (Johnson & Delaney, 2006). According to Foucault (1995), this relation of power is one of discipline, whereby nurses develop techniques that meticulously control the operations of the body, assuring the constant subjection of its forces, and imposing upon patients a relation of docility-utility (Foucault, 1995, p. 137). Through constant coercion and management of time, space, actions and therapeutic regimens, docility is produced (Foucault, 1995). However, this institutional functioning is often enmeshed in a therapeutic and safety rationale, and very rarely does fear of the "Other" explain nursing interventions.

Those who are considered dangerous individuals transgress important boundaries of personal integrity and are often a source of apprehension. For instance, encounters with actively psychotic individuals may induce fear on the part of the nurse, thus producing the deployment of defensive strategies (i.e., creating a distance between the nurse and the patient, use of restraints, use of the seclusion room) to regain a sense of control over the situation. In some cases, working under threat may either facilitate or impede the therapeutic process. Consequently, "nurses face the difficult task of confronting challenges contained in the interpersonal care they are required to render, and in their own psychic make-up defence systems" (Müller & Poggenpoel, 1996, p. 143). When the discrepancy between interpersonal care and the use of defence mechanisms becomes too great, then care may be replaced by custodial (distant) practices (Müller & Poggenpoel, 1996).

In terms of power relations, patients may be conceptualized as exercising power over the nurse inasmuch as they evoke a physical or psychological threat. When this is the case, working with disruptive individuals is difficult, because nurses are caught between

the need to fulfil altruistic professional moral standards while attempting to safeguard and maintain their own personal safety (Hellzén et al., 2004; Needham, 2006). In these situations, nurses redefine their care, and patients maybe positioned away from the nurse as a result of a psychological defence mechanism (Hellzén et al., 2004).

2.2.2 Fear

Working with specific patient populations may cause nurses to experience a variety of emotions, such as fear and repulsion, that can influence the nurse-patient relationship (Holmes & Federman, 2003; Holmes, Perron & O'Byrne, 2006; Kindy, Petersen & Pakhurst, 2005; Peternelj-Taylor, 2004). In this case, working with disruptive or violent patients may impede the altruistic nature of nursing care, since the danger associated with interactions promotes the deployment of self-protective interventions by nurses. According to some authors (Hellzén et al., 2004; Whittington & Balsamo, 1998), individuals who pose a greater risk to the nurses' integrity and evoke feelings of fear are likely to be treated with less trust and less commitment, or neglected altogether. Therefore, it is important to understand how fear contributes to the need for protection felt by nurses who, confronted with dangerous patients, must create a safe zone to maintain their physical and psychological integrity.

It appears that the literature conceptualizes fear in two ways: fear may be understood as the emotional experience of individuals under threat, or fear may be conceptualized as a social phenomenon that requires an analysis of the prevailing cultural narratives of risk.

The afterthought of risk: fear as a social phenomenon

Fear may be understood as a sociological problem in its own right, one that is considered to be under-theorized in the field of social sciences (Furedi, 2006). According to Furedi (2006) this "is particularly striking in relation to the ever-expanding literature on risk. Fear has become the invisible companion of risk" (Furedi, 2006, p. 19). In effect, risk "has come

to stand as one of the focal points of feelings of fear, anxiety and uncertainty" (Lupton, 1999, p. 12). "However, whereas the sociology of risk has become an important field in the discipline, the theorization of fear exists in an underdeveloped form" (Furedi, 2006, p. 19). This point echoes the opinion of Morrison (1990), who describes fear as an unspoken topic in the field of psychiatry despite significant professional socializations to the risks of violence (and its avoidance) embodied by psychiatric patients.

According to Furedi (2006), "fear is situational and is to some extent the product of social construction. It is constituted through the agency of the self in interaction with others. It is also internalized through a cultural script that instructs people as to how to respond to threats to their security" (p. 20). Furedi (2006) goes on to explain that

... fear and the intensity with which it is felt is not directly proportional to the objective character of a specific threat. Adversity, acts of misfortune and threats to personal security do not directly produce fear. The conversion of a response to specific circumstances is mediated through cultural norms that inform people about what is expected of them when confronted with a threat and how they should respond and feel (p. 20).

In forensic psychiatry, Holmes and Federman (2003) believe that fear, or at least the belief that patients are dangerous, is part of a socialization process transmitted by the forensic milieu and amplified by the media in the form of prejudice and stereotypes. Subsequently, the cognitive construction of mentally ill individuals causes nurses to experience threatening sensations and, possibly, fear, which may alter the perception of risk and the way to address it in practice. As Lupton (1999) argues, risk then becomes a strategy of regulatory power that justifies the control of certain individuals and populations. Under cultural narratives of risk that exist in psychiatry, fear of the patient population may lead nurses to engage in restrictive interventions as a means of neutralizing the risk of being violated by a disruptive encounter (Holmes, Perron & Guimond, 2007).

In psychiatry, the study and understanding of fear has largely been overthrown by the practice of assessing and managing risk (Castel, 1991). Rational thinking and ways of

identifying threats before they take effect are regularly put forward to try to manage potential dangers and threats (Lupton, 1999). That is, fear is viewed as something that can be anticipated and controlled without necessarily being experienced. As a central concept driven by fear, anxiety and uncertainty, risk has come to take an important and dependent place in society's decision-making regarding the control over probable adverse events (Bourque, 2006; Lupton, 1999). A better understanding of fear in the forensic nursing domain could provide a supplementary tool to understand the inadequate interaction level between nurses and their patients in forensic psychiatric milieus. The inherent assumption underlying such a theoretical exploration is not one that seeks to blame nurses for unethical behaviour (related to inadequate relationships with their patients), but, rather, to understand how distancing behaviours might be the result of a defensive process sanitized by a cultural narrative of risk.

The individual experience of being under threat

Fear is a complex human emotion, a protective device with which we are all equipped in order to deal with perceived threats (Gower, 2004). Generally speaking, fear may be conceptualized as being "a strong negative emotion elicited by a relatively specific stimulus which is perceived as dangerous or harmful and results in biological and behavioural responses" (Moyland, 1996, p. 21). An important aspect of this definition is the notion of perception. That is, the internalization of fear is a process that results from individual appraisals, and varies from one person to another (Lazarus & Folkman, 1984). Lazarus and Folkman (1984) believe that there exists a relationship between a stressful object and a person's cognitive process. Stressors do not necessarily produce the same response in every individual; what is stressful for one person is not necessarily stressful for another.

The appraisal of a situation is essentially the result of two main evaluative steps (primary and secondary appraisals). Once an event occurs, a cognitive process is

engaged in order to identify the nature of the situation. So the primary evaluation consists of assessing the situation and judging if it is stressful or not. This first portion of the evaluation is influenced by a number of different factors including personal characteristics (beliefs, antecedents, knowledge, etc.), environmental characteristics (the situation's characteristics: intensity and length), the social resources that are available to the individual (peer support to manage the situation), and the milieu's expectations.

Moreover, the primary evaluation enables one to identify if the stressful event is a threat or a challenge. If the person feels threatened, he/she will most likely generate negative emotions (fear, anxiety, and anger) in light of an anticipated harm or loss. On the other hand, if the person feels challenged, he/she will focus on the potential gains attributed to the event, characterized by pleasurable emotions such as eagerness, excitement and exhilaration. Although both appraisals are presented as separate entities, they are not mutually exclusive. It is possible for an individual to appraise a situation both as threatening and challenging, where "the relationship between the threat and challenge appraisals can shift as an encounter unfolds" (Lazarus & Folkman, 1984, p. 33).

Regardless of the perceived threat or challenge, the secondary appraisal calls for the mobilizations of coping efforts in order to manage the situation. Lazarus and Folkman (1984) define types of coping in response to a perceived stressful event: emotion-focused and problem-focused coping. Problem-focused coping strategies "are often directed at defining the problem, generating alternative solutions, weighing the alternatives in terms of their costs and benefits, choosing among them and acting" (Lazarus & Folkman, 1984, p. 152). An emotion-focused coping strategy "consists of cognitive processes directed at lessening the emotional distress and includes strategies such as avoidance, minimization, distancing, selective attention, positive comparisons, and wrestling positive value from negative events" (Lazarus & Folkman, 1984, p. 150). Both types of coping strategies (problem-focused and emotion-focused) may facilitate or impede each other in the

evaluative process, depending on the person's coping resources (problem-solving skills, social skills, social support, material resources). Inevitably, to cope with a situation is essentially an attempt to control it — whether by altering the environment, changing the meaning of the situation, and/or managing one's emotions and behaviours. This complex process is inevitably influenced by the person's "outcome expectancy," in which an evaluation of the situation is believed to lead to certain outcomes, as well as an "efficacy expectation," in which the person is convinced he/she has the capacity to manage the situation (Lazarus & Folkman, 1984). The person will also evaluate the consequences of using certain coping strategies over others, an evaluation that appreciates the psychosocial relationship between the individual, the context and the choice of actions.

The mutually threatening nurse-patient encounter

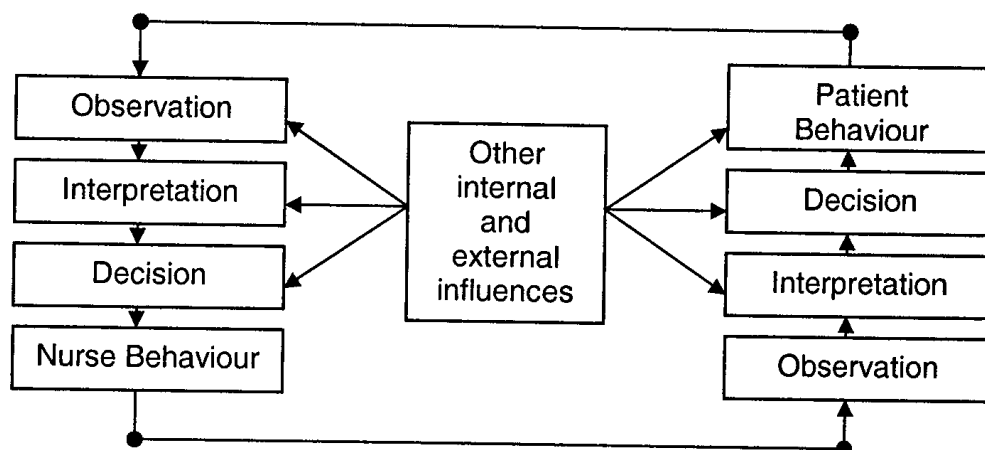
The model developed by Lazarus and Folkman (1984) is extremely important in understanding the internalization of fear within nurse-patient interactions in forensic psychiatry (Whittington & Balsamo, 1998). The adaptation of this model to forensic psychiatry and the description of a threatening encounter are particularly relevant to the topic of this thesis. More importantly, and in relation to the interactional/situational model of violence, the adaptation of Lazarus and Folkman's model to the forensic psychiatric setting also helps re-conceptualize the distribution of power between nurses and patients; that is, patients are no longer considered passive recipients of care, but, rather, active individuals who will influence the way care may (or may not) be provided.

According to Whittington and Balsamo (1998), nurses have numerous encounters with patients during the course of a working day. "By an encounter we mean simply a situation where one person can touch another, regardless of whether touching actually takes place. At each encounter the nurse casually or formally observes the behaviour of the patient, interprets its meaning and makes some decision about whether and what action is required" (Whittington & Balsamo, 1998, p. 72). The patient may also engage in a

cognitive process that analyzes the nurse's behaviours. Thus, nurses and patients engage in reciprocal observations and interpretations.

Figure 1

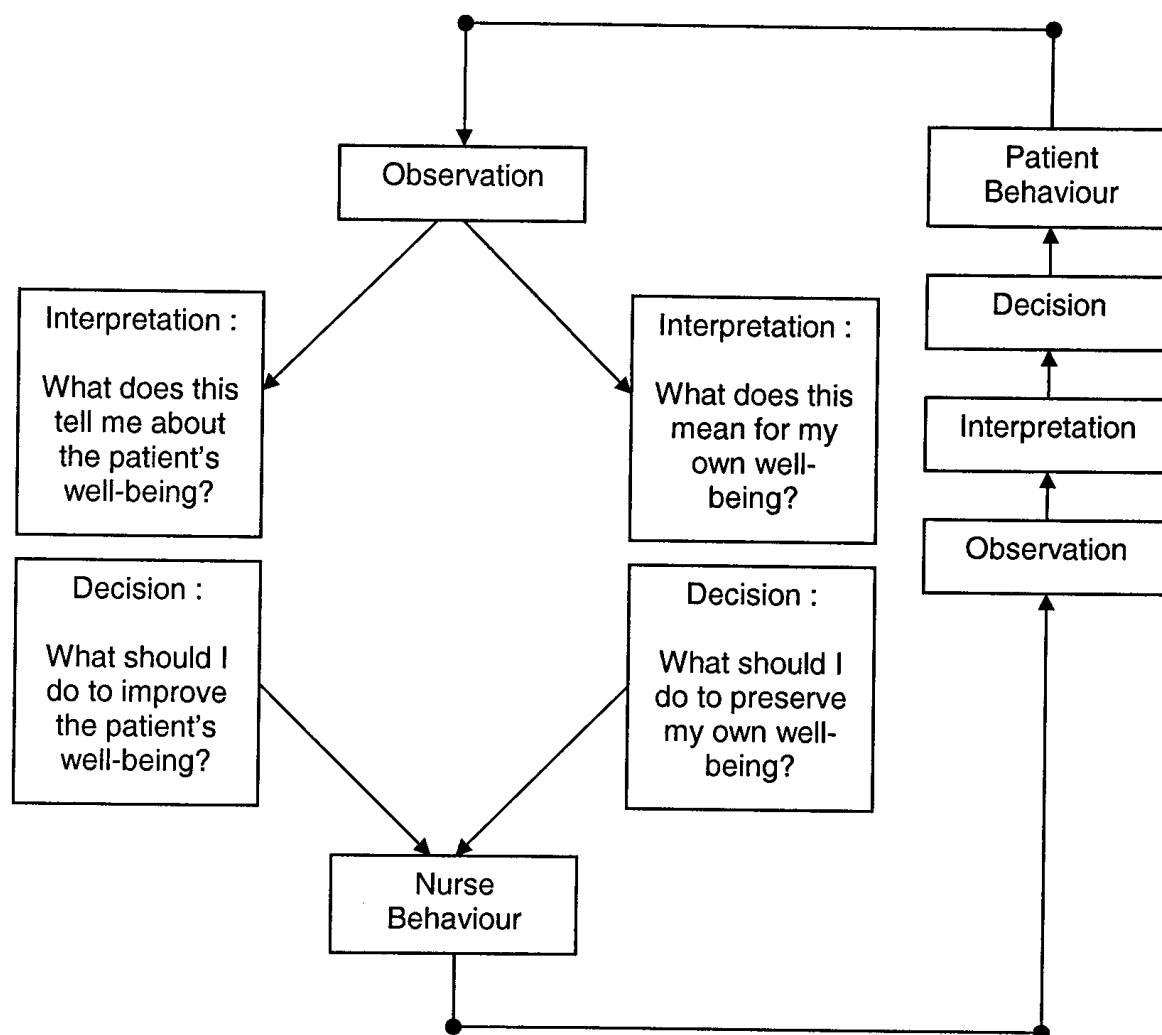
A First Model of Nurse-Patient Encounters
(Whittington & Balsamo, 1998, p. 72)



Because of his/her role, the nurse will interpret the patient's behaviours according to two axes. The first axis consists of evaluating what this behaviour means in terms of the patient's well-being: *What does it tell me about his/her illness?* The second axis consists of evaluating what this behaviour means in terms of its significance for the nurse's own well-being: *What does this mean for my own well-being?* In other words, these coexistent interpretations distinguish a cognitive process in which decisions will be made in light of both a therapeutic rationale (patient's well being) and a self-preservation rationale (nurse's own well-being).

Figure 2

Nurse's Behaviour as a Function of the Therapeutic and Self-Preservation Rationales
(Whittington & Balsamo, 1998, p. 74)



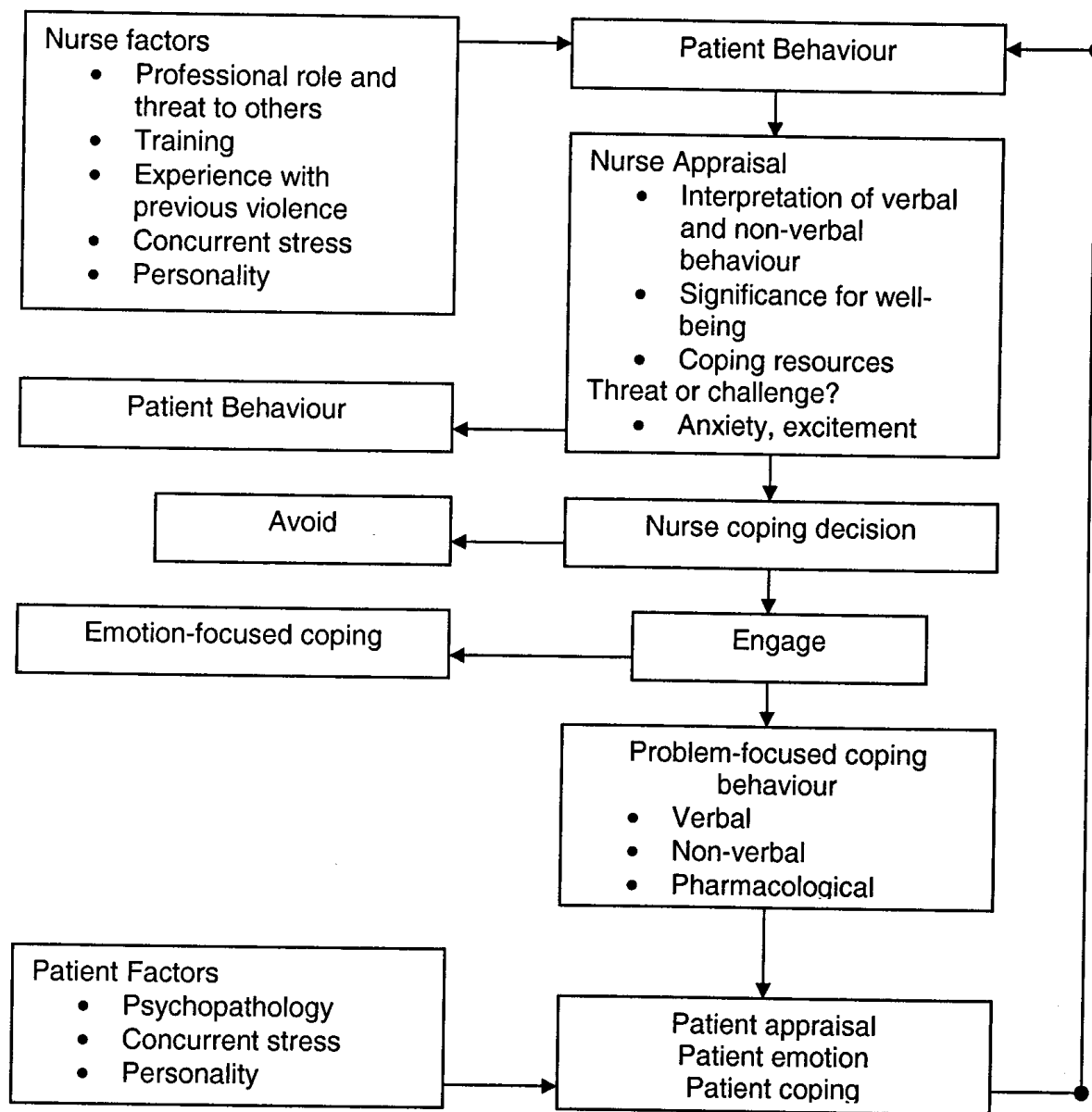
As a result of this dyadic evaluation, nurses' decisions may be influenced by a perceived threat and, possibly, fear, leading to interventions that are deployed to protect the self, rather than care for the other (patient) (Whittington & Balsamo, 1998). In relation to Lazarus and Folkman's (1984) model, Whittington and Balsamo (1998) propose that "the basic idea of Lazarus and Folkman's (1984) approach is (1) that the emotions we experience are partly a function of our cognitive appraisal of a situation and (2) that such appraisal is a function of our evaluation of the significance of an encounter for our well-

being (Primary appraisal: Am I in danger now?) and our awareness of possessing appropriate coping resources (Secondary appraisal: What can I do about it?)” (p. 75).

During an encounter, each nurse will, therefore, address the situation differently. These differences may be explained by the nurse’s appraisal of the situation as either benign/positive (may not need any intervention) or as threatening and/or challenging (Lazarus & Folkman, 1984). In general, when the nurse interprets a threatening or challenging situation, it is supposed that he/she can choose to avoid (flight) or to engage (fight) in the situation (Whittington & Balsamo, 1998). However, it could be argued that, due to their professional role, nurses must *act* against certain threatening situations in order to provide both a safe and therapeutic environment (Moyland, 1996); thus, avoiding a threatening situation may not always be possible, and nurses must act regardless of their emotions. It is possible that nurses may engage in an emotion-focused coping strategy (i.e., deep breathing) and a problem-focused coping strategy (action that will control the situation). If the latter is the case, the way nurses engage in the problem-focused coping strategy is not only dictated by their emotions, but also by the milieu’s expectations (Whittington & Balsamo, 1998). Available resources and the nurse’s belief regarding his/her capacity to manage the situation will dictate the outcome of the intervention. As explained earlier in the sociology of fear, these interventions in threatening situations may very well be socially constructed. As Holmes, Perron and Guimond (2007) have explained, decisions regarding the choice of interventions that will be used in a threatening situation will most often be influenced by peers, and are culturally reinforced by the institution (the use of seclusion, for example).

Figure 3

Stress-Appraisal and Coping in the Nurse-Patient Encounter
(Whittington & Balsamo, 1998, p. 76)



What is important in Whittington and Balsamo's (1998) model is the reciprocal nature of observations, appraisals and action. That is, nurses and patients are constantly in a process of mutual observation and interpretation. If a threat is perceived from either the nurse or the patient, a violent situation may be the end result (Whittington & Balsamo, 1998). However, understanding fear, or, at least threat, as an individual emotion restricts

the possibilities of understanding this emotion as a concept through which public life is administered (Bourke, 2006). Adding a sociological understanding of fear enables us to explore this concept as a driving force in the justification regarding the control of mentally ill individuals (Lawrence, 2002). Therefore, the terms "fear" and "threat" used in this thesis do not necessarily refer to an internalized emotion, but, rather, reflect an empirical reality in which nurses justify interventions on the basis of the risks patients pose to others.

2.3 FORENSIC PSYCHIATRIC NURSING

Forensic psychiatric nursing represents the merging of two distinct disciplinary fields: nursing care and criminology. This particular association between the therapeutic institution and the judicial system stems from a particular social need, one that seeks to provide society with two fundamental services: a social necessity (protection) and a social good (health care) (Paternelj-Taylor, 2008). Forensic psychiatric nursing is, therefore, the intricate combination of the two by providing psychiatric care in a hybrid work environment in which psychiatric hospitals and prisons merge (Holmes, 2005; Paternelj-Taylor, 2008). Here "the mentally ill person as patient intersects with the mentally ill person as criminal" (Sekula, Holmes, Zoucha, Desantis and Olshanky, 2001, p. 55). Nursing practice at this intersection is what makes forensic psychiatry a domain of nursing specialty, its practice in secure hospital settings entailing the creation of unique responsibilities for nurses working in this field (Lynch, 2006). The role of forensic psychiatric nurses is particularly complex as it brings together two socio-professional mandates: to provide both care and social control (Holmes, 2005). The difficulties associated with nursing care in this unique setting revolve around the articulation of therapy and security imperatives (Burrow, 1998; Holmes, 2001a; Holmes & Federman, 2003; Mason, 2002; Paternelj-Taylor, 2004). Forensic psychiatric nurses are constantly torn between the ideal of care — to establish a reciprocal and trusting relationship (Peplau, 1992) — and confronting the realities of a security discourse, one that seeks to control and discipline deviant behaviour. According to Kent-

Wilkinson (2008), it is such binaries (i.e. care and custody) that determine the unique knowledge content of forensic nursing.

Unlike traditional treatment settings, "the interpersonal climate, organizational culture, and social context of forensic settings result in forensic environments being identified among the most severe and extreme environments known to society" (Paternelj-Taylor, 2008, p. 800). The intricate combination of the hospital and the prison entails that hospital-based forensic psychiatric nurses are asked to work with individuals who have violated the law in some way or another, including those who have been diverted from custody for a psychiatric evaluation, and those who are unfit to stand trial or are not criminally responsible on account of mental disorder (Paternelj-Taylor, 2008). If the risk of violence associated with the forensic psychiatric population is not evident, it is nonetheless perceived as so (Mason, Coyle & Lovell, 2008). Fear and the need for personal safety become integral parts of nurses' interactions with patients (Whittington & Balsamo, 1998). The question then becomes, how can nurses balance the need for security (personal and collective) while maintaining a therapeutic environment congruent with nursing ideals of care? Thus it is imperative for nurses to understand the nature of their interactions with patients, and to identify how their need for self-preservation affects the care that is being provided. This reflexive practice calls for an in-depth understanding of psychiatric institutions, as well as the internal mechanisms that influence and regulate the interactions of its populace.

2.3.1 Therapeutic Relationship

Over the years, the association between the sick body and medicine has evolved and has taken the form of a two-way relationship (Armstrong, 1983). In psychiatric nursing, this relationship has evolved from custodial practices (Chatterton, 2000) to the establishment of a reciprocal human relation between nurses and patients; that is, nurses began to explore what transpired during nurse-patient interactions in order to assist psychiatric

patients in their recovery (Peplau, 1988). Nursing in psychiatric settings generally revolves around ideals of care that go beyond the custodial observation of patients, and incorporates the analysis of the nurse's own behaviour. So the ability to engage with the patient and develop a relationship of empathy is of uttermost importance (Peplau, 1997). The difficulty of establishing such a relationship lies in the ambiguity of nurse-patient interactions; both nurses and patients enter the therapeutic relationship with preconceptions and stereotypes about one another (Peplau, 1997). Concurrently, these preconceptions and stereotypes can colour the outcome of the relationship in which the nurse will, with difficulty, assist patients in articulating and exploring reactions to their illness experience. Ideally in the therapeutic relationship, the nurse should inherently be supporting the patient and should approach him/her as a complete person (Gastman, 1998). There is a specific focus for the nurse to see the Other (patient) as a fellow human being (Canales, 2000), as well as to take the opportunity of interaction to enlarge his/her professional understanding of the self in action (Peplau, 1997).

2.3.2 Skills and Competencies

Although forensic psychiatry claims the title of a specialty in nursing, the articulation of a unique body of knowledge (which would orient practice) has not been clearly defined (Sekula et al., 2001). "The lack of identifiable skills and competencies amidst grand narratives surrounding forensic psychiatric nursing and speculative claims tenuously based on the 'specialness' of this practice became starkly obvious" (Mason, Coyle & Lovell, 2008, p. 131). According to Bowring-Lossock (2006), nurses in forensic psychiatry must be competent in several specific areas, including "safety and security; assessment and management of risk; management of violence and aggression; therapies; knowledge of offending behaviour and legislation; report writing 'jail craft' (relating to prison culture); and practical skills (such as first aid)" (p. 781). One of the major problems that cause forensic psychiatric nurses the most difficulty is the management of violence and

aggression, as well as the management of personality disordered patients (Mason, Coyle & Lovell, 2008). In forensic psychiatry, the risk of violence is evident, if not in actuality, then in potentiality (Mason, Coyle & Lovell, 2008). Nursing in this setting has been described as chronically stressful due to the constant violent potential of patients (despite its periodical occurrences) (Mason, Coyle & Lovell, 2008; Whittington & Balsamo, 1998).

"It is clear that working in this specialty area will not appeal to all nurses and equally, not all nurses are intrinsically able to work with this patient group" (Bowring-Lossock, 2006, p. 784). Personal characteristics that have been noted to belong to an effective forensic psychiatric nurse include being laid back, never being threatening, being able to make decisions effectively, appearing relaxed and calm, being detached (not personalizing negative events), and understanding and setting boundaries in the therapeutic relationship (Bowring-Lossock, 2006).

2.3.3 Care versus Custody

Some authors have suggested that, within disciplinary/total institutions such as correctional and forensic psychiatric settings, nurses tend to cast off the therapeutic ideal of care and adopt authoritarian behaviours that are more characteristic of the carceral ideology (Holmes, 2001a, 2005; Holmes & Federman, 2003; Perron, Holmes & Hamonet, 2004). Within the forensic milieu, nurses undergo an indoctrination process as described by Holmes (2001a): the totalitarian regime imposes a modification of nurses' roles and redefines the representation of the person for whom they care. Despite the fact that nurses have the longest contact time with patients, and that, ultimately, the sustained contact would lead to the greatest opportunity to engage in therapeutic interactions, this does not always seem to be the case for forensic psychiatric nurses. It may be difficult for nurses to distance themselves from negative portrayal of this patient population (Mason, 2002; Mason, Lovell & Coyle, 2008). For example, in Canada and the United Kingdom, there continue to be reports of negative views of staff towards mentally-ill offenders, who may be

considered as not deserving respect or regarded as incapable of change and growth (Holmes, 2001a; Holmes & Federman, 2003; Mason, Lovell & Coyle, 2008; Mason, Richman & Mercer, 2006;). Although nurses openly value the nurse-patient relationship in forensic psychiatry and describe their practice as therapeutic, evidence suggests that some nurses operate from a social frame of reference (Martin & Street, 2003). Positive views regarding the patient population are expressed in relation to the degree of control that nurses have over particular situations (Mason, 2002), or in terms of superficial relationships established through social activities which do not progress to realize their therapeutic potential in areas such as counselling and addressing offence issues (Martin & Street, 2003). Discussion over what is being done in terms of therapy remains unclear, and one could question whether "forensic nurses as agents of control may not be as specialized in nursing and caring as they are in custody (Sekula et al., 2001, p. 55).

2.3.4 Dynamic Effects of Mistrust

When exploring the concept of the therapeutic relationship, descriptors such as congruency, genuineness and authenticity on the part of the nurses all seem to underline the importance of a seamless and unambiguous interaction (Welch, 2005). However, the genuineness of a relationship is a relative term, since nurse-patient interactions are influenced by personal and professional boundaries (Andra & Street, 1999). Revealing or concealing information about oneself is not a neutral action, and it is not uncommon for patients and nurses in forensic psychiatry to build a relationship edged by mistrust and concealment. Nurses may conceptualize their patients as being manipulative and lying (Holmes & Federman, 2003; Peternelj-Taylor, 2004), and, as a result, fear being outmanoeuvred, used and abused by patients (Mason, Lovell & Coyle, 2008). Such a situation makes it difficult to engage in a trusting, genuine relationship when nurses feel they have to adapt their responses in order to avoid the manipulative behaviours of the patient population. Similarly, patients may not fully trust the nurses because of the dual

role they occupy as both agents of care and control, that is, nurses working in forensic settings may be invited to participate in the application of disciplinary actions and clarify objectives both in terms of sentencing and therapy (Bessin & Lechien, 2004). Thus, from the patient's perspective, divulging deviant information may be considered more of a risk than a positive action.

2.3.5 Boundary Violations

Forensic psychiatric nurses work in an environment where the boundaries of the therapeutic relationship are frequently tested (Paternelj-Taylor, 2002). These boundaries essentially represent a certain territory within which the patient and the nurse should be able to safely explore treatment issues (Paternelj-Taylor, 2002). However, the inherent difficulties associated with forensic settings may bring nurses to trespass these boundaries; under-involvement (for example, ignoring the patient) and over-involvement (becoming friends) could be considered possible boundary violations and therapeutic dilemmas (Paternelj-Taylor, 2002). Failing to engage and value the person is a form of under-involvement, one that is often masked in superficiality (engaging in friendly banter with the patient; conducting pseudo-interviews in the hallways, avoiding the patient altogether) (Paternelj-Taylor, 2002).

In forensic psychiatry, under-involvement with patients is further contextualized in today's culture of virtual reality, with new technologies of surveillance and security impeding on interpersonal contacts and making them impersonal (Peplau, 1997). In a meticulous analysis of current forensic psychiatric nursing practice, Holmes (2001b) describes how old techniques of surveillance have been replaced by newer technologies. Forensic psychiatric institutions are utilizing audio-visual equipment to observe their hospitalized clients. Initially used exclusively in seclusion rooms, surveillance equipment has now spread to other locations of the psychiatric wards. By addressing the link between the new apparatus of mechanical surveillance and the emergence of a subtle type of

power (disciplinary power), Holmes (2001b) discusses the relative risks in the denaturation of the professional caring relationship. Holmes (2001b) acknowledges that continuous surveillance using cameras or microphones provides improved quality of care and better observation of risky clients. "It remains to be seen, however, at what cost?" (p. 11) Holmes (2001b) questions how apparatus of surveillance are introduced into the global scheme of the institution in light of its therapeutic ideals. However, continuous surveillance, in addition to its disciplinary attributes—subjecting all activities to observation and correction—cannot replace direct care in which the physical presence appears to be indispensable for creating true caring relationships. "Mechanical surveillance does not permit the respect of others so powerfully espoused by the nursing profession. It threatens human dignity under the guise of care and security" (Holmes, 2001b, p. 12). If the relationship between nurses and patients cannot go beyond shallow observation as a form of under-involvement, nurses are at risk of becoming an extension of the panoptic and disciplinary apparatus.

2.3.6 Labelling and Mental Representations

A distinct challenge for nurses working in psychiatry is how they describe—knowingly and unwittingly—the population for whom they are asked to care (Peplau, 1997). According to Shattell (2004), "the quality of patient care is in part determined by the social labelling process" (p. 716), and the current literature reveals that nurses who negatively label patients often carry out distancing behaviours resulting in less than optimal care (Holmes, 2001a; Holmes & Federman, 2003; Müller & Poggenpoel, 1996; Peternelj-Taylor, 2004). Psychiatric nurses react to their patients in many different ways. Depending on this reaction, these nurses may either facilitate or stall the therapeutic process (Müller & Poggenpoel, 1996).

Nurses' reactions to patients, and the labelling process that this generates, are in part related to the mental representations that nurses develop while providing care to certain patient populations. As some authors suggest (Holmes & Federman, 2003;

Holmes, Perron & O'Byrne, 2006; Peternej-Taylor, 2004), the use of pejorative vocabulary or quasi-medical terminology such as monster, psychopath, personality disorder, manipulative, lying, and so on, are all negative labels that help nurses create (and justify) a psychological distance from patients (Holmes, 2001a). These labelling practices, which depersonalize through language, disrupt each nurse's ability to engage in reciprocal dynamic interactions with patients, thus shifting the emphasis from therapy to custodial practices (Holmes & Federman, 2003). In other words, when patients are negatively labelled, the therapeutic encounter suffers, and the role of the nurse is disrupted. The way labels come to construct mentally-ill offenders dictates how nurses interact with patients (Holmes & Federman, 2003; Mason, Richman & Mercer, 2006).

More importantly, the use of labels as a source of information demonstrates how mental representations shape interactions. In effect, interactions between individuals are strongly contextualized, that is, rooted in an immediate situation (Mannoni, 1998). Due to their cognitive capacity, humans are capable of psychological detachments from immediate situations, and refer to perceptions and representations to guide their actions (Mannoni, 1998). These mental representations, however, may not result only from an individualized process. At any given time, mental representations usually correspond to a group's point of view; individuals who live/work in similar environments will share common symbols of representations (social representations) (Holmes & Federman, 2003). These common symbols will represent situations, persons and objects which serve to label something or someone, thus creating a pool of pre-elaborated judgments (stereotypes) regarding certain things or individuals. What makes these social representations dangerous elements is the lack of critique that its labels (dangerous, psychopath, personality disorder) may imply, and the automatic image that they create in the nurse's mind (Mannoni, 1998). For example, a psychiatric diagnosis is a label that usually refers to a set of preconceived behaviours indicating how patients should behave in light of a

specific diagnosis (Holyoake, 1999). Concurrently, a diagnosis, or any other type of labelling, will influence how nurses may interact with the labelled individual because of the label's set of assumptions. Negative labels will, therefore, play an important part in distancing behaviours on the part of nurses. That is, labels create virtual lines of differentiation (Goffman, 1963) representing a particular process of classification which will likely shape the social identity of the labelled individual. Therefore, patients who are identified as rapists, murderers, psychopaths, monsters and the like, may evoke mental representations of evil, disgust or even fear; thus making interactions with these individuals difficult (Holmes, Perron & O'Byrne, 2006; Mason, Richman & Mercer, 2006).

A recent study conducted by Mason, Richman and Mercer (2006) on the use of "Evil" as a clinical term in forensic psychiatry demonstrated how patients who are negatively labelled will most likely receive different approaches to care. What these authors emphasize, and what is different from other studies on labelling, is the reason patients receive a different treatment. Labelling someone as evil positions the patient outside of medical rationalizations, and, therefore, makes him/her a responsible being. The patient becomes more of a criminal rather than a patient. Being purely evil is synonymous with being impossible to be cared for. As the excerpts presented in their article suggest, once a forensic psychiatric patient is no longer defined under medical terminology, then nursing care becomes a "front" for custodial practices.

2.3.7 Othering

The labelling process described above may be referred to as an "othering" process. Othering may be defined as the process that establishes boundaries between groups: those who are labelled different and those who belong to the mainstream (Johnson, Bottorff, Browne, Grewal, Hilton & Clarke, 2004). According to MacCallum (2002), establishing these boundaries often evokes oppositional difference—the other is attributed a negative value as it is positioned outside normality. Most of the literature that addresses

othering practices in health care does so in a negative way. Othering often represents the negative pole of dichotomies between the normal and the abnormal, the good and the bad, and so on. Therefore, othering is inevitably rooted in power relations, where those who are negatively labelled are set out to be marginalized, distanced or neglected altogether (Hellzén et al., 2004).

Canales (2000) proposed a theoretical framework on othering that actually brings nuance to this concept. By analyzing the way people engage with individuals who are considered different from the self (other), Canales (2000) was able to describe two particular processes: Inclusionary and Exclusionary Othering.

Inclusionary Othering

According to Canales (2000), Inclusionary Othering is strongly imbedded within the context of power relations:

The difference between Exclusionary Othering and Inclusionary Othering relates to how power is used, by whom, and with what consequences. Inclusionary practices attempt to use power to create transformative relationships in which consequences are consciousness raising, sense of community, shared power, and inclusion (p. 25).

More importantly, this capacity to use power within the relationship in a positive way revolves around the nurse's ability to take the role of the other, that is, to try to see the world from the other's perspective. In order for Inclusionary Othering to take place, nurses need to reconceptualize meanings and understandings from the patient's perspective. A connection must take place between the patient and the nurse, wherein difference is used as a positive tool within the relationship. This type of inclusion mirrors what Holmes (2002) describes as pastoral power, whereby the nurse sets out to help the other (patient). Through therapeutic encounters and the development of an alliance, nurses are inclined to influence the patient's behaviour.

Exclusionary Othering

On the other hand, Exclusionary Othering takes place when nurses fail to take on the role of the other. As Canales (2000) suggests, this failure may generate nursing interventions that are based on stereotypes rather than on an understanding of the patient's perspective. That is, Exclusionary Othering refers to discrediting attributes that create a spoiled identity (stigma). Based on this identity, patients will most likely suffer some kind of exclusion.

2.3.8 Abjection

The negative labelling and Exclusionary Othering process described above essentially create barriers between staff and the patient population. According to Holmes, Perron and O'Byrne (2006), these barriers may be unconscious mechanisms to distance patients through the use of derogatory terminology. The need to create this distance is, in part, explained by the emotions that some forensic psychiatric patients evoke from nursing staff. A great deal of work needs to be done to understand the mechanisms implicated in producing these responses (such as repulsion, disgust and fear) and to understand how these negative emotions operate.

In this respect, the work of postmodern psychoanalyst Julia Kristeva on abjection proves to be beneficial (Sim, 2002). According to this author, feelings of abjection are primarily developed during infancy and are part of a self-identification process in which the child between six and eighteen months of age rejects certain parts of his/her being. The rejected elements may be such things as faeces and sour milk, but they may also include symbolic representations (Kristeva, 1982). According to Kristeva, this process (of abjection) is necessary for any child who strives to construct his/her own identity and become a person, distinct from the mother; in doing so, the child begins to enter the realm of the symbolic. As such, abjection does not solely manifest itself in relation to one's self and one's body; it is a cognitive process that emerges from the relation with others as a

way to secure the "clean and proper" self within the collective (social) realm. As an example, Kristeva (1982) uses the cadaverous corpse as the utmost portrayal of the abject. In this case, the corpse embodies the interrelationship between life and death. The observer of the corpse is, therefore, forced to recognize that one cannot exist without the other. Symbolically, the dead body represents the intermediate between these states (life and death) and the appreciation of having lived. The proximity of a cadaver to a living body violates the boundaries of the latter—the corpse represents a fundamental pollution because it emphasizes the frailness of the living body (Kristeva, 1982). The abject (the corpse) is considered to be abject because it threatens the non-abject (the clean and proper body and mind) (Kristeva, 1982).

In constructing the self, one's need to create certain boundaries with others is perceived as essential in defining one's subjectivity (Mansfield, 2000). According to Kristeva (1982), creating these boundaries is an ongoing process whereby individuals continuously need to reject "sub-human" matter in order to strengthen their subjectivity and preserve a *Self propre* (clean, proper, self-controlled body and mind). While it is involved in the definition of one's subjectivity, the abject also provides alternate subjectivities, because the ordered self, although comfortable and secure, is also a burden to carry and maintain (Kristeva, 1982). The "abject" refers to anything that is excluded from the "clean and proper" zone (personal or social), whereas "abjection" is a reaction experienced when an individual encounters "abject" objects. These objects could be such things as faeces, vomit, urine, or blood, but may also be individuals such as the disabled, the homeless, the mentally ill, the incarcerated, the demented, etc. The abject can be anything or anyone that does not fall within the established boundaries of the "clean and normal" (Jacob, Gagnon & Holmes, 2009).

Kristeva's concept of abjection is of great importance in understanding the interactions between nurses and patients in forensic psychiatry. Nurses who come in

contact with mentally-disordered offenders are exposed to a facet (criminal history) of these individuals that possesses the power to contaminate. Not only are some patients prone to provoke stronger feelings of abjection due to the crimes they have committed (i.e., rape), but the threat value of these actions is increased because the patients' history has shown that they have actually acted violently (Waddington, Badger & Bull, 2005a). Therefore, not only is the mentally-ill offender a physical threat, but the concrete images of past behaviours become imprinted in the nurse's mind. As Jacob, Gagnon and Holmes (2009) argue, the exposure to criminal history, in addition to the complexities of interpersonal care in forensic psychiatric settings, confront the nurse and disrupt the clear system of order through which human beings learn to secure and maintain their integrity and autonomy. Thus, forensic psychiatric nurses continuously try to re-establish a clean and proper zone by keeping a distance (psychologically and physically) from patients.

Effects of abjection in forensic nursing practice

Protecting the Self from the Other is a reaction that every nurse experiences when caring for mentally-ill offenders (Whittington & Balsamo, 1998). Nurses often question if their personal integrity is at risk when having to interact with patients. Yet, as part of their professional training, the verbalization of emotions that would impede the altruistic nature of nursing care isn't necessarily encouraged. In other words, their experiences of fear, disgust or repulsion may go unrecognized. Behind the appearance of tolerance and calm, nurses may actually be experiencing personal responses that are difficult to handle. As Holmes and colleagues (2006) argue, the impact of abjection on the care of abject individuals has traditionally been silenced in nursing though "the very nature of abjection is to retreat from the abject even in the face of extensive socialization to do otherwise" (p. 306). According to Parker (2004), nurses draw upon a range of unconscious defences to manage these tensions evoked by the disturbances and threats to their own integrity.

However, the deployment of these defence mechanisms "seems to touch on moral aspects of human existence, the question of our willingness or unwillingness to be violated in a relationship" (Hellzén & al., 2004 p. 3). As explained in the review on violence, those who are asked to work with threatening populations may be caught in a moral dilemma such that maintaining one's own rights to safety and offering the best quality of care become paradoxical entities (Needham, 2006). When caring for threatening individuals, nurses might be caught between good intentions to fulfil their profession's moral standards of care and attempts to safeguard and maintain their own personal safety (Needham, 2006). In reaction to a threatening encounter, in which the boundaries that typically maintain a clear distinction between us (the clean and proper) and them (the abject) are transgressed, the nurse inevitably uses defence mechanisms to re-establish these boundaries. According to Jacob, Gagnon and Holmes (2009), these practices are securing boundaries, containing negative feelings, minimizing contamination, and regaining control over the chaotic experiences of abjection.

Securing boundaries

Securing boundaries mostly revolves around the creation of a professional persona that makes nurses capable of setting aside judgments and preconceptions while providing care (Peplau, 1997). However, the efficiency of the professional persona seems to be disrupted when patients are considered to be disruptive/threatening. In such a case, interventions tend to focus on personal protection (Hellzén & al., 2004; Whittington & Balsamo, 1998). Trying to maintain a professional persona then may actually lead to an intensification of the perceived threat in nurses, and to the impoverishment of care in the name of personal security.

Containing negative feelings

Nurses may not always be in a position to understand the effects of their feelings on nursing care. According to Hellzén et al. (1999, 2004), trying to contain negative feelings

evoked by patients (especially over long periods of time) may bring nurses to re-conceptualize the objectives of their care. In effect, working with abjective patients may disrupt the meaning attributed to care; that is, interventions are no longer done for the patient's well-being, but rather for the nurse's need to re-establish professional boundaries. By perceiving themselves as good and well-intentioned (altruistic), nurses attempt to re-establish a sense of cleanness, thus washing away the dirt—personified in the abject individual—they see in their therapeutic encounters (Hellzén et al., 2004). Their negative feelings are masked in favour of their clean, proper and professional selves.

Minimizing contamination

According to Parker (2004), nurses use the “nursing look” and the “nursing scan” to minimize possible victimization (contamination) from patients. The nursing look can be defined as a form of “concrete and practice-orientated knowledge in a receptive persona, which is a metaphor standing for the range of senses through which nurses pick up cues about the patient” (p. 213). In this case, by observing their environment, those who care for people living with mental illness are able to identify and minimize the potential for their own contamination, or evaluate what interventions are necessary to neutralize the threat of being exposed to disturbing visual, physical and verbal exchanges with that specific patient. The nursing scan, on the other hand, is used “to locate patients spatially, identify spatial related problems, ascertain location of technologies that may be required and make the terrain safe for patients” (p. 213). For example, Johnson and Delaney (2006) noted that

... to promote safety, maintaining visibility was one of the salient conditions for keeping the unit safe. Yet, maintaining visibility was challenging because the size and shape of the units To compensate for less-than-ideal spaces, the staff deliberately decided when to open up and close off parts of the space, how to situate people within the space, and how to regulate the flow of people into and out of parts of the space (p. 17).

Regaining control over the chaotic experiences of abjection

According to Hellzén and colleagues (2004), one way to create order when working with abjective individuals is to provide pathological explanations for their behaviour (which may not be the case). Although nurses may not always believe this is the "right" thing to do (Hellzén et al., 1999), pathological explanations justify the use of medication and other interventions needed to control and distance the abject individual.

2.4 TOTAL INSTITUTIONS & POWER

Understanding the medico-legal management of social deviants, as well as the physical structures that are involved in the management of their recovery, has been, and continues to be, an empirical and theoretical endeavour for researchers and clinicians. Under the influence of medicine and its discourse of therapy, it is difficult to access alternative representations of forensic psychiatry or the effects of forensic psychiatric institutions on nursing practice. This section of the literature review will begin by exploring the works of Erving Goffman and Michel Foucault, two authors who have contextualized the psychiatric institution outside of its medical rationalizations, and repositioned its mandate along the lines of other social institutions (i.e., prisons, schools, monasteries, etc.). If the works of these authors share certain similarities, both perspectives complement each other, Lagrange (2003) argues, in order to address their respective deficits. In effect, Goffman's (1990) analysis is essential to understand the inner structure and the internal functioning of psychiatric institutions. Foucault's point of view, on the other hand, harmonizes Goffman's description of internal functioning with the analysis of macro structures and practices, thus positioning the psychiatric institution within a broader strategy of social control (Lagrange, 2003). While Goffman problematizes the internal processes of what he refers to as "total institutions," Foucault seeks to understand the origins and the evolution of these institutions, as well as to explore how certain techniques of power, closely linked to social and political structures, are exercised in the management of individuals (Hacking, 2004;

Lagrange, 2003, p. 369). Hence, Foucault's perspective expands on Goffman's original, yet narrow view of the "total institution," by inscribing it in a governmentality framework.

Examining the forensic psychiatric institution from either Goffman's or Foucault's perspective supposes that we can break away from the particularities of the psychiatric culture of cure and identify common characteristics between the institutional management of mental illness and the general mandate of other social institutions such as schools, monasteries, prisons, hospitals, and so on (Castel, 2002). By doing so, it is then possible to explore how certain types of social structures empirically represent unifying components (Castel, 2002). Goffman's (1990) sociological analysis of asylums looks beyond institutional discourses that theoretically support particular practices (although not necessarily wrong) in order to situate each institutional discourse within a wider frame of reference, one that transcends individual justifications and acknowledges the common determinants of social institutions (Castel, 2002). In this way, Goffman's work goes beyond the discourse of cure produced by physicians, beyond the notions of security produced by administrators, and beyond the discourse of discipline produced by prison guards to unmask the resembling social functions assumed by seemingly different ideologies and establishments (Castel, 2002). Goffman's (1990) work is used here as an alternative analysis to any dominant ideology in health care, although his work continues to be criticized as a wrongful interpretation of psychiatric care (Jones, 2004). Goffman's work can only be beneficial if one seeks to identify the gap that resides between the therapeutic rationalization of mental health care and the much larger institutional objective of social control and its effects on the self (Foucault, 1995).

According to Goffman (1990), both the hospital and the prison represent social institutions where internal mechanisms of functioning are intensified by the breakdown of normal barriers that ordinarily separate the basic spheres of life. Nursing practice in forensic psychiatry is situated at the junction of these two structures where the articulation

between care and social control gives rise to specific social processes. Goffman (1990) identified and explored some of these processes that correspond to the beginning of the inmate's (patient) moral career and a progressive modification of the self. If these processes, qualified as mortifying, affect the inmate's sense of personhood, it has been argued by some researchers (Holmes, 2005; Perron, Holmes & Hamonet, 2004) that they also affect the nursing professionals who are asked to work within total institutions (such as forensic psychiatric settings).

2.4.1 Total Institutions

The prison, the hospital, and the forensic psychiatric institution are all forms of what Goffman (1990) qualifies as "total institutions." Characterized by their internal rules (formal and informal), their own signs of success, symbols of prestige and signs of deviance, total institutions gather most of the structural characteristics designed to take charge of all the needs and desires of particular types of populations. As Castel (2002) explains,

En tant qu'institution sociale, l'institution totale rassemble la plupart des traits structuraux qui caractérisent un groupe d'établissements spécialisés dans le gardiennage des hommes et le contrôle totalitaire de leur mode de vie : l'isolement par rapport au monde extérieur dans un espace clos, [...], la prise en charge de l'ensemble des besoins des individus par l'établissement, l'observance obligée d'un règlement qui s'immisce dans l'intimité du sujet et programme tous les détails de l'existence quotidienne, l'irréversibilité des rôles de membre du personnel et de pensionnaire, la référence constante à une idéologie consacrée comme seul critère d'appréciation de tous les aspects de la conduite, etc., tous ces caractères conviennent à l'hôpital psychiatrique aussi bien qu'à la prison(p. 11)

It is also important to note that the forensic psychiatric hospital, as a total institution, is an environment where interactions between individuals (i.e., nurses and patients) are imposed and highly regulated. As a result, ideal therapeutic (read individualized) interactions between nurses and patients are often overthrown by institutional objectives of effectiveness and security. As Goffman (1990) suggests, the total institution is designed, first and foremost, in the management of large blocks of individuals and their associated methods of surveillance and correction. Therapeutic ideals are,

therefore, inscribed within a highly ritualized way of life where a system of surveillance, sanction and reward is in place to facilitate the conformation of patients to in-house rules (Perron, Holmes & Hamonet, 2004). It is precisely this "docilization" (Holmes, 2005) of inmates (patients) that is of importance for this thesis, because it explains how the institution and its internal functioning "mortify" the self (Goffman, 1990).

Mortification process

The mortification process described by Goffman (1990) is a series of institutional procedures that affect the self in order to progressively reconfigure the patient's identity. As a result, the mortification process leads to what Goffman (1990) describes as a "civil death," whereby the subject is stripped of his/her distinguishing attributes and has conformed to a normalized way of living.

Of the mortification procedures described by Goffman (1990), social isolation and self-image degradation are particularly important in understanding forensic psychiatric nursing practice. Indeed, some researchers (Holmes, 2001a, 2005; Perron, Holmes & Hamonet, 2004) have established that both nurses and patients who live/work in total institutions experience a similar process of mortification.

Social isolation

In forensic psychiatry there exist a number policies and procedures designed to regulate and organize the internal functioning of institutional day-to-day living. The notion of security is of particular importance; most decisions in this type of setting are rationalized in accordance with this imperative (Holmes, 2001a, 2005; Holmes & Federman, 2003; Mason, Coyle & Lovell, 2008). Literally built into the physical configuration of the institution, this notion of security is often materialized by such devices as walls, locked doors and fences. According to Goffman (1990), these physical barriers are also representative of the structural division between the exterior world and the internal

functions of the institution, a distinct characteristic that materializes the isolating barrier needed in the mortification process.

The full meaning for the inmate of being "in" or "on the inside" does not exist apart from the special meaning to him of "getting out" or "getting on the outside." In this sense, total institutions do not really look for cultural victory. They create and sustain a particular kind of tension between the home world and the institutional world and use this persistent tension as strategic leverage in the management of men. (Goffman, 1990, p. 13)

Although social isolation was essentially described for patients who enter the psychiatric hospital, some authors (Holmes, 2005; Perron, Holmes & Hamonet, 2004) have argued that this isolation also affects the nursing personnel who work within these institutions. That is, nurses working in forensic psychiatry have described a kind of physical and psychological isolation that is akin to the feeling of marginalization described by Goffman (1990). Nurses working in forensic psychiatric institutions expressed a strong feeling of isolation from the "outside" nursing community and described how their working conditions went unrecognized at the intersection between the prison and the hospital (Holmes, 2005). As a result, there was a radical shift in how nurses perceived themselves as well as the way they exercised nursing care.

Self-image degradation

It is characteristic of inmates that they come to the institution with a "presenting culture" (to modify a psychiatric phrase) derived from a "home world"—a way of life and a round of activities taken for granted until the point of admission to the institution. (Goffman, 1990, p. 12)

Each individual enters the forensic institution with an imported culture, one that is shaped by different social structures (i.e., the family, the education system, etc.) and that creates a certain frame of reference from which one can consolidate his/her identity (Goffman, 1990). For nurses, part of this frame of reference is the result of their professional socialization (Holmes, 2005; Perron, Holmes & Hamonet, 2004). However, even with the best intentions (therapeutic rationalization), the total institution will not substitute its own unique culture for each individual's (staff and patient) presenting culture.

The total institution somewhat suppresses any previously consolidated identity and imposes its own internal frame of reference. Therefore, previously defined social representations of the self are stripped upon entrance to the total institution. The locus of control is situated outside the individual whose former identity is eroded by a gradual compliance to institutional norms. This aspect of the mortification process may be referred to as self-image degradation. One's perception of the autonomous self is contaminated by routines imposed by the institution. Individuals must carry out specific tasks that are symbolically incongruent with the previously embodied sense of self (Holmes, 2005). For nurses working in forensic psychiatry, this contamination revolves around the deconstruction of their professional frame of reference and its substitution with institutional roles that are highly influenced by a security imperative. Holmes' (2005) research underlines the impossibility of taking on so-called maternal attitudes (attentiveness, compassion, empathy, etc.) considered to be ridiculous or even dangerous in forensic settings, thus resulting in a "masculinization" of care. As such, nurses must adapt their role to forensic norms, highly influenced by the need to create a distance between patients and staff on account of danger. In other words, nurses realize that the forensic setting has modified their "roles, attributes and representations of the patients they cared for, and, as a result, forced them to adapt to the forensic psychiatric milieu by distancing themselves from their previous roles" (Holmes, 2005, p. 10).

Echoing the works of Goffman (1990), other authors (Holmes, 2005; Perron, Holmes & Hamonet, 2004) attest to the difficulty of working in forensic psychiatric settings. Nurses who are themselves "captives" of the institution will have to reorganize their care based on institutional norms and the need to enforce social order, thus incorporating sanctions within professional nursing practice: "members of staff who are in continuous contact with inmates may feel that they, too, are being set a contradictory task, having to coerce inmates into obedience while at the same time giving the impression that humane

standards are being maintained and the rational goals of the institution realized" (Goffman, 1990, p. 92).

Concomitant to the process of mortification are the features related to the management of large blocks of individuals and the associated methods of their surveillance as well as correction. According to Goffman (1990), the total institution is a site where the central relationship between staff and patients is one of surveillance and control: "a seeing to it that everyone does what he has been clearly told is required of him, under conditions where one person's infraction is likely to stand out in relief against the visible, constantly examined compliance of others" (Goffman, 1990, p. 7). Through an omnipresent gaze and its effectiveness in providing opportunities for interventions, nursing personnel create a "personal economy of action" (Goffman, 1990, p. 38). In effect, the penetration and constant sanctioning of the inmate's life forces an adaptation to "house rules." According to Foucault (1995), it is exactly this process of adaptation that captures the intricate relationship between visibility, power, subjectivities and disciplines.

Foucault's (1995) analysis of institutions can be seen as an extension of Goffman's micro-sociologic description of total institutions. Foucault's (1995) perspective explores human action and interactions in light of power and its exercise over individuals. As part of his work, Foucault's insight on power relations implies that technologies of government, as means for the control of conducts, are exercised to modify personal characteristics in order to influence social and personal actions (Holmes & Gastaldo, 2002). If Goffman's meticulous ethnographic work helped understand the culture of asylums, then Foucault (1995) re-inscribed human interactions within a political analysis or "microphysics of power" (Gordon, 1991, p. 3). As such, the following will explore the Foucauldian disciplinary techniques and the power/knowledge dynamics "designed to observe, monitor, shape and control the behaviour of individuals ..." (Gordon, 1991, p. 3).

2.4.2 Biopower

Biopower is a concept that was originally introduced by Foucault (2005). Historically, growing demographics forced the development of powers that would infiltrate the social body and exert its effects over individuals as well as populations (Foucault, 2005). New objectives of governance were "to regulate life, to manage it in its most intricate forms" (Perron, Fluet, Holmes, 2005, p. 537). Foucault (2005) defined bio-power as a form of power that was developed and exercised over individuals and populations in order to facilitate their regulation. In other words, bio-power may be understood as power over all aspects of life. This form of power can be divided in two poles: the anatomo-political (microphysics or individualized forms of power), and the bio-political (macrophysics or forms of power exercised over whole populations) (Gordon, 1991). For purposes of this research project, only the anatomo-political pole (microphysics), or the way power is exercised over individuals, will be explored.

Anatomo-politics: the introduction of disciplines

In his book *Discipline and Punish*, Foucault (1995) articulates the anatomo-political dimension of bio-power (or power over life) by looking at the productive forms of power that seek to generate forces, make them grow and order them (Rabinow, 1984). Foucault (1995) introduces a parallel between the body and a machine that can be rendered docile and useful through the use of disciplinary techniques. Disciplines may be defined as the "methods, which made possible the meticulous control of operations of the body, which assures the constant subjection of its forces and imposed upon them a relation of docility-utility" (Foucault, 1995, p. 137). Foucault uses the soldier as an exemplar of this capacity to shape individuals through disciplinary regimens:

By the late eighteenth century, the soldier has become something that can be made; out of formless clay, an inapt body, the machine required can be constructed; posture is gradually corrected, a calculated constraint runs slowly through each part of the body, mastering it, making it pliable, ready at all times, turning silently into the automatism of habit; in short, one has "got

rid of the peasant" and given him "the air of the soldier." (Foucault, 1995, p. 135)

Foucault's (1995) description of anatomo-politics is useful to explore the power dynamics within psychiatric institutions that exert a hold over patients' bodies and that reconfigure the way they conduct themselves. Foucault (1995) suggests that these forms of power rely on a number of disciplinary techniques to attain governing objectives. Notably, the institution, as a closed environment, provides a fertile ground for disciplinary techniques to be deployed. He describes a number of indicators that benefit institutional disciplines. For example, through the "art of distributions" and the "control of activities," individuals become entangled in the institution's disciplinary matrix (Foucault, 1995, p. 141). The distribution of people in specific spaces and the control of their activities ensure that everyone is assigned a place in the institution and can, therefore, be monitored. In the psychiatric hospital, the benefits of such disciplines have already been discussed (Johnson & Delaney, 2006). Risk of violence is reduced by the effective use of space and time.

In addition to these disciplinary practices whereby individuals are governed through time and space, Foucault (1995) also describes three other techniques that are essential in the management of individuals: hierarchical observation, normalizing judgement and examination.

Hierarchical observation

"The exercise of discipline presupposes a mechanism that coerces by means of observation" (Foucault, 1995, p. 170); that is, for hierarchical observation to induce its effects of power, mechanisms that are capable of constant and complete observation must exist. For example, the configuration of prisons facilitates hierarchical observation, because it promotes the constant visibility of its inmates. In this case, those who are under surveillance are already disciplined because they know they are being watched. Very

often, the capacity to “see all” is enabled by the delegation of observation roles to different members of the institution (nurses for example) or by the use of technology (i.e., cameras) (Holmes, 2001b).

Panoptic power

According to Foucault (1995), the Panopticon developed by Jeremy Bentham in the eighteenth century is the ideal structure for hierarchical observation. Composed of a central observation tower encircled by an annular building where individual cells are positioned, the Panopticon allows one (anonymous) supervisor to monitor all inmates from a distance. It is through this mechanism of surveillance that individuals may become docile and also knowable.

Foucault suggests that the knowledge of human sciences is employed to refine and intensify the exercise of power. [...] Therefore, while Panopticism is said to have enabled the emergence of new forms of knowledge, that knowledge is, in turn, employed to exercise more efficient and effective Panoptic power. For Foucault, power and knowledge not only regularly reinforce one another but are inextricably bound Panopticism therefore is that form of power that enables human beings to be “made subjects.” In becoming aware that, at any moment, they may be being observed and monitored, and that any “indiscretion” will lead to a period of “corrective training,” human beings are said to become subjects of control; indeed, by regulating their own conduct. (Roberts, 2005, p. 35)

Normalizing judgement

“Normalizing judgement complements hierarchical observation by means of micro-penalties, a system of gratification-punishment in which ranking serves as punishment or reward” (Perron, Fluet & Holmes, 2005, p. 539). In other words, normalizing judgement defines how individuals under surveillance are trained in adopting normalized behaviours. In all disciplinary regimes, corrective strategies (micro-penalties) are used to encourage the adoption of prescribed behaviours. As such, disciplinary techniques described by Foucault (1995) go beyond simple punishment to include ways that will provide the corrective measures needed for individuals to attain the set objectives. As Goffman (1990) explained in his book *Asylums*, the privilege system on which psychiatry relies is similar to

Foucault's description of normalizing judgement. Both rely on a double system of punishment (micro-penalties) and gratification (rewards). Hierarchical observation, then, enables normalizing judgement to take place and reform deviant behaviour.

Examination

According to Foucault (1995), "the examination combines the techniques of an observing hierarchy and those of a normalized judgement. It is a normalizing gaze, a surveillance that makes it possible to qualify, to classify and to punish" (p. 184). Similarly, through the acts of seeing and interviewing patients, the medical gaze exercises its power.

Examination evaluates each individual's abilities and knowledge, analyses new learning and behaviours and sanctions the weak, while validating those performances that meet expectations. In order to achieve such intricate control over individuals' actions and thoughts, the state must come to know them better than they know themselves. An individual must therefore open up and confess their deepest secrets. (Perron, Fluet & Holmes, 2005, p. 539)

In doing so, examination is the mechanism that is used to elicit information from patients and to enable correction. It is through the examination that the power/knowledge dyad takes form. The emergence of new knowledge will be used to improve the efficiency of nursing practice and the control it has over patients.

Pastoral power

Nurses often use examination as a subtle and even more individual form of discipline. "Psychiatric nursing care provided to inmates constitutes an important dimension of nursing practice and power" (Holmes, 2005, p. 6). Through the act of therapy, nurses can exercise what can be known as "pastoral power" (Holmes, 2005). "Pastoral power is a form of power that requires a person to serve as a guide for another (for example, a sick or vulnerable person). Pastoral power deals with individuals and seeks their well-being. Through this benevolent power, 'the guide' cares for others" (Holmes, 2002, p. 86). It is through the establishment of a trusting relationship that this type of power is believed to be most effective (Holmes, 2002). Nurses must gain the trust of patients in order to access

their deepest secrets. However, as Holmes (2002) suggests, "it seems that nurses have to work unrelentingly to establish such an alliance with inmates, in order to be 'therapeutically' effective. Nurses are aware that the correctional environment and their dual socio-professional status render the establishment of an 'ideal' alliance impossible, and consequently the use of pastoral power ineffective" (p. 90). It remains difficult to say, however, if different environments (such as the hospital) enable pastoral power to be effective. Although more subtle than disciplinary power, pastoral power serves as an intricate nursing tool in the governance of mentally ill individuals.

The panoptic metaphor

As explained in hierarchical observation, the Panopticon represents an ideal structure that permits complete visibility of inmates/patients and subsequent correction of behaviour. In time, the awareness of being under constant observation is believed to induce self-discipline (change in behaviour) by those being observed. However, the panoptic metaphor, as Foucault (1995) explains, also affects those who are asked to exercise its power (nurses). As Holmes (2005) points out, nurses are both objects and subjects of power within the disciplinary institution (such as forensic psychiatric hospitals). Nurses "are subjects of power to the extent that they use brutal and subtle technologies of 'government' in order to control mentally ill individuals. They are also objects of power in that nursing practice is constrained by formal and informal regulations of the forensic context" (Holmes, 2005, p. 3). As subjects of power, nurses use disciplinary techniques and therapy (pastoral power) to modify patients' behaviours. Yet, Holmes (2005) suggests, nurses working in forensic environments are themselves disciplined in adopting new behaviours. As objects of power, nurses are described as being the victims of institutional procedures that redefine the way nursing care can be provided.

Given the topics and issues that emerge from the literature review, the importance of exploring how the environment in which nurses practice affects the way nursing care is provided becomes apparent.

CHAPTER 3

METHODOLOGICAL CONSIDERATIONS

3.1 RESEARCH CONTEXT

The research context is well-known to the researcher, who has been involved in teaching, disseminating research results and undertaking fieldwork (data collection) as a research assistant in the institution. Thus the researcher was aware of ongoing changes taking place within the institution well before the study began.

Historical overview

The study was conducted in a medium-security, forensic psychiatric hospital in Ontario, Canada. This unique facility has been providing forensic psychiatric care since 1978, when it opened its first 40 bed unit. Despite a foreshadowed closure of all psychiatric facilities in the late 1990s, the Forensic Psychiatric Treatment Division (F.P.T.D.), as well as all other services offered at this particular psychiatric hospital, have continued to subsist. In 2000, the hospital went through a change in governance that involved an institutional amalgamation with a sister site in a bordering urban municipality, thus creating some tensions and new challenges for the hospital under study. Of particular interest to this research project was the introduction of accreditation procedures to the hospital's managerial structure. The accreditation process proves to be an important method of evaluation that enables one to catch a snap-shot understanding of the hospital's past successes and challenges.

The 2002 Accreditation Report clearly states that the new hospital (referring to the amalgamation mentioned above) was "changing from an acute care unit to a long term care specialty unit, transitioning from a referral source based primarily in the community to a level 1 hospital referral base..., and transforming services to tertiary level care"

(Accreditation Report, 2002, p. 22)¹. As a result of this amalgamation, the F.P.T.D.'s specific mandate was redefined in order to fit within a greater Integrated Forensic Program (I.F.P.) comprising three different operating sites with different therapeutic objectives. As it is defined today, the mandate of the F.P.T.D. is to protect society from the in-patient population (detention), but mainly "to provide specialized interdisciplinary assessment, treatment, rehabilitation, and community reintegration to adults with severe psychiatric illness who have come into conflict with the criminal justice system" (Hospital X², 2008)³. These services are in place for "adults (18 years +) who may be or have been found not criminally responsible (NCR) by the judicial system on account of mental illness" (Hospital X, 2008)⁴. In addition to this general mandate, and as a result of its position within the I.F.P., the F.P.T.D. is now considered to be a "transitional service, providing high support and rehabilitation for patients requiring longer lengths of stay" (Hospital X, 2008)⁵.

During this transitional period, uncertainty as to how these changes would actually affect the workforce in the hospital under study was evident. To quote the Feedback section in the 2002 Accreditation Report, "Staff from the [Hospital X] site feel less empowered with information and expressed being 'in the dark' about changes which are happening to them" (Accreditation Report, p. 136)⁶. Uncertainty regarding the hospital's long-term sustainability continued well beyond the first few years that followed the institutional amalgamation and change in governance. Hospital staff felt like there was an "axe hanging over their heads" because a new facility was set to open in 2006 for their sister site, a reality that not only refuelled speculations of program closure, but also re-

¹ Confidential institutional document.

² The hospital under study will be referred to as Hospital X.

³ Confidential institutional document.

⁴ Confidential institutional document.

⁵ Confidential institutional document.

⁶ Confidential institutional document

established a sense of disconnection between the two sites (Accreditation Report, 2005, p. 38)⁷.

As time would tell, the hospital in question did not close, but was urged to modernize its installations. As observed in the 2005 Accreditation Report, the F.P.T.D. was "unsatisfactory from a therapeutic standpoint and quite likely [unsatisfactory] from a safety perspective. While the renovations to the new building are commendable, the fact that it has been ready to move into for almost two years is unacceptable" (Accreditation Report, 2005, p. 150)⁸. The relocation into the new facility was eventually accomplished shortly before this research began in 2008.

With this opportunity for renewal, considerable changes were made regarding the way nursing care was exercised. The relocation was marked by the introduction of security guards to provide perimeter security, the withdrawal of surveillance technologies (cameras) used by nurses, the reduction in the number of seclusion rooms (only one remaining in the new building), the creation of individual rooms for patients and a renewed interest in the implementation of a new philosophy of care (the imposed implementation of a specific nursing conceptual model). At the time the study took place, the F.P.T.D. was subdivided into four specialized units (wards):

- Assessment Unit (South End): a double-locked, 13-bed assessment unit, which provides acute care, assessment and treatment services.
- Transitional Unit (North End): a double-locked, 13-bed transitional unit, which provides care to patients who require longer-term care (longer than 2 years).
- Transition Unit 2 (South End): a double-locked, 20-bed unit providing active psycho-social rehabilitation.

⁷ Confidential institutional document.

⁸ Confidential institutional document.

- Transition Unit 1 (North End): an open, 13-bed ward (with locked entrance of the facility) providing rehabilitation and community programming as well as reintegration services.

3.2 RECRUITMENT AND SAMPLING STRATEGIES

This study began with a meeting between the researcher and nursing management in order to discuss the modalities of the research, and to decide when and how it would be appropriate to begin recruiting participants. Official presentations to the nursing staff were set to begin on July 14 and 15, 2008. In the interim, memos were distributed via e-mail to all staff members, and posters were posted at all nursing stations to familiarize nurses with the project and inform them of scheduled presentation times. The coordinates of the researcher, who had a designated office in the institution (the medical resident's room), were also posted in order to facilitate communication with interested parties. Formal presentations lasting 15 minutes were scheduled three times a day (10:00, 16:00, and 22:30) in order to make day- and night-shift personnel (12-hour shifts) aware of the study and to offer prospective participants the chance to meet the researcher and ask questions or verbalize concerns.

Given the nature of the research questions and the uniqueness of the research milieu, the selection criteria required that each participant be a registered nurse (RN, RPN) of 18 years of age or older and be presently working at the F.P.T.D. Unfortunately, only a small number of nurses came to the formal presentation sessions (a total of seven, including out-patient services), and only one nurse verbalized interest in the study. It was brought to the researcher's attention that it was difficult for nurses to leave the units and attend the predetermined sessions. As a result, informal presentations were given on individual wards to all nursing staff (including casual staff who float between different units throughout the hospital). A total of 18 nurses participated in individual interview sessions. One nurse asked not to be audio-taped, but nevertheless engaged in a discussion with the

researcher, who took notes during the interview. One interview was not transcribed due to poor sound quality.

In research using a grounded theory method, the number of participants is not of significant importance. It is the richness of the data that each participant can bring to the research that is essential for the data collection (Strauss & Corbin, 1998b). In other words, it is not necessarily the participant who is of interest, but, rather, the information that can be obtained. The importance given to the type of information obtained, which guides the study (rather than a fixed number of participants), is a basic tenet of the grounded theory approach. In order to ensure the value and integrity of the data, the researcher must proceed to a simultaneous collection and analysis of data (constant comparison technique) to guide future interviews and to gradually build a theory (explanation) that remains empirically grounded (grounded in the data). This is the same approach taken by the researcher for this study.

Throughout the duration of the study, the researcher continued to recruit participants as long as new data emerged from each of the interviews. After a total of eleven interviews, the researcher identified redundancies in the themes verbalized by participants. However, the researcher proceeded to complete seven additional interviews to define each category and to enrich the theme described by participants in the first eleven interviews ($n=18$). According to Strauss and Corbin (1998b), this type of "theoretical sampling" enables the researcher to establish boundaries for each of the categories, determine tentative specifications regarding the relations between these categories, and ensure theoretical saturation (a necessary element for the closure of sampling in grounded theory). That is, the researcher continues to recruit participants and collect data even if categories already seem to be complete (Strauss & Corbin, 1998b).

As demonstrated in Table 3.1, the research sample predominantly constituted women (13 women versus 5 men), full-time workers who have obtained an RN degree.

Ten (10) participants out of a total of eighteen (18) had over twenty-one (21) years of experience as nurses and eight (8) had over eleven years (11) of experience working at the F.P.T.D.

Table 1
Participants' Profiles

Sex:		5 men and 13 women			
Age:	# of ppl.	Years as a nurse	# of people	Years at the F.P.T.D.	# of people
26 - 30	1	0 - 5	3	0 - 5	7
31 - 35	2	6 - 10	0	6 - 10	3
36 - 40	1	11 - 15	1	11 - 15	4
41 - 45	2	16 - 20	4	16-20	2
46 - 50	3	21 - 25	3	21 and up	2
51 - 55	5	26 and up	7		
56 - 60	2				
Unknown	2				
Socio-Professional Status		Employment Status			
RN	14	Full Time	16		
RPN	4	Part Time	0		
		Casual	2		

All interviews were conducted at the F.P.T.D.. Specific interview locations varied within the division according to the nurse's preferences and availability. In most cases, interviews were conducted in conference rooms positioned on the units, which permitted other staff to locate the participant if an emergency required that additional personnel be present on the floor. Only the researcher and the participant were present in the locked conference rooms, which permitted complete confidentiality.

3.3 RESEARCH DESIGN

A qualitative design, which incorporates explorative and descriptive attributes, was thought to be an appropriate choice for this research project. Not only are qualitative designs most useful when researchers seek to explore social phenomena through naturalistic and interpretive inquiry, but they are also useful in their contribution to knowledge development in research domains where few investigations have been undertaken (Guba & Lincoln, 1994; Lincoln & Guba, 2000). In other words, qualitative research designs can help to describe the day-to-day experience of persons interacting in a specific setting. Such an approach not only seeks to contextualize personal and collective experiences, but also makes it possible for researchers to observe interactive processes in the environment in which they take place (Creswell, 2003). Therefore, this research project tried to explore and explain both mechanisms of interaction (processes) and personal experiences by obtaining detailed descriptions and offering contextual clarifications. Although research results obtained from qualitative designs can be used as preliminary steps for further investigations, qualitative designs are self-sufficient in themselves—no additional methods are needed to complement the research.

3.3.1 Grounded Theory

Given the embryonic state of research regarding fear in forensic psychiatric nursing, and given the nature of the research question, grounded theory was considered to be the research method of choice for this project. Grounded theory represents an inductive and empirical approach to theory development conceptualized by Glaser and Strauss (1967), two American sociologists from the University of California's faculty of nursing doctoral program (Eaves, 2001). In addition to the pertinence of its inductive methodological approach with explicative, descriptive and exploratory properties (Strauss & Corbin, 1998b), grounded theory's roots and contribution to the development of nursing knowledge have proven to be remarkable (Eaves, 2001; Benoliel, 1996). Some authors also believe

grounded theory to be an ideal method of investigation to uncover complex social processes (Annells, 1996; Benoliel, 1996).

Identifying a "basic social process"

As a qualitative research method, grounded theory is supported by the philosophical and theoretical tenets of symbolic interactionism, a school of thought originating from the University of Chicago's Department of Sociology (Eaves, 2001). Symbolic interactionism is largely based on the work of Herbert Blumer, who defines the term according to three premises: "human beings act toward things on the basis of the meanings that the things have for them ...; the meanings of such things are derived from, or arise out of, the social interaction ...; and the meanings are handled in and modified through an interpretive process used by the person in dealing with the things he encounters ..." (Blumer, 1969 p. 2). "Society is not a structure that exists independently of people's actions and interactions. Rather, human society consists of people engaging in action. Group life (i.e., society) presupposes individual and collective interaction. Human society consists of people in association who interact predominantly on a symbolic level" (MacDonald, 2001, p. 117).

True to its theoretical and philosophical roots, grounded theory places an utmost importance on the behaviours of individuals and their attributed importance, when manifested through symbols (i.e., language) and interactions (Annells, 1996; Benoliel, 1996; Blumer, 1969; Eaves, 2001). As such, the grounded theory method allowed the researcher to enter a specific social environment, interview participants, observe the impacts of social interactions on these participants, and subsequently identify the social processes taking place in this environment through the *micro* and *macro* analysis of conditions affecting actions/interactions (Corbin & Strauss, 1990; McCann & Clark, 2003b; Strauss & Corbin, 1998b). Therefore, the use of grounded theory provided the necessary

framework to explore how nurses interpret their interactions with patients and how these interpretations affected the future course of actions (McCann & Clark, 2003a).

Grounded theory is the method of choice when exploring a process. According to Cutcliffe (2005), the goal of using a grounded theory method is to conceptualize specific behaviours and social dynamics in order to identify a primary conceptual element (core category), described as a basic social process (BSP). In other words, grounded theory is believed to possess explanatory attributes, which describe the variations present within individual social behaviours (Annells, 1997; Reed & Runquist, 2007). By using a grounded theory approach, the researcher was able to identify a social process (*Othering*) in forensic psychiatric nursing, where the patient population is considered to be at risk of violent behaviours. The use of a grounded theory approach was further justified for this research, as the identification of a basic social process in forensic psychiatric nursing could help explain (even partially) social realities in other areas of nursing practice that yield common descriptive attributes (other forensic psychiatric units, general psychiatric hospitals, emergency departments, etc.).

There were clear benefits to using grounded theory for this research since

[...] theoretical conclusions drawn from field work are empirically grounded as opposed to the use of empirical work to test grand theory. The formal theoretical categories that ultimately emerged from this research will, hopefully, benefit other nursing researchers and clinicians, in that they have a direct relation to the "realities" of nursing practice and are consequently accessible to clinicians – who are the intended beneficiary of grounded theory. (May, 1990 p. 313)

This project produced a theory (explanation) that is relevant to the field of forensic psychiatric nursing, and also provided insights into nurse–patient interactions in a hospital-based forensic psychiatric institution.

By using the term "theory," it is not the notion of a grand theory that is being evoked, but, rather, the process of extrapolating the meaning of an event, schematically linking different elements of a situation, and renewing one's understanding of a

phenomenon by exploring it from another angle (Paillé, 1994). Although a grounded theory is the result of a rigorous analysis that is grounded in the data (Paillé, 1994), the results of this research remain an interpretation that is the product of an interaction between participants and a particular researcher (Hall & Callery, 2001).

As a novice researcher, one might find it difficult to ground oneself in the data and to adopt a new point of view regarding the research problem (Backman & Kyngäs, 1999). This is why it is recommended that a mentor be present to guide the research process (Benoliel, 1996)—a recommendation that was followed throughout the research. The researcher met with his supervisor (Dr. Dave Holmes) on a weekly basis to discuss and review research material, and to allow Dr. Holmes to oversee the general progress of the project.

Basic tenets and diverging perspectives in grounded theory

Grounded theory is, essentially, the discovery/development/construction of theory from data that has been systematically obtained from research. Both the process and product of the research are shaped by the data rather than by preconceived logically deduced theoretical frameworks. Since its initial conception (Glaser & Strauss, 1967), grounded theory has been subject to many methodological reformulations by different authors. Of these, Barney Glaser, Anselm Strauss, and Kathy Charmaz all represent key innovators in the evolution of grounded theory methodology and diverging perspectives regarding the use of the literature, the researcher's role and the collection and analysis of data in grounded theory.

Traditionally, the Glaserian approach has been associated with the "pure" and original grounded theory approach (Cutcliffe, 2005). As such, the feature that mainly distinguishes Glaser's approach from other grounded theory approaches is his emphasis on the emergence of theory from the data (Boychuck Dushches & Morgan, 2004). Hence, Glaser favours what one could describe as an open approach to research, wherein the

researcher tries to be a-theoretical before entering the research field (Glaser & Holton, 2004). Following an inductive research process, the researcher should enter the field with the fewest predetermined ideas and hypotheses as possible; in other words, the research problem is not predetermined before entering the research setting, as it needs to be discovered in the data (Glaser & Holton, 2004). The researcher's theoretical sensitivity occurs through his immersion into the data and his ability to both generate hypotheses and concepts from the data, and systematically work out these hypotheses and concepts in relation to the data obtained throughout the research. Glaser believes that this approach prevents the imposition of a predetermined theoretical framework and the deductive testing of pre-conceptualized hypotheses. The use of the literature to orient theorization can only be used once core categories have been formulated.

Strauss and Corbin (1998b) also believe that developing sensitivity (having insight into and being able to give meaning to the events and happenings in the data) occurs while working with the data and being immersed in the analysis. However, they do not believe that such a procedure happens haphazardly; "rather, they happen to prepared minds during the interplay with data" (Strauss & Corbin, 1998b, p. 47). Thus, who the researcher is, what he knows, and the theories that exist inside his head all contribute to the development of sensitivity. Furthermore, Strauss and Corbin (1998b) state, "It is by using what we bring to the data in a systematic and aware way that we become sensitive to meaning without forcing our explanations on data" (p. 47). Consequently, Strauss and Corbin (1998b) view the researcher as a value-mediated tool who is not only shaped by the data, but also shapes the data by using his background information. Exposing this background information ensures a transparent approach. In other words, the researchers cannot be a-theoretical before entering the research field, and literature reviews are essential in the formulation of research problems. Although one needs to be aware of the threat of imposing pre-conceived frameworks into the research, it must also be put forth

that any conceptualization or theory is value-laden; that is to say that the end product of the research is a human construction, which is the result of a specific relationship between participants and a particular researcher. Although the resulting conceptualization is the result of a rigorous analytic process, it remains influenced by the researcher's paradigmatic position and theoretical sensitivity.

3.3.2 The Paradigmatic Link: Postmodern Grounded Theory

"Paradigm" is defined as a distinct world view representing a set of basic beliefs that define the nature of the world, while resting solely on faith (however well-argued) due to the inability to establish its ultimate truthfulness (Guba & Lincoln, 1994). In fact, paradigms are described as transitional world views, which are created in response to a specific need within the scientific community, one that demands new ways of explaining the nature of the world (Guba & Lincoln, 1994; Khun, 1998). However, a paradigm does not cease to exist once a new one is introduced to a field of inquiry. As such, the coexistence of multiple paradigms renders dialogue between those who adhere to differing world views difficult (Holmes & Gastaldo, 2004), even more so when the methods of inquiry, the researcher's position in the production of knowledge and the truth-value of the envisioned findings are being discussed. According to Guba and Lincoln (1994), paradigms of inquiry can be divided into four categories: positivism, post-positivism, critical theory and constructivism—each defining a clear position for the qualitative researcher.

Following the initial publication of *The Discovery of Grounded Theory* in 1967, Barney G. Glaser and Anselm L. Strauss foreshadowed the evolution of their research method by encouraging other researchers to build on its embryonic state in the field of sociology. However, what the creators of grounded theory failed to envision was the paradigmatic clash that would be created between the two authors over the years, one that, through the works of Strauss and Corbin, slowly expanded the post-positivist view of the "original" grounded theory towards the constructivist paradigm (Annells, 1996; Hall &

Callery, 2001; Mills, Chapman, Bonner & Francis, 2007). While the original version of the grounded theory method was intrinsically situated within the post-positivist tradition, Annells (1996) suggests that Strauss and Corbin's description of a theoretically sensitive researcher, who uses a conditional matrix to incorporate macro-social perspectives to the ensuing theory, will inevitably introduce "issues of class, gender, race, power and the like" (Annells, 1996, p. 390), a perspective that is congruent with postmodern thought (Mills, Bonner & Francis, 2006a).

The goal of using grounded theory for this research project was to unmask realities often taken for granted in forensic psychiatric nursing and in the health care system in general. From a postmodern perspective, this inquiry centred on issues of power relations between nurses and patients, a complex social process in which fear (real or perceived) determines the course of "therapeutic" actions (Whittington & Balsamo, 1998). However, one is forced to conclude that, "when grounded theory method reflects the philosophical attributes of the post-positivist inquiry paradigm, it cannot be appraised as being postmodernist in perspective but rather seems to be a feature of the modernist phase" (Annells, 1996, p. 390). By using Strauss and Corbin's (1998b) version of grounded theory, the researcher's intention is to ensure its compatibility with the roots of his research questions, which are situated at the heart of postmodern thought.

Furthermore, Annells (1996) argues that "when a grounded theory method is applied within a constructivist inquiry paradigm, the method may be viewed as moving toward the postmodernist perspective, as the constructivist paradigm is seen by some ... to reflect postmodernist concerns" (p. 390). The constructivist thread can be traced back to the initial work of Strauss and his collaboration with Corbin during the 1990s (Mills, Bonner & Francis, 2006b). Although these authors have been criticized for creating a more prescriptive framework with which to engage in grounded theory (Heath & Crowley, 2004; Johnson, 1999) and for abstaining themselves from ontological and epistemological

discussions, the underlying description of their method indicates a new-founded transition towards relativist ontology and subjective/transactional epistemology (Annells, 1996; Mills, Bonner & Francis, 2006b).

The fact that grounded theory has undergone a paradigmatic shift over the years suggests it now features specific characteristics indicative of a greater compatibility with critical theory paradigm and postmodernism. For example, Strauss and Corbin (1998b) recognize that reality is always interpreted differently and that the researcher's perspective, one that is an outcome of multiple interactions between the inquirer and the participants, is reflected in the ensuing theory. By taking into account the influence of personal knowledge and professional experience, Strauss and Corbin (1998b) recognize that these factors are valuable tools in developing the researcher's theoretical sensitivity, in that the researcher provides unique insight into the findings, and is able to give meaning to the events and happenings in the data.

For the research presented here, the use of a grounded theory approach allowed the researcher to maximize his own sensitivity in order to produce findings that attest to the influence of personal knowledge and professional experiences as well as the voices of participants whose roles were to co-construct the ensuing theory. Adopting a grounded theory method also allowed the researcher to contextualize the research phenomenon both within forensic psychiatric nursing practice and the specificity of its environments of "care" where the goals of therapeutic interactions are intertwined with security imperatives (Holmes, 2001a; Holmes & Federman, 2003; Peternej-Taylor, 2004). In effect, the works of Strauss and Corbin (1998a) support the relationship between time and place when constructing realities, a feature that is essential to postmodernist thought, which views "reality" as the product of social and historical constructions.

3.4 DATA COLLECTION

In order to explain variations in social behaviour within its natural context, there are a number of different complementary sources of information that help to grasp the complexity of the phenomenon being studied. For this particular research, semi-structured interviews were used as the primary source of data, complemented by direct observations, memos and journals as well as mute evidence (documents),

3.4.1 Semi-Structured Interviews

Interviews are one of the most common techniques used for data collection in social sciences (Peretz, 2004) and typically give the researcher a chance to explore the meanings and personal experiences of participants, as expressed in their own words. This type of data collection is compatible with grounded theory, which has a tendency to move away from a reliance on observation, towards a reliance on unstructured, retrospective interviews (Beloniel, 1996; Morse, 2001). It is from participant stories that researchers can best identify processes (Morse, 2001).

For this project, semi-structured interviews lasting roughly 60 minutes were conducted with participating nursing staff. These interviews took place in locked conference rooms located on the nursing units. All interviews were audio-taped (except one), transcribed and analyzed by the researcher promptly after each interview. The immediate analysis of transcription is congruent with grounded theory's inductive approach, which encourages the simultaneous collection and analysis of data in order to guide future interviews based on emerging themes and categories (Paillé, 1994; Strauss & Corbin, 1998b). Notes were taken during the interview with the participant who did not wish to be audio-recorded.

3.4.2 Direct Observation

Direct observation consists of witnessing first-hand the social behaviours of individuals and groups in their own environment, without modifying their day-to-day interactions (Peretz,

2004). Thus, the researcher did not participate in the daily activities of nurses working at the F.P.T.D., but, rather, adopted a passive observer role. As Peretz (2004) suggests, direct observation is the result of a particular relationship between participants, who are aware of the researcher's presence and motives, and the researcher. In this study, the researcher identified key informants early on in order to facilitate his introduction to the research milieu. This allowed him to penetrate the realities of nurses working at the FTU and to render his presence "invisible," i.e., with time, participants became familiar with the researcher's presence, which permitted him access to valuable information regarding social interactions, institutional functioning, unspoken practices, beliefs, thoughts, and so on. It is important to state that this intrusion was difficult. Depending on which staff members were present in the nursing stations, and the degree to which nurses were familiar with the researcher, there were numerous hours spent in the nursing stations when the researcher felt unwelcome. Given time and the knowledge that the researcher was himself a psychiatric nurse, nursing staff became more inclined to discuss issues regarding their practice. Although many refused to participate formally, nursing staff often shared their opinions in group discussions that took place in the nursing stations.

In order to carry out his research objectives, the researcher was assigned the medical resident room as an office, which provided him with continual direct access to the research setting and to prospective participants for a period of two months. The researcher was conscious that his presence could affect individual and group behaviour. However, the prolonged presence of the researcher within the research setting facilitated his integration into the F.P.T.D. and, hopefully, did not disturb the natural course of events at the F.P.T.D. The researcher was present at the institution for a total of 21 days from July 14, 2008, to September 3, 2008. Each day, the researcher spent time on the units in the morning, afternoon, evening and night. Approximately 65 hours (3 hours per day) of observation were completed.

Direct observation was not intended to examine actual nurse–patient interactions, but, rather, to describe the milieu (architecture of the setting, special positioning of workspaces, etc.). An observation grid was used to guide these activities (refer to APPENDIX B). Observations and thoughts were documented as memos, which helped in the analysis of the data that was collected during interviews and that was found in various mute evidences (documents).

3.4.3 Memos and Journals

Memos are essentially a way to document thoughts and create a tangible paper trail that explains the researcher's thinking process throughout the research project. For this particular project, memos were integrated into the researcher's journal, and were organized according to three different categories (Shatzman & Strauss, 1973): observation (descriptions of the social organization), methodological notes (comments on interaction problems) and theoretical notes (all notes pertaining to conceptual notions that came to mind). Although these memos were intended to follow observations (Shatzman & Strauss, 1973), these reflections were also completed following each interview and sporadically, if needed. The journal was also used to document daily agendas and explore personal feelings and thoughts throughout the research process.

3.4.4 Mute Evidence

Various institutional documents (Hospital mandate, unit mandate, Accreditation Reports, etc.) were used to complement the data collection and to increase the depth of the analysis. Nursing notes were not subject to analysis.

3.5 DATA ANALYSIS

For this research, data analysis followed the basic principles of grounded theory, as adapted and displayed in a sequential fashion by Paillé (1994). Paillé's (1994) work does not seek to direct how one conducts qualitative research (methodology), but, rather, guides the analysis of the data. In addition, Paillé's (1994) adaptation of the method

substitutes the multiple coding stages developed by Strauss and Corbin with a series of successive steps of an iterative process. This process represents the results of a rigorous interpretation etched by a sequential series of reflections and constructions that shed light on a phenomenon, one that is always more integrated and empirically grounded in the data itself (Paillé, 1994).

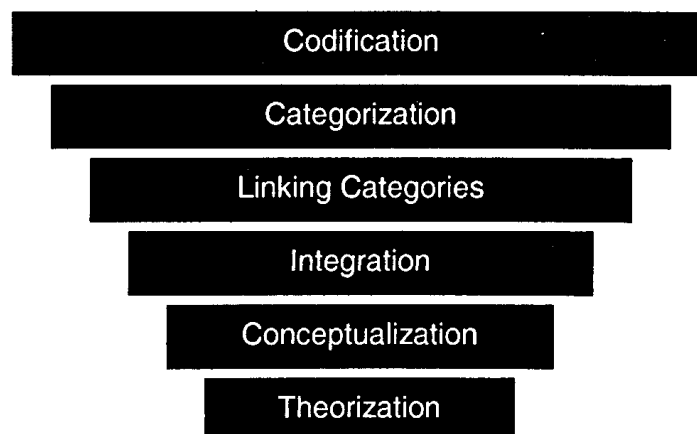
One of the most important characteristics of grounded theory analysis is the simultaneous collection and analysis of data. Each series of interviews is followed by data transcription and analysis that, in turn, guides future interviews, observations, etc. As such, carrying out a grounded theory research method is not so much a process of coding as it is a process of constant interrogation and verification of data through interviews (Paillé, 1994).

Steps of grounded theory analysis

Six successive steps have been identified by Paillé (1994) when conducting a grounded theory analysis. Although these steps are presented as separate entities, the researcher must not view them as mutually exclusive, nor assume that the progression between each step is linear (Paillé, 1994). The steps are illustrated in the following figure (Figure 3.1) and will be examined step by step.

Figure 4

Grounded Theory Analysis (Paillé, 1994)



Codification

The objective of codification is to reveal, name, summarize and label, line by line, the contents of the transcriptions obtained from the interviews. In this study, the researcher read each interview and attempted to qualify, with words or expressions, the general idea of each line or group of lines. In order to do so, the researcher asked himself: What do we have here? What is the participant talking about? By doing so, the researcher was able to summarize words or expressions, and use the participant's own words to create codes. The researcher is aware that the analysis will never perfectly reflect the content being analyzed. By definition, an analysis is supposed to reveal the essential properties of the object being analyzed, and these essential properties may vary depending on the researcher's subjectivity/sensitivity (Paillé, 1994). In reality, the researcher went back and forth from codification to categorization.

As Paillé (1994) suggests, the researcher should limit the number and construction of codes, and remain grounded in the data. Thus, the researcher was conscious of previously constructed codes, in order to ensure that each idea was constantly explained using the same code, and that this code reflected, as closely as possible, what the participants had explained. In the beginning, the researcher analyzed his codes, regrouped them, classified them, and attempted to create hierarchies. This exercise, which is suggested by Paillé (1994), helped identify overlap between initial codes and the formation of categories.

Categorization

The second phase of a grounded theory analysis essentially seeks to elevate the analysis on a more conceptual level. In this phase, the researcher attempted to describe the general phenomenon or events that emerged from the data by asking: What is happening in the data? What phenomenon am I looking at? In order to respond to these questions, the researcher used two techniques suggested by Paillé (1994).

1. Make up a list of categories identified at the end of the coding phase.
2. Take an un-marked transcription and write the categories in the margins as opposed to the codes identified earlier.

These exercises not only helped to define categories by trying to identify whether variations in the data could be explained by other categories, but also enabled the researcher to use his theoretical sensitivity. Because a grounded theory relies on the constant comparison of data, the researcher's sensitivity to the phenomenon being studied became more refined, and it helped him to make sense of the data, name phenomenon, extrapolate meanings and link different parts of the study as it evolved (Paillé, 1994; Strauss & Corbin 1998b).

According to Paillé (1994), each category is mutually exclusive, meaning that each category defines, in rich detail, a specific aspect of analysis. Table 3.2 identifies the final categories for this research.

Figure 5

Final Categories

1. Context
2. Nursing Care
3. Fear
4. Othering

Linking categories

This next step in grounded theory analysis seeks to link the categories together—to move from a static position to a dynamic one, which is finalized in the conceptualization phase. According to Paillé (1994), there exist three approaches to link categories: the empirical approach, the theoretical approach and the speculative approach. The empirical approach

is based on the comparison of each of the categories and the phenomenon they describe. At this stage, the researcher simply explores possible links between the categories by looking at the empirical data. Although the process of linking categories is largely an empirical endeavour, it is nonetheless influenced by theoretical perspectives incorporated into the research by the researcher. The theoretical approach helps identify links between categories. Finally, the speculative approach (which is rarely employed) draws from the researcher's experience to contribute to the analysis process.

Instead of selecting one approach over another, this researcher decided to combine all three when attempting to draw connections between categories. As such, the researcher's experience as a psychiatric nurse, as well as the theoretical perspectives that have influenced his thoughts, all contributed to the comparison and explanation of links made between the empirical data.

Integration

Once the categories were linked, the researcher asked himself: What is the phenomenon that I am looking at? This question enabled the researcher to determine the phenomenon that was empirically observed. This step involved re-reading the researcher's journal (memos) and analyzing schemas in order to identify a common thread in the study that had not been revealed to this point. By reverting back to the raw data and comparing it with the links made between the categories, the researcher was able to identify a certain congruency that emerged between the gross data and the direction that the research had taken during the analysis.

Conceptualization

The fifth step of the analysis consists of attempting to reproduce the structural organization and relations between categories (Paillé, 1994). This process enabled the researcher to understand the research phenomenon in all of its complexity. Explanatory links were established between the nature of the phenomenon, its causes and its consequences for

nursing practice at the F.P.T.D. It also enabled the researcher to identify a basic social process (Othering).

Theorization

The sixth and final step of the analysis is theorization. At this stage of the process, the theory was well-substantiated. Theorizing is not something that is done at the end of the study, but rather represents the product of a rigorous process (Paillé, 1994). In other words, the theory was being produced as the researcher followed each of the steps. However, this production must be understood as a human construction, even though it relies on empirical material. It is a construction for which the researcher takes full responsibility.

Once all the steps of grounded theory analysis were completed, the researcher was able to create a complex schema that reflects the empirical data used to answer the research questions. The presentation of the research as a descriptive theory gives insight into the effects of fear (threat) on nurse–patient interactions in a hospital-based forensic psychiatric environment. See Chapter 4 (Results) for a complete account of the theoretical production and Chapter 5 (Discussion) for the theoretical discussion.

3.6 RIGOUR CRITERIA

The identification of criteria used to evaluate research that was carried out using a grounded theory approach helps one to determine the trustworthiness of the study by evaluating its strengths and limitations. For this project, Chiovitti and Piran's (2003) rigour criteria for evaluating grounded theory was applied. These criteria consist of credibility, auditability and fittingness.

3.6.1 Credibility

The first criterion, credibility, was used to “ensure that the phenomenon investigated was accurately identified and delineated” (Chiovitti & Piran, 2003, p. 430). In other words, credibility was used to assess the truth-value of findings by addressing the inductive nature

of grounded theory and allowing participants to speak through the data. As much as possible, the research used participants' actual words to describe the phenomenon of study, and articulated the assumptions, epistemological positions and theoretical works that have influenced the research process. In addition, the researcher engaged in a reflexive process to evaluate himself as a human instrument (Guba & Lincoln, 2005) by critically examining his effects as a researcher on the research process (Hall & Callery, 2001). This process was predominantly conducted through self-reflections and memos, written in the researcher's journal.

3.6.2 Auditability

"Auditability refers to the ability of another researcher to follow the methods and conclusions of the original researcher" (Chiovitti & Piran, 2003, p. 432). Auditability does not presume that findings could be reproduced, but, rather, that the researcher's thought process, methodological and analytical processes can be rationalized in light of the ensuing theory. In order to ensure this, the researcher used a framework presented by Paillé (1994) to identify the different steps used in the analysis and to ascertain that readers were able to understand how the data was shaped by the participants and the researcher.

3.6.3 Fittingness

"Fittingness, also referred to as transferability, pertains to the probability that the research findings have meaning to other similar situations" (Chiovitti & Piran, p. 433). Fittingness, or transferability, is not synonymous with the term generalizability. This criterion entails that the research sample, as well as the context, are described well- enough to ensure applicability in other areas that share similar characteristics. Through detailed contextual descriptions, including the type of population and sample of participants being studied, this research could be transferable to other areas of nursing practice where the threat of violence influences nurse-patient interactions (emergency settings for example).

3.7 ETHICS

3.7.1 Conducting Research on Sensitive Topics

Given the unique nature of forensic psychiatric settings, there exist particular ethical tensions regarding the care of mentally-ill offenders (Holmes, 2005; Holmes & Federman, 2003; Mason, 2002). It is conceivable that doing research in such an environment remains delicate, since personal, professional and organizational practices and discourses are subject to scrutiny and criticism. Research, as an invasive look into the realities of those working in forensic psychiatry, could possibly be perceived as a threat to the organization and to prospective research participants. Therefore, it is believed that this research fits the criteria for "sensitive research" (Renzetti & Lee, 1993).

It is not uncommon for qualitative researchers in the health and social fields to raise questions regarding the sensitivity of their research (McCosker, Barnard & Gerber, 2001), as it potentially affects all stages of a research project, from the study's design to the dissemination of research findings. A research project can be classified as sensitive for multiple reasons, ranging from direct repercussions to research participants or the organization, the level of discomfort (taboo) that the research entails for society (McCosker, Barnard & Gerber, 2001), or even the particular socio-political context in which the research takes place (Renzetti & Lee, 1993).

It is implicitly assumed that sensitive research involves topics that pose a level of risk to those being studied, risk that could potentially affect the collection, holding and/or dissemination of data. The disruptive nature of sensitive research, which challenges the status quo or widely-accepted ways of seeing the world, creates discomfort/uneasiness; this needs to be anticipated by the researcher, whose research can be seen as a possible threat to the participants or organizations involved. Should a perceived threat exist between the researcher and the participant, there is always the possibility that a relationship will develop wherein defensive mechanisms (mistrust, concealment and

dissimulation) are adopted by participants to resist the intrusiveness of the researcher. According to Renzetti and Lee (1993), three broad areas of concern have been identified as possible threats to sensitive research. These hold significant meaning for this particular forensic psychiatric research project.

Intrusive threat

The nature of this research project, which was to explore, describe and explain how fear influences nurse–patient interactions, could be considered threatening to the participants. In this research, fear was acknowledged to be a topic that is not often openly discussed in forensic psychiatric nursing, likely due to the macho culture that may be present in psychiatric settings (Holmes, 2005; Morrison, 1990) and the subsequent reluctance to reveal personal feelings (Mason, 2002). The threat to participants primarily revolved around the comparison that they made between themselves and others. The following quote attests to this: “Hopefully, you’ll be able to tell me if I’m normal” (Trevor: Post-interview comment). Participants are aware only of their accounts and behaviours, and are unable to judge the “normalcy” of their accounts. Only the researcher is in a position to compare participants, a factor that could create unease for the participant, who might feel that his/her feelings/practice may be inadequate or judged.

Threat of sanction

The second threat that could be perceived by the participants of the research project is the fear of scrutiny, which exists particularly in organizational settings (Renzetti & Lee, 1993). In such settings, the researcher is thought to be a menace to traditional ways of doing things by pointing out activities and practices that could be considered deviant, yet have been generally accepted among the participants or their institutions. In other words, participants might feel that their practice is being evaluated, possibly discredited or even prosecuted by public and/or professional authorities following the publication of results. According to Punch (1998), this problem is part of a wider ethical dilemma that positions

the protection of the subjects versus the academic freedom to conduct research and publish research findings.

Political threat

The third and final threat that could have been perceived by the participants in the study relates to the disruptive nature of the research (Renzetti & Lee, 1993). The potential threat that this research could pose to participants essentially is its possibility of disrupting the status quo. The researcher entering an organization can be seen as an uncontrollable variable within a closed, controlled system, a variable that could disrupt the culture of the organization. This is particularly true in an organization where strongly imbedded, internal normative order provides a sense of identity for its members (Renzetti & Lee, 1993). In particular, the researcher may be perceived as a political threat to the organization's status, the image of the organization's governing agencies, the professional status of nurses, etc. Such perceptions could create barriers for researchers conducting studies on sensitive topics, since participants might attempt to protect themselves from perceived negative criticism not only from the researcher, but also academics and laypersons who might come across the research findings.

It became apparent during the collection of data that the notion of sensitive research was extremely important to this project. Had the research study not ensured confidentiality, the threat of participating in the study, the vulnerability of explaining professional practice, and the feelings that result from open disclosure would certainly have created a barrier for many of the nursing staff. As one of the participants explains, "Confidentiality? In this institution, nothing is confidential" (Loraine – Interview notes).

In general, the researcher attempted to identify potential threats and to reassure participants that the nature of the research project was not intended to be an examination of professional practice, but, rather, was intended to provide a better understanding of a social process: how fear influences the interaction between the nurse and the patient in

forensic psychiatry. When the time comes to publish and disseminate the research findings, the researcher will judiciously take into account the following restrictions: intrusive threat, threat of sanction, political threat.

3.7.2 Consent and Confidentiality

Prior to each interview, participants were required to read and sign two copies of a consent form (see APPENDIX A) and were given one of the copies. The consent briefly reiterated key features of the research protocol (goal of the study, questions, etc.). The participants were informed that, at any time, they could withdraw from the study without any prejudice, and their motive for withdrawal did not need to be shared with the researcher.

The confidentiality of each contributor in the future dissemination of results was guaranteed. Each participant was attributed a random, alpha-numeric code in order to make it impossible for anyone to link a transcription to a particular participant, should they attempt to do so. For example, informant FPTD-CN1 could very well be the last person that was interviewed for the research. These codes were further substituted with fictitious participant names. Furthermore, the institution was also reassured that the name of the research environment would remain anonymous in the future dissemination of the results. The content of the interviews (tapes and transcriptions) were never handled by a third party other than the main researcher's supervisor, Dr. Dave Holmes. All material was kept locked in the main researcher's supervisor's office, situated at the University of Ottawa. Data will be kept for a period of five years following the completion of the study, after which the material will be destroyed (transcriptions will be shredded and tapes demagnetized).

CHAPTER 4

RESEARCH RESULTS

This chapter presents the results of the data analysis. In keeping with an inductive methodological framework, the use of a grounded theory method produced four mutually exclusive categories: 1.) Context, 2.) Nursing Care, 3.) Fear, and 4.) Othering. These categories were the result of a rigorous process that sheds light on a phenomenon, a process that is always more integrated and empirically grounded in the data itself. By using constant comparison principles, the analysis revealed that the fourth category (Othering) was the site of a basic social process and primary conceptual element (core category) where all other categories converged. The categories under study in this forensic psychiatric practice are composed of many complex dimensions, which will be described hereafter.

4.1 CATEGORY 1: CONTEXT

4.1.1 History

First moment

Second moment

4.1.2 The Forensic Psychiatric Treatment Division (F.P.T.D.)

Configuration

4.1.3 Human Resources

Nursing hierarchy

Hierarchy & discipline

As the data indicates, the nursing practice under study was influenced by the context in which it took place. It is therefore of significant importance to describe the physical and human structure that constitutes the Forensic Psychiatric Treatment Division (F.P.T.D.) in order to understand the environment in which nursing care is being exercised. The following section will begin by providing a historical overview of the research setting, followed by a description of the F.P.T.D.'s mandate and configuration. It will then conclude with a description of human resources.

4.1.1 History

The hospital in which the F.P.T.D. is currently located opened in the late 1800s as one of the province's insane asylums. Thus it can be considered to be a vestige of the asylum culture in which large numbers of individuals were taken in charge, treated and obliged to live outside the pale of polite society. Not until 1978 was the foundation of the F.P.T.D. created, and the hospital opened its first 40-bed, medium-security forensic unit. Since then, the F.P.T.D. has expanded its capacity, divided into four specialized units and modernized its facilities at two distinct moments in the hospital's history.

First moment

The first moment in the F.P.T.D.'s history, as described by the participants, occurred in the early 1990s when both the staff and patient population were relocated within the hospital in order to "refit" the forensic psychiatric unit. Unfortunately, this experience was tainted by the murder of an in-patient by a co-patient. This moment in the F.P.T.D.'s history marked the introduction of surveillance technologies (cameras and two-way mirrors, for example) within the nursing units. Although a language of security and safety promoted the need for these technologies, a few participants remained skeptical about the positive effects of such measures on nursing care. The period of the late 1980s to early 1990s epitomized what one of the participants described as a time when hospitals were asked to become more efficient and productive. Budget cuts, layoffs, and standardization of practices were just

some of the strategies put into place to provide optimal patient care while simultaneously decreasing costs. In psychiatry, the introduction of surveillance technologies were optimized and believed to enable fewer nursing staff to supervise more patients. This initiated what this participant believed to be the development of a "find and fix approach" that resulted, in part, in the creation of a distance between nurses and patients. Nurses were no longer in contact with patients, but became distant, reactive observers.

Back in the '80s and '90s in health care, there were efficiencies. In my view, the discipline of nursing and health institutions looked for cuts, savings, tick sheets: the find and fix approach to health care, I call it. Hospital restructuring throughout Canada went through cuts, and they went through layoffs, and they ended up at an approach that was a scarcity approach...versus looking at what nurses actually bring to the table. ...if you consider a nurse in a control room watching a camera, responding to any activity, they thought that was the best approach. Since then, we have learned that prevention is part of the battle. ...They do not need to be behind glass. They need to be out, listening, helping. ...We had the opportunity here when we moved to the [F.P.T.D.] to change. A lot of the nurses...are going through difficulties with that change. They grew up in the '80s and '90s with the find and fix approach to nursing And we are trying to implement a different approach where you are in relation with the patient, you are understanding of the meanings of those things that are important to that patient to help them during their stay here. (Marc: lines 198-221)

Second moment

The second moment in the F.T.P.D's history, as described by the participants and the well-documented event, was the anticipated closure of the psychiatric institution in the late 1990s, to be followed by an institutional amalgamation, a redefinition of the hospital's mandate, and, finally, a physical relocation in 2008.

Though slated for closure in 1999, an ongoing need for mental health services in the province enabled the hospital to continue its work, notably because of its distinct forensic psychiatric services. As the following nurse explains, the eventual closure of the hospital in the late 1990s prompted many staff to migrate to forensics for job security, regardless of their interest in this line of work.

A lot of people came to forensics because of [job] security. When they talked about the other units starting to close, forensics looked like it was going to

hold. And so people have migrated here. People have stayed here when they did not want to, because there are no other options to move to. And so that tends to burn you out. You just get to the point where you think, "Well I am stuck here until..." and I hear people counting down: "I have three years, two months and sixteen days until I can retire." So all of that stuff demotivates you. (Julie: lines 698-707)

In 2000, the hospital went through a change in governance that involved an institutional amalgamation with a sister site located in a bordering urban municipality. Consequently, this merger created tensions and challenges for the hospital under study. Of particular interest to this research project was the introduction of accreditation procedures to the hospital's managerial structure. The accreditation process proved to be an important method of evaluation that enabled the researcher to capture a "snap-shot" understanding of the hospital's past successes and challenges.

The 2002 Accreditation Report clearly stated that the new hospital (referring to the aforementioned amalgamation) "chang[ed] from an acute care unit to a long term care specialty unit, transitioning from a referral source based primarily in the community to a level 1 hospital referral base..., and transforming services to tertiary level care" (Accreditation Report, 2002, p. 22)⁹. As a result of the amalgamation, the F.P.T.D.'s mandate was redefined in order to fit within a greater Integrated Forensic Program (I.F.P.) comprised of three different operating sites, each maintaining different therapeutic objectives. As it is defined today, the mandate of the F.P.T.D. is "to provide specialized interdisciplinary assessment, treatment, rehabilitation, and community reintegration to adults with severe psychiatric illness who have come into conflict with the criminal justice system" (Hospital X¹⁰, 2008)¹¹. These services are in place for "adults (18 years +) who may be or have been found not criminally responsible (NCR) by the judicial system on

⁹ Confidential institutional document.

¹⁰ The hospital under study will be referred to as Hospital X.

¹¹ Confidential institutional document.

account of mental illness" (Hospital X, 2008)¹². In addition to this general mandate, and as a result of its position within the I.F.P., the F.P.T.D. is now considered to be a "transitional service, providing high support and rehabilitation for patients requiring longer lengths of stay" (Hospital X, No date)¹³. Services provided by this facility are considered to be long-term, as opposed to the short-term services (shorter than six months) provided by the sister site:

The other site tries to have people discharged in six months or less. They focus on short-term rehab, getting the person out into the community. Our focus is longer term. We are looking at an average stay of three years, or more. So, we have some clients that have been here 20 some years, but that again is the other side of the equation. We rarely have anyone leave here in less than a year. But our average is about three years. So we focus more on the patients that are more difficult to service—people that will not respond to medication and some therapy. (Julie: lines 362-370)

During this transitional period, uncertainty as to how these changes would actually affect the workforce in the hospital under study was evident. As stated in the Feedback section of the F.P.T.D's 2002 Accreditation Report, "Staff from the [Hospital X] site feel less empowered with information and expressed being 'in the dark' about changes which are happening to them" (Accreditation Report, p. 136)¹⁴. The uncertainty regarding the hospital's long-term sustainability continued well beyond the first few years that followed the institutional amalgamation and change in governance. Hospital staff felt that there was an "axe hanging" over their heads because a new facility was set to open in 2006 for their sister site; a reality that not only refuelled speculations of program closure but also re-established a sense of disconnect between the two sites (Accreditation Report, 2005, p. 38)¹⁵.

In actuality, the hospital did not close, but instead was urged to modernize its installations (move into a new building). As the 2005 Accreditation Report noted, the

¹² Confidential institutional document.

¹³ Confidential institutional document.

¹⁴ Confidential institutional document.

¹⁵ Confidential institutional document.

F.P.T.D. was "unsatisfactory from a therapeutic standpoint and quite likely from a safety perspective. While the renovations to the new building are commendable, the fact that it has been ready to move into for almost two years is unacceptable" (Accreditation Report, 2005, p. 150)¹⁶. The relocation into the new facility was realized shortly before this research began in 2008. With this opportunity for renewal, the hospital made considerable changes to the exercise of nursing care. The relocation was marked by the introduction of security guards to provide perimeter security, the withdrawal of surveillance technologies (cameras) used by nurses, the reduction in the number of seclusion rooms (only one remaining in the new building), the creation of individual rooms for patients and a renewed interest in the implementation of a new philosophy of care (the imposed implementation of a specific nursing conceptual care model). As the following participant explains, the new vision has created an incentive for nurses to "handle themselves differently. "

We went from four, to one [seclusion room]. I was always concerned ...that people are reluctant to bother putting a patient in the quiet room for a time out because they do not want to occupy it in case we have somebody that would really need it, or it could go the other way. We do not have as many, so we handle ourselves differently with people that are agitated. You get in there earlier, which is what you are supposed to do anyway. You are supposed to get in there earlier and offer alternatives to calm themselves down or offer a PRN. (Patricia: lines 341-350)

4.1.2 The Forensic Psychiatric Treatment Division (F.P.T.D.)

The forensic division's environment often evokes images of prison settings because of its distinct link to the judicial system and its mandate to protect society from the in-patient population (detention). But as many participants explained, the research environment is, above all, a hospital:

From a nursing perspective, I tend to talk about safety, control and those things, versus a prison is more secure because they have the presence of correctional officers, and the role of the correctional officer is that of a peace officer—to control the environment. That is what society has put in place. Here, we are a hospital and we are a mental health centre. Our mission is

¹⁶ Confidential institutional document.

wellness, so there is a difference in the mandate or expectation by society.
(Marc: lines 128-135)

In a hospital-based forensic program, the patients are committed because the crime they have committed is believed to be the result of a mental illness, whereas in prison, individuals have perpetrated a crime, have been committed and may have mental health issues.

The reason they go into the correctional system is that they are identified as someone who has been guilty of a crime but they have a mental health issue; where with us, they have a mental health issue and on account of that issue, they are in the system. So in prison they are there because of the crime. In here, they are here because of their mental health issue that made them commit an offence. (Marc: lines 111-117)

One's inability to be held responsible for their crime due to mental illness also has implications on the type of "sentence" that the person will be given. The forensic psychiatric system does not function by terms, but with risks. Forensic psychiatric patients can return to society only when they are believed to no longer pose a significant risk to themselves or the population. Therefore, the forensic psychiatric hospital has the power to indefinitely detain those who are considered to be "at risk."

...in 1991, the whole system changed. Prior to 1991...in order to get released ..., they had to prove they were no longer suffering from a mental illness. Well people like schizophrenics had no hope of that, right? They were always going to have an illness no matter what. But axis II people, who did not have a pervasive psychiatric illness in the first place, could quite easily show in a year or two that they no longer suffered from a mental illness. So it behaved people who were child molesters or who were sex offenders...to come into the system because they could get out much quicker. ...Now, I think to be vacated you have to show that you are no longer a risk, or that you are not a significant risk to society. ...if you are a schizophrenic, and you take your medication and you are compliant and you have gone to your groups...your risk is quite low. But axis II persons are very difficult to change, right? So they are here for a lot longer than the people that have a significant mental illness. ...The ones we get now are the people that actually did not study the system well enough. I mean we have a fellow upstairs that said, "I have never had a mental illness. I faked it all to get in here." And our psychologist says, "Well that alone says that you are not well." (Julie: lines 1159-1199)

While the context for this research has elements typical of a hospital, it is also considered to be unique in the sense that it employs contracted correctional officers to assume its responsibilities of detention by providing perimeter security. Correctional officers regulate access to and from the building, while all patient-related activities within the building remain under medical authority. In other words, the safety of those within the nursing units (which are located inside the secured perimeter) is, therefore, assumed by nursing staff. As a result, discursive practices pertaining to safety issues (rather than security issues) are employed when speaking about patients and their behaviours.

We have actually contracted officers to provide perimeter security, which means we have a responsibility to the government to make sure that people are detained. The safety inside the building is maintained by nurses. The security aspect is perimeter security that people are detained. Anything else that happens in the building is a safety issue. (Marc: lines 476-483)

In other words, nursing interventions become justifiable not only from a therapeutic standpoint, but also according to the need for social control. More often than not, nurses use the terms of "security" and "safety" interchangeably to discuss their concerns regarding the F.T.P.D's environment and the population for whom they care. However, the need for the hospital to distinguish its identity and consequently distance itself from a correctional function was made evident. Although nurses often expressed a similarity between their roles and those of correctional officers, they did not want to be identified as such. For the following participant, using a discourse of safety rather than security is a way to ensure this distinction.

I would like to believe that nurses provide a safe environment. ...Safety is part of their primary function in all environments, not just here on forensic services. ...If I talk to nurses about security, the first thing they talk about is wands.... I can remember nurses, if they were taking a patient to an appointment, they would put handcuffs on him. That is totally inappropriate. So...when they are talking about a patient that they are concerned about I would say, "What are your safety concerns?" The elopement risk, assault, harm to self. "What are your safety risks with this individual?" Not security risks. Security is provided by peace officers. ...safety is provided by people; that is my view. (Marc: line 437-449)

We have to check patients when they come in for bringing in knives and things like that for the safety of others in the environment, not for security. Because if it is security, we will get security guards. If it is safety, nurses can provide that. Who is better to understand the person with more in-depth knowledge and understanding than a nurse? A security guard provides security; he does not provide the relationship. The nurses provide the relationship and the safety. (Marc: line 459-467)

As these excerpts suggest, dangerous behaviours and subsequent nursing interventions are understood in terms of a greater therapeutic plan. In other words, if nurses carry out social control interventions, these actions will be rationalized as different than those carried out by a correctional officer because they are formulated under a therapeutic language of safety.

Configuration of the F.P.T.D.

Depending on the way in which an area is configured, walls can evoke feelings of both fear and security (Marcuse, 1997). Seclusion rooms, double-locked doors and protected nursing stations all generate a variety of emotions (both positive and negative), which in turn generate representations of forensic psychiatric settings. Essentially, these divisions function as boundaries between the dangerous and the non-dangerous, the social and the intimate, the sick and the well, the carer and the cared for. The F.P.T.D. is a highly organized space that not only creates these boundaries between patients and staff, but also between patients themselves. The institution is divided in such a way that some patients are grouped together in relation to their levels of privileges, dangerousness, diagnosis and prognosis.

The assessment end and the more hard to manage and the more dangerous people per se were at one end, locked separately from the other end. So we had 9 beds at one end, and nineteen beds...at the other end. (Patricia: lines 201-205)

As part of a hospital culture, nurses tend to redefine the hospital's space in terms of its therapeutic objectives. Having recently moved from an older building, the F.T.P.D nurses often described therapeutic elements by comparing their new environment to their old

nursing units. As the nurses suggest, the F.P.T.D. has reached therapeutic-milieu standards as it is clean, bright, void of prison attributes (for example, there are no more prison bars on some of the patients' rooms) and includes private spaces for patients (private rooms and some private bathrooms).

Well [the other wards] were really dirty and tight-quartered. They shared three or four patients in a dorm over there. Whereas here, they all have their personal space. People that are sick and they just need some quiet time on their own or in their own belongings. ...Like if they wanted to go to the TV room, well, there are people in there. If they wanted to go to their dorm, well, there are people in there. There were only dividers with curtains. I mean one guy wanted to have the radio on, the other guy was trying to sleep. I think it was the clash there. ...And this is clean. It is a very clean unit, where the other one was old and dungeony. It was very cold; ...it felt like a jail, kind of. (Trevor: lines 523-537)

Despite certain changes that were implemented in the recent move, the F.P.T.D. continues to possess characteristics that are comparable to a correctional facility's. As a freestanding unit, the F.P.T.D. is partially surrounded by fences and barbwire, and correctional officers provide perimeter security. In addition, a single monitoring station is directly situated behind two locked doors on the second floor (the main in-patient entrance) in order to monitor and control people (both patients and staff) as they pass through the building. Correctional staff monitor and control specific areas of the building, including the locked doors leading to administration and in-patient units. Security procedures are primarily enforced through the use of cameras located throughout the facility (including in-patient units and nursing stations) and a "remote control" of all locked doors. However, despite these security measures, correctional staff do not specifically attend to all cameras located in the in-patient units, and, generally, only monitor different access points within the building. In fact, no one officially monitors in-patient spaces. Nursing staff have only "remote control" of a few locked doors within their specific units; only with the use of magnetic keys, which must be obtained from a secure central dispenser positioned in front of the monitoring station, are nurses then able to navigate between these locked doors.

To better understand the structural impact of the division, it is important to describe its physical layout. The F.P.T.D. is divided into four distinct floors. The first floor is an unlocked environment housing secretaries, the boardroom, out-patient forensic services, as well as a few offices for other support staff. The main entrance with double-locked doors that provides access to the third and fourth floors (in-patient units) is located on the second floor. The second floor also contains a section for the administration, the nurse manager's office, a small kitchen, a gym for the staff, and an additional section with a gym for patients, and offices for Program Nurses as well as occupational therapists, to name a few.

In order to provide a better understanding of subsequent in-patient floors, the fourth floor will be described first, as it follows the normal progression of a patient within the institution.

The fourth floor is divided in two sections: the south end, a 13-bed assessment unit that provides acute care and assessment and treatment services; and the north end, a 13-bed transitional unit that provides care to patients who require long-term care (longer than 2 years). Both units are locked and represent the most "at risk" area of nursing practice, because patients residing in these units are either less stable or the most difficult to manage. Essentially, patients who are housed in the assessment end of the unit make do with fewer belongings and privileges. The assessment ward represents the entrance point of the psychiatric institution for most of the patients. At this level, patients are subjected to heightened regulation, evaluation and scrutiny from staff, because they have not yet "earned," or are in the process of "earning," institutional privileges. This area houses the only seclusion room. Both units are separated by a dining room, which is directly connected to the nursing station. Common areas are located at each end of the wards. Therefore, although nurses can directly supervise the dining room, they have restricted visibility of the wards and other common in-patient spaces.

The third floor's structure is identical to the fourth floor. It is also divided in two sections: the south end, a 20-bed unit providing active psycho-social rehabilitation; and the north end, an open, 13-bed ward providing rehabilitation and community programming as well as reintegration services. The north end is not locked during the day, and patients must sign in and out in order for nurses to monitor their activities. As its design indicates, the facility is structured to support the progression of the patient. Patients are meant to evolve and progress from an acute and dependant environment (no privileges) to a social reintegration and autonomous environment (additional privileges). Most importantly, the F.P.T.D. remains a highly-regulated and controlled setting where all patient needs are met ,and where patients must consult with staff before initiating specific actions.

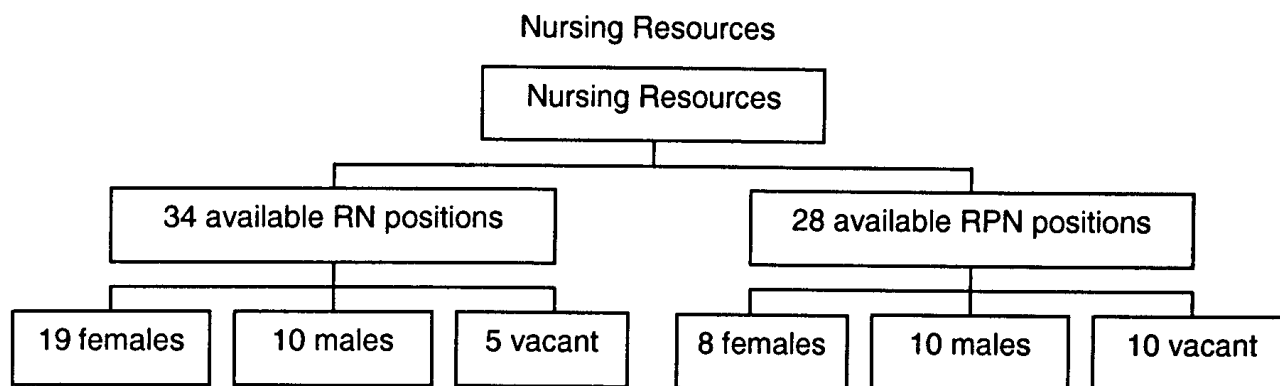
Basically everything is provided for you. So if there is something else you want, yes, you better ask for it... or you are never going to see it. (Rachelle: lines 274-276)

Despite being secure settings, the different wards are generally open. The doors between the wards and the nursing office are half-doors, which restrict physical access to the nursing station while enabling verbal and visual contact between staff and patients. The nursing stations have been described by some nurses as creating a "fishbowl" effect, whereby staff are actually under the gaze of patients as opposed to the other way around.

4.1.3 Nursing Resources

At the time data collection was initiated for this research project, 27 female and 20 male nurses worked in the units. In addition, there were 10 male Registered Nurses (RNs) and 19 female RNs, with 5 positions vacant, and 10 male RPNs and 8 Female RPNs, with 10 positions vacant. As displayed in Figure 4.1 below, the forensic psychiatric staff environment comprises a 60/40 female to male ratio, a reality that differs significantly from other areas of traditional nursing practice.

Figure 6

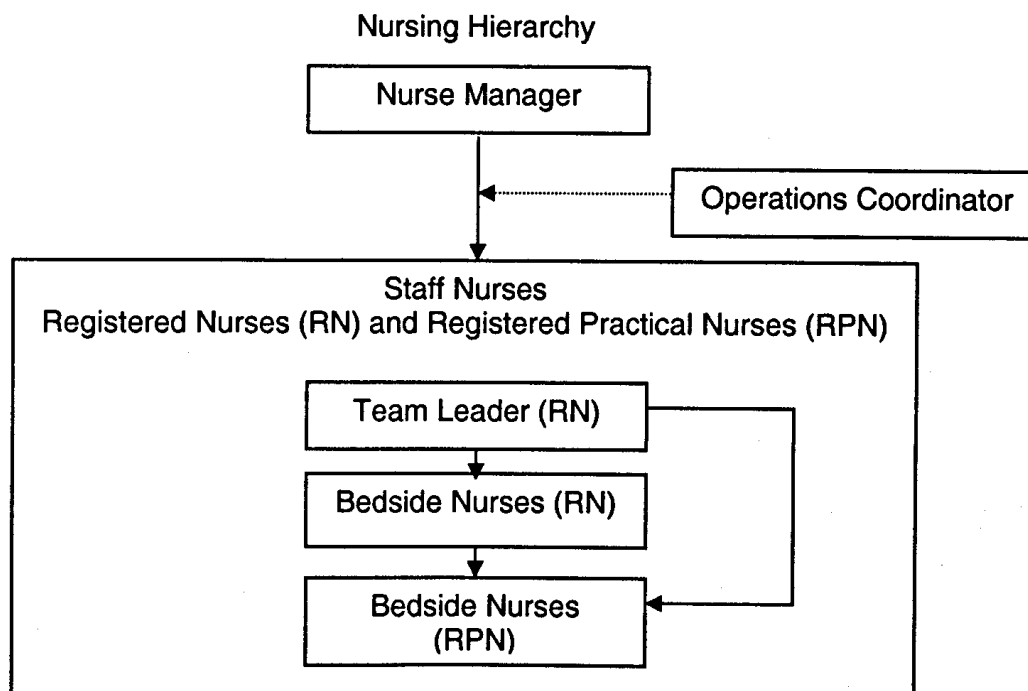


During the week, six full-time nurses and one program nurse customarily work the day shift on each of the wards. During the evenings and on weekends, there ought to be four staff present on each of the wards. In terms of the number of RNs and RPNs on these shifts, generally three to five RNs and two to three RPNs work the day shift on each ward during the week; this is usually reduced to two RNs and two RPNs per ward for the night shift.

Nursing hierarchy

The human resources of the institution generally follow a hierarchical organization. For the purpose of this research, only the nursing divisions will be described below:

Figure 7



As described in Figure 4.2, a nursing manager oversees the general functioning of the F.T.P.U. Recently, the Operations Coordinator position was added to the nursing hierarchy to oversee micro-management issues. The Operations Coordinator is, therefore, a link between the Nurse Manager and the two Team Leaders (or nurses in charge) who work in the in-patient units (fourth floor and third floor). Team Leader positions must be filled by registered nurses (RNs) who will assign tasks (for example, determining who will administer medication to patients) to the remaining nursing staff, and will oversee the general day-to-day functioning of the unit, including coordinating break times and outings with patients. The Team Leader role can be assigned to a particular nurse or can rotate between Registered Nurses. The rest of the nursing workforce is comprised of Registered Nurses and Registered Practical Nurses. Despite their different educational backgrounds, these two types of nurses are not easily differentiated on the units, as all nurses under the Team Leader position are given similar tasks. The only differentiating attributes noted between the two groups are the eligibility for leadership (Team Leader) and the right to give injections (RNs only). However, as stated in their job descriptions, RNs are in place to "lead and guide other nursing staff team members in daily work assignments, ensuring work is completed to standards" (Hospital X, No date)¹⁷. In other words, theoretically, RNs are in a position to oversee the work of RPNs who hold an assistive role.

Hierarchy and discipline

The research clearly identified that tensions between staff members (horizontal tensions) as well as between staff and nursing management (vertical tensions) existed, due to the fact that both individuals and groups held diverging opinions regarding various issues. In fact, the 2007 Employee Satisfaction and Empowerment Survey (ESES) revealed that bullying remains an issue and that "overall, there is less trust and more fear than last year to be able to express views with managers honestly" (ESES, 2007). However, one issue

¹⁷ Confidential institutional document.

in particular was more significant than the others for the purposes of this research: the forceful implementation of the TIDAL nursing conceptual model. As the 2005 Accreditation report suggested, the implementation of the TIDAL nursing conceptual model was strongly advocated to bring about change in nursing practices and give patients a voice. In other words, the forceful implementation of the TIDAL nursing conceptual model intended to change the institutional(ized) culture. As the following participant suggests, to this day, a cultural change needs to be supported and reinforced. At the F.P.T.D., re-enforcement was enacted by the creation of a nursing position that would enforce conformity at the clinical level (a disciplinary presence in the Foucauldian sense).

I wish the TIDAL was working. But as with any system (I had a conversation last week about this) is that maintenance is key to supporting change.... We went through a process here where we had a nurse educator and we ended up educating everyone into the TIDAL model. But after 2005, we did not have nurse managers or service coordinators or frontline people to help the maintenance approach to the TIDAL model. The nurses got the education... but then failed to deliver a shift in their practice. And that would have been through maintenance. So we are going to look at it again and we are going to see. We have just hired another occupational coordinator who would be our front-line, in-the-trench type of management person and representation. Then that person may be able to help sustain the maintenance of a TIDAL model approach with the nurses.... But you need someone to do the maintenance—to help coaching, teaching, to continue the buy-in—when you are looking in such a shift in approach to care. (Marc: lines 302-317)

The Occupational Coordinator position was essentially created to replace the clinical manager position (a middle manager position) that was taken away in the 1990s, thus re-creating a hierarchical and disciplinary figure within nursing units. This (re)created position was believed to be an important element in ensuring that there would be consequences to actions.

They tried, from the 90s throughout health care, to take away managers and leave the nurses, who are all peer relationships, to work together. It has not worked. ...To change behaviour, there has to be a perceived understanding that...JD is here and if I come in fifteen minutes late every day, JD eventually is going to say something to me. If there is no JD, and there is just a peer, they have no authority to say anything to me, so I can continue to behave by coming in fifteen minutes late. I can continue to avoid the TIDAL model when

I am requested, because JD is not around. So there has to be someone ... representing consequences to actions. (Marc: lines 341-353)

Well, there needs to be consistent leadership on the front line There has to be that in the background, a legitimate authority that can (I hate to say it and it would be rarely used), but a legitimate authority that can discipline if required. (Greg: lines 533- 541)

The need for "disciplinary" nursing positions reflects the nature of this particular forensic psychiatric work environment, where day-to-day interventions are task-oriented (technical) and hierarchically defined. A good example of this technicality was provided during the interview portion of this research, where it was hypothesized that interactions would need to be regulated and officialized on the nursing assignment sheet. This official task would ensure that nurses would be present on the floor, as opposed to staying in the nursing office, away from patients.

Maybe as part of our assignment sheet, there needs to be, broken up into one-hour slots each day, that one staff member is expected to be down into the TV room, whether you are sitting there, just watching TV with the group, or.... It creates opportunities for developing relationships so, if you can build it into the expectations, and have some of the structure support that, it would be one way to do it; but you do not want to only depend on that, because it does not necessarily change attitudes. The optimum is people having the attitude that it is important to be down there; it is meaningful. We are here for the patients and this is a good thing for the patients. Shifting to that kind of attitude and culture, it takes time.... (Greg: lines 151-160)

The group as "disciplinary" body

According to the late French philosopher Michel Foucault, "discipline" refers to a certain type of technology that seeks to exert a hold over others' bodies, and assures a constant subjection of its forces (Foucault, 1995). This research revealed the nursing group to be a disciplinary body. The nursing group served as a site where discussions could take place; ideas regarding interventions could be generated; and where informal leaders or figures of authority could be present. Final decisions were usually reflective of a group decision (majority).

Again, it depends on the situation, but we would discuss it as a team. ...if I think he should be locked up immediately and someone else thinks he just wants ...to talk, okay then; let's try it. (Philip: lines 610-613)

In any particular event, a group discussion would take place, and the group would determine an outcome.

...we end up with a situation that there is more discussion amongst people, and then there is also some dictatorship that occurs. ...We all come to a consensus and we vote, and we decide ...how we proceed. If I have an issue, we collaborate as a group. (Mar: lines 340-410)

The previous remark reveals that the notion of autonomy is questioned. The group is seen as a place where ideas can be discussed, but it is also a place where ideas can be forced onto others.

I do not have to agree with what you are doing, as long as it is the team consensus that this is a good thing. I do not have to agree with it, as long as I understand that there is a significant portion of the team that does. (Dustin: lines 491-494)

The nursing group was thus described as a disciplinary body in which the dominant view may be imposed over alternative ways of acting. Opposition to these dominant viewpoints might cause some nurses to become excluded from the group, and, consequently, to lose the safety that being part of the group provides. Although this contextual element (nurses disciplined through fear) was not a core objective of the actual research, it plays an important role in the discussion. The following quotes highlight its importance:

I think people have tried to hear, but have been squashed in terms of trying to promote things, because there are different camps of ways of looking at things. (Greg: lines 506-509)

...the people that feel that way are very powerful or kind of intimidating people, so everybody else just sits quiet. Because you do not want to be seen as an opposer to the thing. I have had male nurses saying to me, "Well you know, you could be in a lot of trouble one night; you could be in a lot of trouble and we'd be awfully slow to get there." (Julie: lines 729-736)

4.2 CATEGORY 2: NURSING CARE

4.2.1 Work Division

4.2.2 Security-Minded

Nursing assessment

4.2.3 Consumerist Mentality

Misuse of consumerism

4.2.4 Professionalism

Communication

Trust

Ethics

De-professionalization

4.2.5 Control

Being fearless

Being authoritative

Negotiation

Feedback loop

4.2.6 Male Culture

Gender expectations

The second descriptive category (nursing care) that emerged from the analysis of the data revolved around the exercise of nursing care in a hospital-based, forensic psychiatric environment. The following section will begin by addressing the division of nursing work, followed by the description of security imperatives that are at the forefront of many nurse-patient interactions. It will then summarize a predominant consumerist approach to care that was described by participants, and will address control issues within nurse-patient interactions. The final sections of this category aim to describe professional dimensions of nursing care, and conclude with a description of the gendered dynamics at play within the F.P.T.D.

4.2.1 Work Division

In this specific forensic psychiatric environment, nursing care is described as being hierarchically structured, task-oriented and spatially divided. A Charge Nurse has the responsibility to assign tasks to fellow nurses on the unit, who must then carry them out during the course of the shift. Generally speaking, each nurse is permanently assigned to a certain number of prime patients, but does not necessarily have any planned interactions with them on a daily basis. Essentially, nurses follow the progression of their prime patients, and are the "resource persons" called upon when team meetings (kardex) and review boards occur. In order to effectively track their patients' progress, nurses may not only personally assess them, but also count on a number of different sources to monitor progress over time.

You know, I try to get out on the floor. If I see somebody, I will say, "Hi, how are you doing today?" Try to have a brief interaction. And I can say, well, he was pleasant, or he was mad. If they say, "Not too good", I will try and say, "Well, what is the matter?" or something, but if I had not been at that point at that particular time, I would not have run into that patient. So that is where your colleagues come into play. (Jordan: lines 304-311)

You are seeing, you are observing them from the office. A lot of the patients, they are always at the office. You are out on the ward; you are making rounds; you see what is going on. You know if they are going to groups. You know if they are going to their vocational. You know if they are using privs or

not, and if they are using them appropriately or are they coming back on time? Are they checking? So you are assessing them like that. (Nicole: lines 589-596)

Daily task assignments are not necessarily patient-centred, but rather group-focused. At any given moment, one nurse will be responsible for medication distribution for the whole unit; one nurse will be at the door wandering patients and making sure that patients are checking in according to their disposition; one nurse will be escorting patients outside, and so on. Each patient has to deal with different nurses, depending on the situation. This fragmentation of nursing care is partly explained by the role each nurse plays within the institution. As one nurse describes it, nurses are valued for their versatility and their ability to accommodate different roles.

A little bit of everything is put onto the nurses. ...I consider that we sort of can, sort of jump in and help out no matter what the role is. And you know, we are very versatile, and because we are nurses, I think we can sort of help out with anything. Unfortunately, when we do that, we are not just nurses, we are not doing nursing stuff, it seems, which is what we want to do, but.... (Patricia: lines 1080-1105)

Yet versatility was not necessarily described as a positive attribute. In fact, versatility was described as impeding on nursing actions. Because the nurses are versatile, their "helping out" prevents them from performing nursing tasks as frequently.

The task-oriented approach to nursing care involves the positioning of nurses in specific geographic spaces, with specific functions that are rooted in institutional routines. For example, the nurse "at the door" must remain at the door in order to monitor patients who are passing through the units. This task forces the nurse not only to remain in a specific geographic space to ensure proper security, but also to assure ward functioning. Thus, nurses are required to extend their roles and include a number of related tasks to ensure that the units run safely and properly. Although these tasks may be interpreted as bridging care and custody, the research results seem to indicate otherwise.

In effect, in addition to a care and custody function, nurses have an institutionalized managerial function. The triad of care, custody and institutional functioning defines nursing in this research, and provides new ways of understanding the way in which care is exercised. In order to carry out the aforementioned multi-level tasks, other areas of nursing have been displaced from the units and situated outside of ward functioning (doing groups). As such, there is a redefinition of nursing care on the wards that may not necessarily be considered to be "nursing," but to be managerial- and security-oriented.

Well, I am on the door usually, wandering people in and out for their privileges. I mean, there is not, like, a sit-down-and-have-a-chat interaction much. But you see them, ask them how they are, you joke around a bit with them. You know, stuff like that. I mean, if they have a problem or something, they will come to you and want to talk to you about it. (Trevor: lines 225- 230)

4.2.2 Security-Minded

According to some participants, nurses may have difficulty appropriately integrating security imperatives into nursing care. Often set at opposing ends of a continuum, these seemingly opposite mandates can create practical dilemmas for nurses, who may become preoccupied by one practice (security measures) over the other (nursing care).

I think it causes conflict internally within people's minds, and differing opinions in terms of approaches to treatment plans and things. I think the conflict inside is that you can become a little preoccupied with the security and the legalistic aspects of it. And that has an impact on the care and treatment you can provide as well. So reconciling those two is difficult. (Greg: lines 71-76)

Although establishing a secure environment was described by participants as being important, they cautioned against the potential negative effects of overemphasizing it. Despite having correctional officers to assume perimeter security, nurses are required to reinforce certain actions to create a secure environment.

I do not think security always has to be on the forefront. I think you can walk on that unit, and, if people are doing the right things, security should just be happening in the background anyways. So when you are working with a patient one-to-one or trying to develop a relationship, I think that you need to

trust that you are in a secure environment, and your focus should shift to the caring. The therapeutic relationship...; it is easy for the security aspect to dominate and limit therapeutic opportunities. (Greg: lines 107-117)

The perception of security was described as being a priority, because it is considered to be a necessary requirement for nurses to feel safe.

... it is part of our role, and it is security-minded. And if you cannot feel safe, then you cannot do your job, because of the potential for danger. (Patricia: lines 315-317)

Safety was described in therapeutic terms: being "safe" essentially means that nurses are looking out for the welfare of both patients and fellow staff.

Our priority is to make sure that the unit is safe so other patients do not get hurt, but that staff does not get hurt either. (Patricia: lines 317-319)

However, safety was also described as a security imperative, in that being security-minded is a central element of forensic psychiatric nursing. Some nurses actually identified with the role of a correctional officer, a way of thinking that they have adopted in response to their awareness of the potential for dangers in their line of work.

I think we are up there with corrections; I think we are similar to corrections. But because we are in a mental health system, we handle ourselves differently. But we have to be a correctional officer, so we are geared...; yes, you would have to say it is dangerous, because we are geared to not allowing weapons or potential weapons, so you have to think like that. So obviously we think like that, because it can be dangerous ... and over the years, we have had some really bad people and really dangerous people. (Patricia: lines 263- 271)

In essence, not only do security and nursing care coexist, but one also needs to be present for the other to take place. Coupled with institutional demands, the perception of being safe must be present if nurses want to apply therapeutic principles. If this perception of security cannot be achieved, then nursing care becomes difficult to exercise.

There are situations where security will trump what is a treatment focus as well. ...We know that, every day, it is therapeutic to take these patients outside, ...get them off the unit, get some sunlight, socialize a bit, move around a bit outside. But we need two staff to be a part of that. We want to re-enforce that the yard needs to be searched beforehand, and because of competing demands, sometimes that cannot be. "I am sorry, we do not have the staff today to be able to go out and search the yard and take two of us

down with you guys." So unfortunately, that therapeutic opportunity cannot happen because of security issues. So that is a struggle. You realize the meaningfulness of taking this group outside; yet there are security considerations as well. (Greg: lines 84-98)

Nursing assessment

Given the coexistence of care and security imperatives, nurses are summoned to integrate practices that may differ from other types of nursing. For example, nurses are asked to wand patients who are returning to the units in order to intercept any contraband (metal objects such as knives). For some, this type of intervention may be considered an untherapeutic action and a reflection of overpowering security imperatives. However, most nurses suggest that this kind of intervention is part of the F.P.T.D.'s routine and has little impact on the nurse-patient relationship. As this nurse would suggest, patients in all healthcare sectors have rules to follow, and this milieu is no exception. Rules may be more stringent, but patients expect it.

I went into that role for a long time. The patients are not offended when you wand them or you scrutinized their pockets. They know that that is part of the rules. I suppose rehab has their rules about not smoking dope or whatever. So, it is just an expectation. I suppose it is like going into a general hospital and they tell you, you know, do not light a cigarette when you walk into the building. Same way everybody has to live by rules. These guys probably have more stringent rules then maybe a rehab unit. (Patricia: lines 320- 327)

Other types of interventions such as ward searches have been described as having more of a negative impact on nursing care. Random ward searches are considered to be more intrusive, and force nurses to take punitive action if the search reveals the presence of contraband. As a hypothetical solution, alternating the staff who perform ward searches was mentioned to the interviewer, because it would dissociate security enforcement roles from patient care roles. Possessing both the authorization to care and to punish creates a tension that is believed to set back the nurse-patient relationship.

It is not the wandering or the routine stuff. ...I do not think that is as interfering as the ward searches. I think the ward searches can really set back a relationship. If you are searching somebody, you find contraband and...you are just at the point where the client is starting to work with you, and then if

...you find contraband, and you say, "You cannot have this" and stuff, ...all of a sudden you are against them. ...I have always felt like ...when it came to doing ward searches, we should swap staff for the ward search. Send our staff up and send their staff down. Let their staff search our clients, because they are not directly working with them. (Mary: lines 388-404)

Some nursing actions may be perceived as negatively affecting the nurse-patient relationship. However, other actions, such as routine wandering, do not bear the same negative connotation. In fact, nurses have reorganized these security measures into their daily practice. The brief interaction that is created when applying security measures has been conceptualized as an opportunity to create a therapeutic situation. The encounter enables the nurse to have a quick exchange with the patient and perform an assessment. While wandering remains a security intervention, the way the nurse approaches the situation gives it a therapeutic connotation.

We are able to blend both. ...To be honest all the staff are supposed to be able to wand the patients. ...It takes you less than five seconds To me, it is a very brief interaction. It gives you quick assessments, and you know, that tells you even before they are leaving...; a lot of times I will stop a patient: "I need to talk to you for a minute. You know, you had an issue last night and I want to know that you are OK, because I am letting you out the door and that is my responsibility. So how are you today?" (Patricia: lines 722-738)

In some respects, nurses have developed ways of rationalizing and integrating security interventions into their nursing routine. This amalgamation and adaptation of roles in nursing practice is interesting, because although the technical task remains identical, its rationale changes. In effect, nurses have appropriated their roles vis-à-vis the unit's security measures by rationalizing their actions from a therapeutic perspective.

4.2.3 Consumerist Mentality

Patient contact was a recurring theme in the participants' accounts regarding their views of nursing care. As the following nurse explains, some staff venture out on the floor to seek interactions, while others tend to congregate in the office.

You know, there are some people that will go out and play cards and be visible and be seen. But there is also a lot of people who prefer to just kind of stay in the office. (Julie: lines 624-627)

As such, nursing care was described on a continuum ranging from passive (consumerist) to active approaches. Nurses can convene actively with patients on the floor, but, usually, it is the patients who "seek out" the nurses. This passive approach or consumerist mentality exemplifies how nurses function on the units by letting patients approach them, on their own terms:

The way it works here is, like, people have their one assigned person. They do their monthly conference notes and they follow their progress. The daily assignment, we get them in the morning and you kind of just meet up with everybody on the unit through the day. Typically they will post them on the wall. So ...if anybody has a request or they need to talk to their nurse ..., just look on the wall and find out who it is and seek them out. (Isabelle: lines 187-193)

These attitudes are, in part, the result of a rigid framework imposed by the environment, where opportunities to create interactions are described as being restricted. Engaging with patients becomes difficult, because there is little room for planned interaction; nurses' passivity enables the patient to engage with them on the patient's own terms.

I find the other difficult part is, because of the clientele that we have..., there is good times and bad times to meet with them. I may have two hours in the morning and I am thinking: "Okay, I am going to go in there; we are going to sit down for an hour; we are going to sit down and have a talk." You get everything in place, you come in, and there is no way they are going to talk to you then. No way. If you would have come one hour before or three hours later, maybe. But then you have to have your conferences, and you have to have all that stuff. (Tracy: lines 607- 617)

Consequently, the consumerist approach is rationalized in terms of its altruistic benefits. The fact that nurses are available at the nursing office, and that patients have access to them, decreases the perception of pressured interactions in which the patient may or may not want to engage, and fits well within a highly structured environment.

What I usually do is I let them know that I am there, and if they are in the mood to be talking, or if they have a question, then they can come and approach me. I do not go out and search them out, other than to let them know I am there. I sense most of the time that if I do that, they get a feeling of being pressured sometimes if you kind of go running after them. (Nathalie: lines 259-263)

division between the two worlds: the carer and the cared for. To encourage opportunities for exchange with patients, some nurses believe that their presence in common areas could break down this barrier and might foster interactions.

It is better to be out on the floor. Even if you stay in this TV room, and you are sitting talking to a couple of patients, and they get up and leave..., stay there for half an hour or so; they will come back and sit. And it is amazing, when you are just kind of hanging out. They are more open to talk to you than if you say "Could I have 10 minutes of your time please? I need you to fill out this form." It does not work that way. ...I would rather be out. It creates more paperwork, more charting, but I do not mind that either. (Sylvie: lines 486-514)

Misuse of the consumerism

Floor presence and active patient engagement were described as a personal choice: some stay in the office; others will be out on the floor. As these next participants explain, being in the office may be a way for nurses to purposely avoid patients.

I think you have a variety of staff. I think you have your staff that do not mind going out on the ward, playing cards like [Sam] does. ...It is a way to interact. I think others, and in all fairness to them, the more you make yourself available you know... you can go home feeling skinned alive. You do not want to talk; do not want to think; do not want to answer another question. ...You can go home pretty fried. (Rachelle: lines 262-270)

It depends how motivated you are. If you are motivated... you can probably make it at least half of your day spent quality time with the clients. ...If you are not motivated, though, you can certainly find a lot of things to do in the office that will occupy you for twelve hours, and you never have to talk to a patient. And because there is no real middle-manager there, there is nobody monitoring that. (Mary: lines 778-787)

As such, this willingness to distance staff from patients redefines the presumed motives of altruism attributed to all nursing staff. In fact, participants clearly noted confrontational dynamics between different staff members and patients.

Again, you know, if you are watchful of these fellows, you can see how some patients and some staff can be the reasons why these patients escalate. (Sylvie: lines 303-305)

Sometimes it is a standing joke. If the patient sees certain people that are working that day, they will not bother coming around as much, because they know. (Rachelle: lines 65-67)

Sometimes it is a standing joke. If the patient sees certain people that are working that day, they will not bother coming around as much, because they know. (Rachelle: lines 65-67)

As the following nurse explained, some patients are literally discouraged to interact with staff. The consumerist approach to nursing practice may be a way to completely ignore some patients.

Sometimes I get really frustrated, because sometimes you say to yourself, "My God people, you know why you are here to work. You are here to help the patient. If somebody comes to the door, do not tell them to go away." (Jordan: lines 564-570)

4.2.4 Professionalism

In this research, participants described a set of characteristics, competencies and skills that were expected in their line of practice. As a result, this section will address the professional elements of communication, trust and ethics, as described in the participants' conceptualizations of nursing care.

Communication

Communication was considered to be an important aspect of psychiatric nursing practice. Generally speaking, good communication skills were juxtaposed against the nurses' ability to avoid physical interventions (altercations).

But if you do not have confidence in your ability to talk a patient down, if your only confidence is that you can strong-arm a patient down who gets all the way out of behaviour, then psychiatric nursing has lost its flavour.... And this is my best asset I can talk down most situations. I can deal with it.... So, I really think that your best skill in psychiatry is communication. (Julie: lines 858- 890)

Avoiding physical confrontation was usually part of a preventive strategy and was mediated by the use of various de-escalation techniques such as offering PRN medication, separating the patient from the group, or going out for a cigarette, etc.

I mean, no one wants to wrestle someone into seclusion. I will offer the medication, and if they take it, great. But if they do not, it is a last resort. ... You can ask them to go to their bedroom..., take a breather, slow down, think about it. And we will go out for a cigarette. A lot of times that works. Some people might call it a bribe, but I mean, if a cigarette is all it is going to

take to calm him down, and they are not going to be in seclusion, or, you do not need that PRN, you know, that is great. (Trevor: lines 505-516)

Early intervention and effective communication with patients often involved the establishment of a good relationship and frequent interactions for continuous assessments.

I spend a lot of one-on-one time with all the patients.... It gives you that extra opportunity to really get to know who they are today. (Kristen: lines 223-229)

In order to establish this relationship and effectively communicate with each patient, nurses also described the need to adapt their approach. There is a skill attributed to the way nurses address patients in order to encourage a dialogue and avoid physical interventions.

Well, the nurses that are intimidated. You know, you see somebody getting a little agitated, and you are reluctant to go and offer the PRN or to talk to them. And then there are the ones: "Well you are getting agitated, you better go into the quiet room or you better get into your room." And you know, the last thing an agitated person wants to hear is that they are agitated. I have found more success with: "You seem kind of upset. Do you want to go and talk about it?" Usually once you start talking to them, I can get them to take a PRN. Then they will take the time out, and then we can discuss the issue better later on in the day. (Mary: lines 222-231)

Adapting your approach

The individuality of each patient generated discussions regarding the nurses' need to adapt their individual approaches. In this case, communication was as much about the immediacy of the nurse-patient interaction as it was about the nurses' reflections on how to best engage and create a trusting relationship with each patient.

I think you find that in nursing, in any situation, everybody's approach is different; how they handle different situations is different. (Nicole: lines 170-172)

... in my practice, I have learned that consistency, my approach, my behaviour and the way I am, helps develop that trust and relationship quicker. (Marc: lines 784-786)

Some nurses talked about using humour as an "ice-breaker" or even as a way to discuss more important issues (such as the offence).

Like my own prime patient, I have a really good rapport with. ... we have a trusting relationship and we can talk about his offence, and sometimes we joke about it. Sometimes I joke around with the guys as a way to getting them to talking about stuff like that.... There are some guys I would never joke around with. ...It is all individual. (Philip: lines 212-220)

Nurses need to increase their awareness of their verbal and non-verbal communication styles and modify them if necessary. Should nurses wish to influence patient behaviour, they need to be able to effectively communicate their thoughts to the patient, especially in a crisis situation.

It is all in your approach: ...from the body language, your stance, your distance, your eye contact, your tone of voice, the language you use—all your communication skills are the main tool box of what you will bring to help someone. And it may be through diversion, it may be through suggestion to change their environment, it may be suggestion to try some psychopharmacological agent There are a lot of options that are available. But in order to get someone to appreciate the options available, it is all in the nurse's approach to the individual. (Marc: lines 179- 189)

Therefore, nurses often reflect on both the verbal and non-verbal cues that may influence their approach with each patient. The result of this reflection, however, may not necessarily foster interaction. In fact, knowing the patients and anticipating a negative response may actually foster avoidance.

I am always cautious and guarded. But again, if you make the eye contact and you go out and you are not threatening to them, then I do not feel ...that they are going to be threatening back. I have had situations where the worst thing I could do was make eye contact. And if that is a problem for somebody, then I do not make it. But you know, you kind of sense that, and pick up on it really quick, that that makes the person uncomfortable.... There is one on this floor that I do not give the first interaction. I let him, just because sometimes, just saying good morning is enough to say, "Well, what the fuck is so good about it?", and set somebody off, so I kind of go by their mood. (Rachelle: lines 95-106)

Thus, the adaptation of an approach was described as a learned behaviour. As nurses evolve in the setting and interact with patients, a clinical cycle of mutual observation and interpretation occurs and shapes the way nurses approach patients.

Trust

Communication skills were further described as a means of developing a rapport and establishing trust with patients. A strong relationship would, in part, create an alliance and a feeling of security, so that nurses felt that patients would defend them on the units.

I have seen residents say to one resident, "Do not speak to her that way," or "Watch the way that you are acting around her; it is inappropriate...." So a lot of the time, you do not even have to say anything or do anything. (Kristen: lines 316-320)

By establishing a trusting relationship with patients and encouraging personal disclosure, nurses also described being more inclined to obtain valuable patient information that would in turn allow them to better influence patient behaviour. Ideally, the aim of a trusting rapport between nurses and patients is to open true dialogue (non-censorship). Trust is believed to enable patients to disclose all thoughts to nurses, who can then use this information to direct clinical objectives.

Trust is probably the most difficult thing to establish. But once you have it, you know you have it, because they will come to you, and they will disclose things to you. ...That is the evidence that you have their trust. It is when they start disclosing things that they kept buried or that they did not feel comfortable talking to anybody else about. ...That is their goal—to build that relationship and get that trust. Because if somebody does not trust, they are not going to listen to what you say; they are not going to take any information from you and use it. (Mary: lines 848-883)

A component of this trust-based relationship is primarily disciplinary. In a way, the relationship is leveraged to acquire in-depth knowledge of the patient, document this information, and report issues that will ultimately influence clinical objectives (described in terms of a contract with patients).

And yes, it is developing a rapport with your prime, and he starts to trust you ..., and that is the way it should be.... I can find out as much as possible about him to be able to report to the doctor so that he knows.... That is part of my role as a primary nurse....(Patricia: lines 1061-1066)

The fragility of this trust was evident. Nurses and patients constantly redefined the notion of trust as events occurred on the units (breaches, assaults, etc.). In effect, trust

was not described on a linear continuum of events, but rather as part of a fragmented cycle wherein nurses continually try to encourage patients to see them as working together in their best interest, even if the institutional structure or some interventions may not always be perceived as such.

There were times where, you know, you kind of lose your rapport with the patient. But in the long term, I think they do realize that you are working for their benefit. If they can separate *that* from the hospital dynamics: "I am locked in here, these people have me locked in here." There is a lot of that in the forensic environment. A lot of patients look at us nurses as keeping them locked up, forgetting that we are here to help them. We are here to rehabilitate them. (Jordan: lines 52-59)

Ultimately, the nurse-patient bond created within the institution will influence the patients to stay connected with the system and seek care if needed in the future.

And even a lot of the guys out there now have an absolute [discharge] and they still stay connected. ...They can choose to walk away. But hopefully, you have taught them well enough to know that this is not a bad thing to be connected to. (Sylvie: lines 1065-1069)

Trying to relate

Nurses described the active strategies they use to establish trust and create bonds with patients. Some nurses emphasized the need to spend time with patients and establish a common ground to create a tangible alliance.

You just have to put in the time Find some common ground and build from there. It really depends on the patient. ...I tend to use my age as a benefit with the younger ones, because they often feel like I understand where they are coming from a lot more than somebody who is old enough to be their mother. (Isabelle: lines 101- 107)

Some guys respond better to just having a guy around. Not be physical or anything, just to relate to. (Philip: lines 94-95)

Relating to patients was often explained as being able to understand where the patient was coming from in order to encourage the nurse-patient bond and the creation of trust.

I can relate to an elderly man in his seventies. I can relate to a young guy who is eighteen years old. I have had a grand father. I have stepchildren, and my own kids are teenager. ...I do not have a hard time developing a rapport with any of my clients. I can relate to anything they do. I mean, I have family and friends from all different socio-economic factors. I have rich

friends and family, and not-so-rich friends and family, and I can relate to it all.
(Philip: line 146-153)

Establishing a rapport of trust is, therefore, an active and conscious nursing intervention. As opposed to a passive, laid-back attitude, establishing rapport with a patient demands that nurses try to engage with patients and to find something that allows both the patient and the nurse to relate to one another.

Being vulnerable

The forensic psychiatric environment is generally labelled as a environment where it is difficult for nurses to show any sort of vulnerability. However, "making yourself vulnerable" as a person has been described as being essential to creating trust in the nurse-patient relationship.

I think they need to know we are real. If we are going to reach them, and help them with their future, we need to be vulnerable to some extent. Not vulnerable in a safety issue, but vulnerable in a personal way. (Sylvie: lines 700-703)

The notion of vulnerability is juxtaposed against the rigid representation of the forensic psychiatric environment and the way that some patients are perceived (manipulators). Vulnerability is described here as an attempt to see the good in people and create therapeutic moments. Vulnerability is about being able to give the patient some control in the relationship, decreasing the patient's perception of the nurse as an authority and a disciplinarian, and, as a result, normalizing interactions.

Some of the young men, you know in their twenties, have been in and out of jail. They can, they play you. But you know that. You know that they are going to test you. They test all of us. You see it happening. But again, you see them respond that way with some who have not given them the same respect that you would want in return. ...Where someone might say: "You stupid ass. You know it is your own damn fault." That is all they hear. So are they going to want to open up to that person? So that is what I meant. You almost have to make yourself vulnerable ...; if you say something, you have to be prepared to repeat what you have said. So if you say something wrong—and it has happened—I have no problem saying, "You know what, if I said that at that time, I apologize. That was not my intent." So right away, they know that if there is something said that they do not understand, they can choo—se how they approach it. (Sylvie: lines 723-745)

Being trust(worthy)

Strengths of the nurse–patient relationship were often described in terms of its capacity to evoke feelings of empathy. (A good patient is one who is sick, knows it, and wants to get better.) Because of these feelings of empathy and the recognition of patient vulnerability (the sick individual), the following nurse describes wanting to both develop a good relationship with the patient and to develop trust.

I try to be their friend. You have to realize they are sick, and, you know, if they are taking treatment and they realize they are sick and they are trying to get better. I mean, you do feel for the people to a certain amount. There is no sense putting up a wall and not being able to work with that person. Because I mean, it is my career, and this person is here to be helped, so you try to do your best not to have a bad relationship with that person. (Trevor: lines 99-105)

However, sometimes the trusting rapport is replaced by feelings of apprehension and mistrust. Given particular circumstances, the nurse or the patient may feel that the trust within the relationship is gone, and, consequently, interactions become difficult to maintain (fragmented trust). In this particular example, the nurse explains how, in one instance, a patient assaulted him/her, and, as a result, re-building trust was extremely difficult, even impossible.

Q: So how are you able to build trust with that person again?

A: You do not. You are very watchful; you are guarded.... It affects your relationship.... (Marc: lines 884-887)

There are clinical situations that will create certain ruptures in the nurse–patient relationship; for example, for a variety of reasons (violence, deviant or manipulative behaviour, etc.), some patients will be classified as being difficult to engage with. As the research results demonstrate, this type of classification will define some patients as being more or less appropriate for nurses to try to engage with. Building a good rapport with some patients and a less satisfactory rapport with others, also creates dichotomous classifications (good and bad patients).

I guess, just making sure that you know the patients well enough to know who is kind of a bit of a con, and who is more, can be trusted. Like if you can take their word for it or not. You just kind of get a sense of people. You really have to build a rapport and get to know the patients. (Isabelle: lines 90-96)

In other situations, building a trusting relationship is not always a goal, particularly in the case of assessment patients. These individuals may be in the process of being pathologized or criminalized, and have a relatively short, predetermined length of stay in the hospital. Lack of time and a possible lack of therapeutic possibilities render a nurse's attempt to engage with the patient useless.

Not necessarily the assessment patients. ...If you are the prime nurses, you know, they are here for 30 days. ...The facility is new to them. ...So you are sort of their resource person to go to. Or if they are upset and they want to talk about something. And you are the person to prepare their intake in combination with the social worker and everybody else. You are trying to get a full picture on the patient, and you are having to prepare a report for them. ...]You are not looking at building a relationship with them, short of making yourself available to them, letting them know that if they need somebody to talk to, you are willing to; whereas the longer-term patients, you are trying to build a relationship with them. (Nicole: lines 611-624)

Ethics

According to the nurses who participated in the study, establishing trust with patients involves a number of ethical elements that need to be taken into consideration when caring for mentally ill offenders. Not necessarily in order of their importance, the elements of a trusting and ethical relationship are accountability, competence, respect, and being non-judgmental.

Accountability

Being accountable to patients was described in terms of the responsibility that nurses have towards patients. A self-directed ethics of care gives importance to the patients' demands as well as the nurses' responsibility to see that all patients are treated respectfully.

With the long-term patients, you have to have trust. They have to know when I am telling them something that that is the way it is. That is the truth, and they have to trust that I am not brushing them off, that I have taken their concern seriously, and have actually checked to see: "Okay, what can we do about this situation?" (Dustin: lines 499-504)

Well, I think it is easy as you want it to be. I mean, if I tell a guy, "At eleven o'clock I am going to take you over to Pin Money, "at eleven o'clock I better be there to take him to Pin Money. If I am there at..., or even if I do not show up, he is going to think: "Oh, I do not believe a word he says,"...things like that. You have to be accountable to them. (Philip: lines 648-653)

Due to the F.T.P.D's forensic psychiatric structure, accountability can become a nebulous concept: to whom and to what are nurses accountable? The security aspect of forensic psychiatric nursing care results in nurses being seen both as the ones who carry the keys (guards) and those who make decisions regarding care. Their added responsibility to enforce security measures requires that nurses be held accountable, to the public and to society at large, to limit the risk of patients re-offending, and to help control and contain this population of offenders. Yet, the priorities of his/her position as a caregiver makes the nurse, first and foremost, accountable to the patient. For example, patient accountability often translates to advocating on behalf of the patient on the ward.

I guess they do see that we carry the keys and we are involved in making decisions about their care. But as a nurse, I try and also advocate. ...For example, we have programs where we have to keep their money in the office. Well, I do not always agree with that. If they are competent financially, that is their money, and I will advocate for them. If they are being unreasonable, if they cannot handle their money, the doctor should make them financially incompetent. (Philip: lines 392-400)

This next excerpt, however, provides interesting insights into the clinical reality of accountability and exclusion of ethical constructs. In this case, the nurse who is trying to accommodate a "demanding" patient is seen by peers as being weak and "giving in to the patient."

Like: "Oh yes, go ahead. She just did that the other day. You are giving in to her again." Or, you know, "She is walking all over you," or stuff like that. ... You have to be strict to a certain point. But when does the strictness ...come to the point where you are actually mean. ...Say a patient comes up to me. ...you are put in a difficult situation because some staff just told the person "No,"and they are coming to you for another answer. I try to talk to that other person first, but I find...they are just saying it because they do not like the patient. ...I have even come to the point where I have said, "Fine, then I will take them and I will go and do it," ...because it is not right. We are not here to sit back and sit in a chair and just, you know. And I am not painting myself

to being somebody perfect, and that might be what it sounds like. But I enjoy my job, and I enjoy being here, and when I am here, I am here for the patients. (Jordan: lines 587-604)

Competence

For the purpose of this research, competence was described in clinical terms; the patient must be able to grasp that the nurse is competent regardless of the the nurse's socio-professional status (RN versus RPN). Nurses display competence by the way they act and by the way they handle themselves in the workplace.

Sometimes with a clientele that is a little older than me, they might ask me to go get another nurse, because they just see me as a young kid. All you can really do is just put in the time, and show them that you are competent, and eventually they will get to know you and know that you know what you are talking about. (Isabelle: lines 114-120)

Clinical competence in forensic psychiatry is related to general psychiatric constructs with added judicial implications. For example, some participants spoke about specific legal elements associated with forensic psychiatric practice.

My comfort level has always been pretty good. Once I got past that first year: to learn the rules and disposition orders, assessment, and the legal terminology and what they could and could not do, and being able to help patients, you know, ask for privileges within the guidelines. (Patricia lines 92-96)

However, forensic psychiatric competencies are not tangible. Nurses spoke about their performance being shaped more from clinical experience than by theoretical constructs.

And before we went back, we got two weeks of orientation and training. Now, how beneficial is that? ...Basically, we were the ones that gave the information to be taught back to us.... (Julie: lines 185-190)

Participants indicated that clinical competence is developed over time and through mentoring, peer influences and self-directed learning.

Initially, I felt overwhelmed, but I just kind of sat back, did a lot of reading, listened to a lot of people, took a lot of advice, and kind of learned how to manage myself and manage my thoughts with this person, because when you are dealing with somebody..., some of these patients have really horrific backgrounds. (Jordan: 20-25)

Respect

Nurses often compared their line of work to nursing in correctional settings. In these comparisons, respect was viewed as being culturally imposed: "If you want respect, you have to give respect." In this sense, giving respect to patients enables the nurse to diminish the power relations that exist between themselves, the carer (who in this setting may be associated with correctional officers) and the cared for, thus establishing an environment that is conducive for personal disclosure.

That is another big thing with these guys. Because these guys have been in jail before... and that was kind of the same thing that I was taught at the [jail] from the client inmates, "If you want respect, you have to give respect." And if you give a guy respect, he is going to open up to you a little more, too. You talk to him on his level. You know; I am not up here and he is down here. We are on the same level. (Philip: lines 379-385)

In this regard, respect refers to a dynamic concept influenced by the jailhouse mentality, "if you want respect, you have to give respect," so that nurses treat others as they would like to be treated.

I think I get along well with the patients, because I try very hard to treat everyone the same. I try to be professional with them. I am always sort of taking the approach that no matter how ill that person is, or how much of a management problem they may or may not be, you still want to treat them the way you would want to be treated. And I have always found that that has made a huge difference in how that patient treats me in return. (Nicole: 209-216)

Being non-judgmental

Adopting a non-judgmental approach was a standard that many nurses tried to achieve. Knowing that the patient had a criminal history often made this difficult. In order that staff engage with patients objectively, professional standards require a detachment from judgments that such a history might evoke.

It is not that you forget this horrible background. It is not my place to judge them. My treatment of them should not be based on whether or not I think what they did was right or wrong, or how the legal system played out. I may think that they just had a good lawyer and they should be sitting in jail. However, ... it is not my job, it is not my role, it is not my place to judge how

the system has put things in motion. It is my place to deal with the here and now. (Nicole: lines 242-249)

The patient's history, combined with nurse's experience of that patient in the clinical setting, may add to the difficulty of nurses to remain non-judgmental, because they then must engage with patients, knowing very well that they may become the target of foul treatment. For some, it is a source of motivation to break down barriers.

A lot of the male patients, the older male patients, do not have respect for women. But again, if you know that, and you approach people on their level with respect and with dignity, and value what they say, and listen, then that breaks down that woman barrier. "You know, she is not the typical bitch." I mean, a lot of them, their index offences are probably battery against a girlfriend, a wife, a partner, a mother. ...you have to break those barriers down. (Sylvie: 635-645)

De-professionalization

Despite having professional boundaries regulating their practice, many participants conceptualized the hospital as a home for patients. Nurses often referred to their role as replacing or substituting what had been lost with hospitalization (substituting the family).

In some ways, like you are family for them. The ones that have been here for that number of years, the staff are all they have ever had for a long, long time. ...I guess you tend to develop a long-term relationship with them. (Nicole: lines 527-535)

By conceptualizing the hospital as a home for some patients, some participants expressed the need to create a comfortable environment. A good sense of humour and laid-back attitudes are employed by staff to create a "positive," friendly atmosphere that is beneficial for both staff and patients.

I am not everybody, but I look at it as this is their home and we are pretty much their family, and that is as good as they are going to get. So I try and make it as fun for them as I can. I joke with a lot of guys. ...If I can get them to laugh, well, that makes me feel better, and it makes them feel better. ...you still have to be professional. ...but I can treat you like a pal when I am here. That is kind of how I approach it. (Philip: lines 783-802)

However, this laid-back attitude increases the permeability of interpersonal boundaries so that consumer-provider dynamics are not always clear. The line that separates

professional behaviour from unprofessional behaviour becomes extremely fine. A good example of how nurses work on the fine line of professionalism becomes apparent when examining the language they use with patients. The friendly approach dissociates the professional through their use of lay terminology; for example, patients are told to "go fuck themselves." Nurses are aware that this type of behaviour is considered pejorative, as is evident when they compare themselves with new staff who may oppose such behaviour, but are expected to get accustomed to it.

I mean, some people are dry. ...you cannot learn this stuff in school. So I may say something to a patient that, someone right out of school, if they heard me say it, I could probably be written up. ...You know: "Go fuck yourself" or something. You know, just kidding around. But, if someone else heard it, they would be like: "Oh my God, that is terrible communication.... You cannot say that." So, I mean, there is a lot of feeling things out; ...it has to be a bit of a joky environment.... Like I try to joke with the patients and stuff, just so they are comfortable with me and I am comfortable with them. ...But I mean, some people look at it, say, a new staff might say the way I approach the patient or something, they may think that is not right, but they will find their nitch. (Trevor: lines 713-743)

Although cursing with patients may be considered unethical, this type of behaviour exemplifies what a nurse explained as the muddling of consumer-provider boundaries. The laid-back attitude justifies these approaches in certain situations. The nurse is believed to be in a position to judge if it is appropriate to use "joky," sarcastic language that might be considered offensive if taken out of context.

You kind of hear things that could be taken that way if you wanted to. Interpret something that way. Something that is just kind of maybe on the edge, but you do not know the complete situation, and if you jumped in, you could really take it the wrong way; whereby if the staff has worked with this patient for a while, knows them really well and the patient knows the staff really well, they have developed such a rapport that the staff knows what works, what approach works the best. Now, that approach might end up being something like kind of a joking, sarcastic type of an approach, and some of the words that might be used in that kind of an approach would be very misconstrued by another staff who absolutely has no idea what the total situation was. They would not have seen the whole picture. They would hear a word and they would go, "Oh my God, oh my God, they are being abused," you know..., and jump all over it, and make a big mountain out of a small hill. And that I have seen happen. Or even staff talking amongst themselves and another walking by and misinterpreting the whole conversation... and taking

it further, and, you know... staff being put off work while it is being investigated... like just a little bit ridiculous, to say the least. (Nathalie: lines 523-542)

In this case, the nurse-patient rapport has become exclusive. No one is in a position to judge the actions that are taking place within that relationship. Although most of the analysis to this point has been based on interviews, the insertion of observational data seems appropriate at this time. The following describes an incident, observed from the nursing station on a change of shift, that exemplifies de-professionalization through language and authority:

During hand over, nurses stayed in the office and casually talked among each other. No one left the office to do rounds and meet with patients. One patient who has been hospitalized for years shows up at the office window and his prime nurse right away tells him, with a shooing gesture, "FUCK OFF!" As the patient walks down the ward, the nurse looks at me and asks me who I am. I answer by saying that I am a researcher here, and I am conducting interviews with nursing staff for my research. The nurse goes on telling me, "You know, that is therapeutic for some patients." (Direct observation)

4.2.5 Control

The notion of control as both a clinical obligation and a way to present oneself was an important aspect described by the participants. This section explores the different ways in which nurses talked about control over themselves and the patient.

Being fearless

In psychiatric facilities, nurses are confronted with acutely ill patients who may be threatening due to the way they present themselves (verbally and non-verbally) or how they are presented (history).

Over the years I have had a patient come running at me, stop and go toe to toe. And he was bigger than me. I just sort of stood my ground and...I remember thinking, "Okay, if he hits me, it will probably only hurt for a little while.... Maybe he will not break my jaw and I will not get hurt." But I am thinking this as he is screaming at me...I did not want to step back because I was afraid that he would then come toward me. Seeing as a fleeting thing you know. ...It was very brief, probably less than 20 seconds or something.... I just stood my ground. (Patricia: lines 546-5559)

There are times when they are right in your face and making threats that, you know, at some level that they are perfectly willing to carry through on. (Dustin: lines 218-220)

Working in a closed environment and having to ensure patient safety forces nurses to intervene regardless of their feelings. Nurses must often ignore a flight response and engage with individuals who may be considered a threat.

There is one seclusion. Where we used to have three, and often would need all three. Well this morning, we had a couple situations here where, for safety purposes, ideally that individual would be in an open quiet room for twenty minutes or half an hour where they could be observed on camera. Here we do not have the room.

Q: So what do you do with that?

A: We just let it go. There is nothing you can do. (Dustin: lines 118-126)

The issue of control regarding threatening situations was raised by many of the nurses. In addition to being confronted by a threat, nurses must also remain in control of the threatening situation (or at least appear to be).

In that situation.... You knew that if you flinched you were going to lose the control of the situation.... If you allow that, you lose control of the situation. (Tracy: lines 422-425)

The threatening situation is not always described in terms of an immediate violent encounter with the patient. Nurses are also forced to interact with the potential threat that becomes pervasive with an awareness of the patient's history. While immediate interactions may not be threatening, the thought of the patient's past behaviour may very well be.

I cannot tell you that I would not be guarded. You know, it depends on the crime. Like I said, there are horrific crimes out there. I think I try hard, and I think I am successful at trying not to show this patient that I know what he did and I am afraid. I am trying to be relaxed, but, my initial reaction, you know, when I look at that person... sometimes it goes through my mind and I say, "Wow, how could this person ever [have] done that? This person does not look like somebody who could have done that." You get all these things coming through your mind. You have one specific view of one specific...say it is a rapist or a child molester or something. And then you look at them and say, "Wow, how could they do that?" (Jordan: lines 518-530)

As such, being able to control and act as though one is in control remains a valued psychiatric ability; yet the obligation to demonstrate control may very well mask the threatening experience. As these next few passages explain, not showing fear may be part of a group dynamic (performance), but it may also involve power struggles between patients and nurses, wherein the loss of control puts the patient in a position of authority.

One of my first experiences, as I told you, when I went there, I was really afraid. The first day we had a client who was self-abusive and he would start to have flashbacks and he would pound himself. And I thought, I cannot let staff here think that I am afraid to get involved. So I started down the hall.... Of course, I was working with a whole new group of people. ...I thought I had to prove myself. I was not comfortable to say I was afraid. (Julie: lines 48-113)

I had a patient come at me...he was probably from me to you, beet red. He was a personality disorder, screaming mad at me because I confined him. ...]And I was sitting there. I mean you have to think, "If I show anything, then I lost." So you just have to be firm. ...You just have to remain in control and remain firm. I mean, sometimes you have to show one side. You may fear inside, but you are not going to show that to him because you cannot....

Q: What happens if you do?

A: You lose control and you cannot. ...I guess I would feel that if it was not going well I would almost tag it off with a co-worker. (Tracy: lines 297-318)

Nurses' distinct identities are partly based on their ability to handle themselves in threatening situations and on how they present themselves—as either in control of an unstable situation or not. Although nurses may feel fearful in certain situations, they can't always reveal their emotions.

Being authoritative

According to the nurses' descriptions above, being in control necessitates that certain emotions (such as fear) be hidden and that a particular front (calm and controlled) be presented, despite the threatening situation. In addition, nurses may also assert their authority in order to conceal their true emotional state.

And I tried to redirect him about three times, because I have known this client for quite a long time. I could not get him redirected, so the only other

approach I could have was to be firm and say, "I am going to have them come and get you...." (Julie: lines 530-533)

Nurses describe a number of different situations where they needed to assert authority. In this last excerpt, the nurse described the use of authority to regain control over a patient who was considered to be psychiatrically unstable. In other cases, nurses displayed authority to defend themselves in a threatening situation, while others used counter threats to control the patient. However, psychiatric crises are not the only times when a nurse must intervene in an authoritative manner.

Displaying authority and control in psychiatry is not necessarily about a "psychiatric" situation; it also concerns social dynamics that exist within the institution. Nurses must portray themselves as an authoritative/controlling figure to enforce social order (for example, to impose rules). The institution imposes social dynamics and certain rules of functioning that nurses must implement. If patients do not adhere to these rules, then the situation becomes a control issue for nurses, who must deploy authoritative actions, and, possibly, generate confrontational altercations.

I mean some of these guys come in; they have lost all control. They are locked up, they are being told what they have to do, they know people are watching them and recording everything that they are doing. They have no control over what they wear, when they shower, when they can eat, what they eat, when they can go to bed, when they can wake up. They have no control. And there are some staff around here, that, when the clients start to try exert some control, the staff become very defensive, and it becomes a control issue and so it is, you know, "You are going to do what I say" type of thing. And that attitude frequently resulted in unnecessary altercations. (Mary: lines 117-127)

Negotiation

Despite the need to be in control and to control unstable situations, nurses also describe the possibility of being flexible in their approach and of making daily encounters less confrontational.

We have to be rigid. Like, we do have black and white rules. I find I tend to explain the rules to people more; rather than just say, "Well that is the rule," I

will say, "That is the rule because." And I find that tends to take away a lot of that barrier that is there with the simple explanation. (Mary: lines 241-245)

However, being flexible in this environment proves to be difficult because of strict regulations. Experience was described as being helpful in navigating between what is and is not acceptable.

We are really rigid on things like contraband. That is really black and white, no questions. But I think little things like checking every hour. Somebody might be five minutes late and the general consensus for all the staff is that you talk to the patient and you want an explanation why they are late. If it sounds legitimate, that you know this patient is very seldom late, then you give him some latitude. If they are fifteen minutes late, there is no latitude. ...I mean [Bobby] was late, but he falls asleep all the time downstairs. ...So I think it is an individual thing... and part of it is just experience. (Patricia: lines 916-930)

In addition, being flexible and negotiating with the patient does not happen in a social vacuum. Decisions are made within a social context. As this nurse explains, flexibility is not always possible, because others (the group) are opposed to it. Nurses need to navigate between issues of control and personal choice, while keeping in mind the functioning and safety of the environment, their own safety, as well as the opinions of co-workers.

I am having a conversation with a client and he is saying, "I would like the door open for an hour." "Okay, you want me to stay in here for an hour before I come out... well, you are going to unlock the door... well, I want the door open." And well: "No. I can open it a crack, but we are not leaving the door right open; that is too much stimulation." And then you will have somebody in the background piping, "No we do not leave the doors open under any circumstances." Well okay. I guess...we will have to take a different plan. (Dustin: lines 369-380)

Marrying both the need to encourage personal choice and the need to display authority can be difficult, particularly when the need to control surroundings for safety and security purposes may in fact create unnecessary restrictive actions.

Sometimes I have seen people be forcibly put into seclusion that might have walked if they had a bit more time spent with them. ...Lots of times, I think seclusion can be avoided with the approach that the staff takes. In my experience, I can probably count on one hand the number of seclusions that were necessary because of the client's behaviour. There were probably dozens that I felt were unnecessary because the confrontational approach that the nurse held with the client. (Mary: lines 435-459)

Feedback loop

Institutional(ized) psychiatry largely revolves around a system of rewards and punishments, commonly known as the privilege system. The logic of such a system is that patients are rewarded for compliance with disposition orders and treatment plans, while punitive consequences are applied to deviant behaviour. This feedback loop ultimately serves as a reinforcement strategy to diminish unwanted behaviours and encourage appropriate behaviours. In everyday practice, the nurse's role regarding the privilege system can be summarized as follows: they must see that the patient is compliant with his or her treatment plan, take away privileges if necessary, give feedback to the doctors when the time comes to ask for privileges (conferences) or change disposition orders (review boards). Despite this practice's therapeutic intentions, the patients are coerced into docility. In order to produce docility, the privilege system is often applied as soon as a deviant behaviour takes place. For example, a patient who has ground privileges can be denied access to the yard because of aggressive behaviours on the floor. This power relation is a constant reminder that the nursing staff has control over the patient's actions and needs. This position enables the nurse to communicate authority, and forces respect from the patient.

Well, you kind of let them know that, well, I can act the same way as you are. The only difference is, I am getting things you are going to need for your comfort. (Dustin: lines 482-484)

This process is not necessarily overt and confrontational. Nurses can wait for a conference with the doctor or a review board to report patient non-compliance with their treatment plan. Thus, the privilege system can be used as a leverage mechanism to force adherence.

They [privileges] are used as the barter some of the time. I think they are. ... Like I had a patient this morning who has no privileges. But we suspect he is cheating his meds. Now when he came into the dinning room, there was no one else around. ...I asked him to sit and take his medication. And I am not feeling comfortable that he is taking them: "I would like you to sit here for five

or ten minutes." And he did not. He sat down, took his meds. He got up and was heading out of the dinning room, and another staff said... "I would not put up with that. He needs to sit down." And I said, "I am not going to physically make him sit down." But if he had one-to-one privs by now, which he would be getting soon, I will be the first one to say, "Since you cannot follow direction within the walls here, I would not feel comfortable taking you out today to the canteen." And that I think is a genuine concern. But other people would be more inclined to say, "If you do not take your pills, you do not go out today". (Rachelle: lines 314-332)

These restrictive interventions are often rationalized as being altruistic and therapeutic, because they are believed to be used in the best interest of patients.

Well, I think they appreciate that. No matter how ill they are, and even though you may have to tell them things that they do not want to hear or impose rules and regulations that they are not happy with. You can still do it in a certain way that you are respectful of them. (Nicole: lines 220-224)

The privilege system is, in itself, a way to make the patient appreciate the consequences of his or her actions, and, to some extent, create a sense of responsibility. With time, patients will understand not do some things, because they know there are negative repercussions associated with these actions. Taking responsibility for one's actions was further explained by describing a unique way in which to use the seclusion room. When the patient does not act appropriately, the patient is brought to an open, quiet room for safety purposes, where s/he is required to stay, without the door being locked. The patient is required to stay in this room; the consequence of his/her leaving the room is to have the door locked, thus rendering the patient in a real, locked seclusion situation. In both cases, the patient cannot leave the space. However, the open, quiet room allots responsibility to the patient, who must make the choice of whether to have the door locked or not. The open, quiet room is described here as part of the privilege system, in which the room is used as a method of controlling the patient's environment to help de-escalate certain situations. In this particular hospital, seclusion was seen as being more humane than using other types of restraints, because it does not restrict the body and is considered safer. The person remains free to walk around, and staff do not have to struggle with the

patient to put restraints on. Seclusion is considered to be a last-resort intervention, as opposed to the open, quiet room, which is used as a way to re-establish good behaviour. If the patient is not cooperative, then seclusion is justifiable: the patient is responsible for escalating the situation to a locked seclusion.

4.2.6 Male culture

According to the participants, nursing care is highly contextual. Working in forensic psychiatry is a unique working experience. The exposure to, and involvement in, the care of mentally ill offenders was, in itself, described as not being for everybody. Not every nurse is considered to be ready or willing to work in this environment.

And there is a big turnover, too. You may see a new part-time staff a couple shifts and then you will hear in a month that they are gone. Like I say, you can do it or you cannot. There is a real fine line. (Trevor: lines 757-759)

During the interviews, some of the participants highlighted personal characteristics that were believed to be important to work in this particular environment. These characteristics, which include being laid-back, very strong, forthcoming with directions, and able to hold one's ground and stand up to patients in tough situations, often carry connotations of masculinity, and define the way nurses present themselves in the workplace.

You definitely have to be laid-back. I mean, you have to let things kind of roll off and you cannot take things real personal. (Trevor: lines 811-816)

I think that you would see in the majority of females that they are very strong. Very forthcoming with direction. They are able to stand up in a tough situation. If you are not, then really this is not the place for you. (Julie: lines 915-918)

As these excerpts suggest, the traditionally masculine attributes described by the nurses are far from being presented negatively in terms of toughness or confrontation. Rather, nurses described these masculine attributes in a positive, constructive manner.

You know, corrections are the ones that are authoritarian. This is not what the setting is supposed to be for us. And that is not my role. Now, fair, upfront, outspoken...I will tell you the way it is (Sylvie: lines 655-660)

These attributes are further situated within a context that was described as having at its core a strong male culture, in which weaknesses are masked and masculine attributes may prevail over feminine/emotional attributes, a phenomenon described as a form of masculinization.

I just see a typical strong male culture, which I think is a good thing. ... it is funny, I wonder if the females become a little masculinized in an environment like this. ... not in terms of their physical features but in terms of their interpersonal. (Greg: lines 212-219)

Gendered expectations

According to the participants, males have a general affinity towards psychiatry. The importance of having a male nursing presence on the wards is explained in part by social realities. Some tasks are required to be gender specific. For example, a male patient who has committed an offence against children will most likely be accompanied in the community by a man to ensure proper supervision.

... the only thing really that I can think of off-hand that being female is, that we are not allowed to take male patients that do not have their own privileges into the community, because there have been issues in the past. Like, we cannot take them into the bathrooms, so some jobs like community tend to have to go to male staff. (Isabelle: lines 511-515)

Okay, you are not allowed to be gender specific per se. If we have a sexual offender, it becomes gender specific quite quickly. (Tracy: lines 383-384)

However, participants described specific dynamics that exist within their practice and revealed that gender is a central element of forensic psychiatric nursing, especially in potentially violent situations. As such, participants not only described a predominant male implication as a figure of authority and protection, but also as providing role models for the in-patient population. Within these descriptions, a subtle, yet important female component was also evident.

Authority and protection

Male forensic psychiatric nurses are described in terms of presence. Men are considered to have an effect on both the patients and the general ward dynamics (ward atmosphere).

It is not so much that he could do more than us or we could not handle it
It just keeps that level down a little bit. (Tracy: lines 403-405)

As far as psychiatric crisis and those types of things, I think that there is probably less because there are males in the environment. If there is all females in the environment, and the female is trying to provide an intervention, and the larger male patient chose not to participate or needed to be restrained because of dangerous behaviour...then it would be different in this world. The males actually help settle those types of things. (Marc: lines 805-812)

As these next participants explain, men are summoned in violent situations, but also enforce a degree of docility simply by being present on the ward.

Not just on forensics, but in the whole psychiatric setting. Anytime there is a problem, men are summoned to the problem, moreso than women. Even though there is a policy in the hospital that there is no gender specifics, that is just in writing. Because there definitely is. And if you are a man with any kind of size, too, you are definitely getting called. And you are going to go in and you are going to be the ones with the hands on the violent patient; or put people in seclusion; or hold them down for needles. Very seldom do you have women doing it. Which is, which is fine. I mean, me as a man, I would rather do that than put a woman in jeopardy. And I think in the patient's eyes, too. I do not know for sure, but I think that when they see men coming, I think they are a little more nervous. You know: "I do not have much of choice here. There is a few men coming. I should cooperate." Whereas if it is women, I think they feel they have more control. (Trevor: lines 248-263)

There is a lot less horseplaying. ...like a big guy trying to bully the little nurse and trying to use his size to intimidate her to get what he wants. That does not happen so much if there are five guys on. (Philip: lines 496-504)

The physical contribution of men in this environment is practically unavoidable. This physical contribution is usually needed in times of imminent threat. The gendered representations are very divisive: women usually take on secure roles (preparing the needle, preparing the seclusion room, making sure other patients are not in the way), while there was a tendency to ask men to confront and control violent patients.

Usually when a patient was acting out, they went to a quiet room, time-out type situation. So the males kind of handled the actual handson and the women kind of got everything organized. (Julie: lines 63-65)

Some of the female staff that I have worked with over the years, I would take over some of the very few of the male staff I have worked with over the years. You know, if you know how to handle yourself, it is not going to matter so much your gender; not as much anyway. I mean, it still matters, you are not going to be getting too far if you put a 4½-foot-tall female staff that weighs maybe 100 pounds against a 300-pound six-foot-six guy. That just is not going to happen. But you know, as a rule, there is a bit of a difference; again it depends on who they are. (Nathalie: lines 738-746)

Participants did not discuss a division of roles, but, rather, an assumed gender expectation. Given a violent situation, male presence provides a "macho," protective connotation, according to male staff. Men are larger, stronger and more inclined to be called upon in these situations. When it comes to controlling a man of any size, then one must match force with force.

I will tell you something... nine times out of ten, if there is verbal escalation or there is potential for violence, it is always the men that get called. And I agree with it, and I disagree with it, because I have had instances where some female nurses have started arguments with patients...and then she would come to me, asking me to go talk to him while he is all agitated. ...I mean, I could defuse the situation, but there is potential for violence. But I will be the first guy to stand there to help out, too, you know. ...There is an expectation and there always has been. And, not being the big macho guy, but I would jump in over any women here. It is just basics. I mean men are stronger than women. Well, most men. But I would take a punch before I watched one of my female co-workers take a punch. It is just a guy thing. ...It is kind of an unwritten rule and it always has been. And like...some guys disagree with it, but most guys just accept it. (Philip: lines 101-127)

In a psychiatric crisis, it goes to the macho-ism or the male dominant society, that males will push the females aside and lead the intervention when it becomes physical and violent. ...If you are thinking of an intervention where it has to get to control, then you need to match the force with force. If you have someone who is physically fit, 200 pounds, then you need to have a presence that can manage that. ...that would probably be males versus a 100-pound attractive female that is not physically fit or someone who may be obese. (Marc: lines 819-860)

Because there are no security guards, some staff members are more inclined to adopt and enact a protection role. In this research, both men and women described taking on security guard roles. However, a distinction was made between being security-minded,

which affects all staff, and being assigned the actual physical role associated with security.

Not all the time, like being a guy, you do feel like being a guard sometimes; or the heavy; or the big brother kind of thing where you have to lay down the law. (Philip: lines 459-461)

Although some women may be able to adopt this role, it is usually assigned to men (not necessarily in an official capacity). This role division is situated within a general view that males are not only the protectors (physically involved) but also potential victims, while women are perceived as being protected by their maternal attributes.

If anything, I would probably feel safer because I am a female. ...I do not know if it has to do with the mother-son relationship that they had when they were younger, but they almost see you like as a mother figure. ...I probably feel safer because I am female, because the men, if there is a problem, they are the first ones that are attacked. (Kristen: lines 421-437)

Most male patients will not hit a female staff. It is seen as cowardess. (Julie: lines 1005-1006)

The authoritative presence of men in forensic psychiatry was also described in terms of perceived threat from the patients. Having men on the ward may provoke male patients to become defensive, while a female presence may not elicit the same effect. Females carry the social attributes of being maternal and soft, which may prove to be an advantage in some situations.

Generally, I think, as a female we tend to be able to talk people down a lot more effectively than the male staff. With the male staff, even the staff that are not confrontational, when a client is agitated they see the male and they start posturing and they do not want to be seen as the lesser man. Whereas when a female comes into the picture, if their approach is not confrontational, they can often defuse the situation very quickly and effectively, simply because they are not threatening to the male patient. (Mary: lines 264-274)

In other words, a male's or female's ability to diffuse a threatening situation is not necessarily due to their skills, but, rather, to the social expectations of their gender. In some cases, female attributes may be less provoking, thus permitting a verbal de-escalation and re-direction rather than an invasive/coercive intervention.

When we were still on [the other ward] we had one guy who was going to take on 20 guys down there. We got called to a code white. He was just waiting for the first guy to step up. Along comes this little nurse, talks to him for one second, holds his hand and walks down the hall. And they go in the quiet room. She walked him right into the quiet room and he agreed to stay there. Well, you did not need guys that time. He felt comfortable and he felt safe and trusted her to do that. It is the rapport you develop with each client. Some guys need the father figure, some guys do not..., but it is nice to have both male and female on the unit. It really is. (Philip: lines 468-477)

There is a particular experience of being a male or female nurse in forensic psychiatry, because each gender elicits different responses from male patients, who may recreate wider social dynamics within the institution. Regardless of sharing an identical professional mandate as nurses, male and female nurses may actually bring something different to the table, simply because their gender roles complement each other.

Most of our patients are male. Most of them have lived through a male dominant society. Most of them have come from a socio-economical background where they probably are not coming in here from the high end of society. They are coming in from the lower end. So there is a lot of, there is a lot of male dominance at that level. And it comes in here. ...So that may be a challenge for our patient. Therefore, their approach to the nurses may be different than their approach to me. If I come in and had a conversation with them, they may answer me different that if a female...came in and had a conversation. (Marc: lines 765-778)

Well usually we always like to have men available. Of course, you know, I think that is a necessity. But in another aspect, sometimes a male with a male makes a male patient feel threatened. And sometimes a woman can handle the situation better. And I know a few patients I can name in my hand, who I know, if it comes to a situation, we are not going to get a male to approach this patient. We are going to get a female to approach the patient, you know; so you kind of have to look at that, and working here for that long, it is kind of like an innate sense. You can tell what patients feel threatened by a male presence kind of thing, you know. It is there and you know. (Jordan: lines 365-375)

Despite an obvious emphasis on the "natural" selection of men adopting role-model and protector roles, participants emphasized the individuality of each patient who may respond differently to different staff at different times.

Some patients respond better to a woman, ...some to a male. You use what is at your disposal I guess. ...like today, our little one was not going to comply. She was given direction; it was a male staff. They came and got me,

because it was a female client. I went and she happened to be OK with me, where she was not with the female staff the other day. (Tracy: lines 360-365)

Being a role model - someone to relate to

Gendered roles in the F.T.P.D environment were also rationalized in terms of the population being cared for. In this unit, one finds a greater proportion of male patients on the wards, and, it is reasonable to believe that they may prefer to relate to other men.

I do not think it is right that an all-male population should not have access to one male staff. And I am not talking just about a security point of view. ...a male patient may have a problem that they are only comfortable discussing with another male. I mean, they should have that opportunity. (Nicole: lines 735-743)

And some of the guys here, too, they will listen to a man over a woman. Could be cultural; could just be behaviour. But some guys respond better to just having a guy around, not be physical or anything, just to relate to. (Philip: lines 92-95)

Male staff are expected to become role models: to show male patients how to behave and to provide a positive male figure.

Because most of our clients are male. And they need a positive gender role model. That is what it comes down to. (Julie: lines 996-997)

I know that the environment is different because we have co-ed. I think that with the male nurses, it changes the environment, and it goes back to the perception of the patients. If it was 100% female environment, it would be different than they are today with our co-ed mix. I think that the ability to have men in nursing, in this environment, is very positive for our patients. Our patients can then look at them as role models. They can look to them as example of males reintegrating into society. (Marc: lines 797-805)

4.3 CATEGORY 3: FEAR

4.3.1 Risk

Learning the risks

The "at risk person"

The boundless institution

4.3.2 Internalizing Fear

Anticipating fear

Interventions directed at the self

Interventions directed towards the patient

Interventions directed towards the environment

Safety in numbers

4.3.3 (In)visibility

Spaces and bodies

Technology and surveillance

The third descriptive category to emerge from the data essentially documents the notion of fear and how it affects nursing care in this forensic psychiatric setting. This section will begin by describing the notion of risk: how nurses are socialized in a culture of risk, how nurses define an "at risk person" in the clinical setting, and how risk is institutionally contained (risk is contained within the specific structure of the psychiatric institution). It will then summarize how nurses internalize fear, and how interventions are designed to minimize potential threats. The final section of this category will describe the concept of

(in)visibility, which refers to the position and surveillance of bodies within a delimited space (the nursing units).

4.3.1 Risk

The forensic psychiatric environment was described in terms of risks, specifically, how risks are identified and avoided. This environment is generally defined by the potentiality of dangers and the need for nurses to "learn the risks" as well as define the "at risk person."

Learning the risks: "having your guard up"

When entering the forensic psychiatric setting, nurses often described the environment as an unknown territory, one that evoked fearful anticipation and preconceptions based on examples they had encountered in their social lives (social scheme of reference).

When we were students, we were not even allowed to tour that unit because they said it would be so disruptive to the clients. So I had absolutely no idea where I was going. I went home and told my husband I would have to quit my job, because I was sure I would be killed. I would not survive there at all. I was not a fighter; I was not somebody who could defend myself. And the best advice I got from my geriatrics friends was, "Keep your back to the wall."
(Julie: lines 15-22)

Generally speaking, gradual exposure to the forensic psychiatric setting helps nurses become acquainted with and accustomed to the environment, the patients and their histories. Although personal experiences vary from one nurse to another, it was often a patient's criminal background that was the most difficult for nurses grasp and work with.

Did the type of work shock me? No. ...But, becoming more aware of how severe some of the crimes were, of what some of the people committed—yes, that was a little bit of a shock. (Kristen: lines 57- 61)

As nurses gain more experience in the field of forensic psychiatry, they are exposed to a number of clinical situations, and become professionally socialized, which will affect their practice and influence the way they will deal with up-coming clinical challenges. As this nurse explains, "something" happens over time. A certain attention is drawn towards the nurse's need to become aware of potential dangers. Nurses develop a new clinical scheme of reference that demands a need for heightened awareness and suspicion. This

process could be considered as a rite of passage from "being green" to becoming experienced.

Maybe it is because I am new and I have not had an awful lot of experience in this field. Not to put myself down but...I have seen a lot, but at the same time I have not seen a lot. So maybe because I have not seen as much as I will see over the years to come...maybe that is why...like, do not get me wrong...I always have my guard up. But I guess...there are other people that have their guards up more than what I do, and I am just not there yet. So ... like I said, maybe it is because I am new...there is more to come for me to see. That maybe I will...have my guard up even more than what I do now. (Kristen: lines 197- 210)

Developing suspicion and awareness in forensic psychiatry is, in part, instilled by the field of psychiatry, where different types of illnesses demand that nurses be aware of their surroundings and the patients with whom they are working. (This is also described as developing a "sixth sense" or sharpened awareness.) In this research, the development of a new clinical scheme of reference essentially means that there is a process that changes the nurse's original nursing scheme of reference (the patient as well-intentioned and willing to be helped) to one in which his/her attitude toward the patient is tinged with mistrust. As the following nurse suggested, what could be considered as a "naïve" nursing perspective (considering the forensic patient to be like any other patient) is not necessarily bad. However, one incident can change a nurse's naïve perspective, causing them to become guarded.

Being naïve can get you a long way. However, there only needs to be one bad incident.... I know one woman who worked here for years without a single major incident, and then she was not paying attention to her patient downtown, and he assaulted a little girl. ...and this lady was extremely naïve. ...it was not a problem for her for twenty years, but there is that one incident and that is all it takes. (Dustin: lines 573-580)

As the participants explain, nurses must learn to distinguish between ill patients and deviant patients in order to avoid being manipulated. Some patients are perceived as mischievous, manipulative and scheming. Through their practice, nurses not only learn to keep a safe, physical distance, but a psychological distance, as well. They learn to

negotiate what information they are willing to disclose with patients, since this information could potentially put nurses in a position of vulnerability (becoming a victim).

There was a female who absolutely did not want to come to forensics. She told them she did not want to come; she was terrified.... When she arrived, there were several kind of bully, axis-II type clients on our unit who realized that she was easily intimidated, that she was probably more vulnerable than some of the rest of us. And they used that against her. And to the point where she actually got upset one day and said, "If I was a man, I could do something about this...but I am not, so I cannot". After that, she actually ended up... being held hostage one day in a seclusion room. ...So I was always really careful not to show any vulnerability, to stand up and look tough even if I was not tough at all. (Julie: lines 119-133)

The identification of deviant patients was often related to a specific patient population: Axis II patients. However, nurses are socialized to be aware of the possibility for deviance, and accordingly, adopt this practice in their daily work.

You have to be looking at deviance as opposed to psychiatric symptoms...and that is harder because...we are not born looking for deviant behaviours. Older nurses can see it a block away, and we try to teach the younger nurses. But we have had some female nurses who have fallen prey to having relationships with patients, bringing drugs for patients, and that goes back to us not doing a good job teaching, not letting them know the risks. (Julie: lines 1212- 1221)

Continual awareness of the potential for deviant and dangerous patient behaviour is a socialized and valued component of working in forensic psychiatry, so much so that, sometimes, the criminal background of the patient seems to overshadow the person-to-person relationship ideally espoused by a nursing framework. The forensic milieu establishes an attitude that this person is, and always will be (or could become), dangerous. There is a static element of risk that nurses are conditioned not to forget. As this nurse explains, not acknowledging the risk of working in forensics is extremely dangerous; every effort will be made to make sure the new nurses take all necessary risks into account. New nurses are summoned, therefore, to assimilate this culture of risk, and are expected to develop an awareness that was defined by most nurses as "having your guard up."

I do not think I would ever hear anybody say they are scared. We have a lot of part-time people who are not even aware of the risk and the dangers. ...We were discussing the risk, because sometimes part-time people put themselves at higher risk than they need to. Just because they do not know. And they do not know the patients. They have not made any effort to learn the patients. ... You have to realize that things can happen, and you need to do these rounds, ... because I said, "One night one patient murdered another." "Oh my gosh, you know somebody?" and I said, "Ya, this is a forensic unit...there is a potential situation going on here that you need to be aware of." I do not know where they thought they were. ...they had no idea of the risk. When I talk to students, and sometimes I get a chance to do the little orientations when students come around...,I always try to take just a few minutes and make them keenly aware of what can happen when you let your guard down... when you stop being diligent... (Julie: lines 1078-1098)

For some, this notion of awareness—"having your guard up"—means to be "street smart" and aware of one's surroundings. Essentially, this general awareness would prevent nurses from getting into an unwanted situation. However, working in forensic psychiatry involves a specific type of awareness, one that is defined by the patient's criminal background and the potential threat that it suggests.

In forensics, the ritual of verbally describing past events to other nurses is very important to diminish the nurse's initial naïve perspective, and to make them aware of the potential dangers that can exist. As such, nurses do not need to experience threat directly (many nurses in this environment discuss physical violence as a rare occurrence) to have any specific recollection of adverse events. The forensic milieu is a site where heuristics (recalling past events) shapes the rules and procedures of everyday practice. As this nurse explains, past events must to be taken into consideration.

... and you know, we have got a pellet gun brought onto the ward by a really offender kind of guy and held someone hostage. There have been very serious things over the years. (Patricia: lines 198-201)

As a social environment, the forensic milieu is, therefore, a site of constant formulation and reformulation. The forensic milieu is shaped by events that have taken place in the past, occur in the present and will transpire in the future. Decisions are formulated in view of past clinical events. By doing so, nurses work in the potentiality of

what could happen in light of their recollection of past incidents and the applicability of these incidents in everyday practice. When an incident occurs, it is often used as an example to foster precautionary action in the future. The following nurse explains how some routine regulations have come to be, and how they are the direct result of past incidents on the units.

We have to supply the deodorant. We used to allow family members to bring deodorant in. ...she [a visitor] came to visit; she was allowed to bring toothpaste, deodorant, all that stuff, because he wanted his own special brand. And at that time we allowed it. But he had a file that she had shoved down inside the deodorant. So it was all contained, but she had taken the lid off, shoved it down the side, small enough. And it was a file to file out the windows. The toothpaste was the same, only a longer file. The comb that we put in there.... We had another patient actually go to [jail] and he took the comb, broke off some teeth and...filed it down into a shiv, wrapped it with tape and shoved it into his laundry hamper. And it was actually for another patient. ...We provide toothpaste; we cut their toothbrush, their comb. They are allowed a comb, but we monitor when it comes back in, and the deodorant.... And that is in a plastic cup. And the little bars of soap, we used to cut them. But prior to cutting them, we used to let them bring in their own bars of soap, and we had a patient who put two or three bars of soap in a sock and had it hidden under his pillow. (Patricia: lines 882-909)

Actual anxiety/fear producing situations are, in themselves, described as scattered events. The immediacy of a threat is not always present, but the possibility for adverse events to occur is always real. The experience or recollection of adverse events makes a patient's potential for harm tangible. What is learned from these events is that complacency is dangerous; a nurse needs to have his/her guard up.

Q: You were talking a little bit about pellet guns...maybe hostage situations and that.... How did those experiences affect your view of care?

A: Well, usually when something like that happened, you scrutinize what you have done at that time, or what you could have done different, or did you notice something that you should have told somebody. Because there is this big dynamic thing that happens, so you always sort of look at the big picture at the time that all that stuff happens: "Did I miss something, or did I do something or...." All it did for me, really: remind me of where I was. ...one of the things I would tell the staff was, "Probably your own worst enemy is complacency...." It is not lack of knowledge, because you always educated yourself, or you should educate yourself, but it is complacency. When you get too comfortable in your role, and you think something cannot happen to you. ...When things like that happen, it just sort of woke you back up again

and made you a little bit more careful, and I have always been very careful and very security-oriented (Patricia: lines 225-246)

Letting one's guard down and being complacent creates an opportunity for negative consequences to arise.

The "at risk" person

During the course of the research, a murder took place in western Canada. A young man was brutally murdered by a psychotic individual on a Greyhound bus. The news of this event broke the day that one of the interviews was scheduled. The nurse used this example to explain the relativity of dangerousness and risk. Society at large is dangerous and individuals should be careful when they label all forensic patients as being dangerous or more dangerous than people one might meet outside the hospital.

I do not think that we are working with dangerous, not on this unit... dangerous people. Again, I think you could be on the street and run into more of a challenge with a person that possibly has a psychiatric illness that is not diagnosed and is not medicated, and is not, you know, connected to a support system.... (Sylvie: lines 76-79)

However, working in psychiatry involves working in a confined and confining environment, where nurses have difficulty believing that they could ever be completely safe.

I mean you are never 100% safe, right? There could always be, and there always is going to be, somebody flying off the handle. (Tracy: lines 281-283)

Potential for violence is present with all psychiatric populations, not just forensic psychiatric patients. However, there are some areas of practice that are considered to be more "at risk" than others. For example, admission units and assessment units are considered to be more at risk, because the patient population that is being treated on these units has characteristics that increase the perception of risk.

I mean [the admission unit] probably has a higher potential because they are getting all the fresh admissions and unstables and people on drugs. You do not know what is rolling into your door. I would think that, because of their instability, it would be higher. (Julie: lines 1134-1139)

An acute unit, you do not know your clients that are coming in. ...I did shifts at [the admission unit] and it could be pretty dangerous when police officers bring a big guy in who is handcuffed, undo the cuffs, and say, "There you go... bye." If he has him in handcuffs, what are we to expect? (Philip: lines 256-263)

In this research, nurses have defined specific instances where "having your guard up" is particularly important. In doing so, nurses have developed a clinical conceptualization of the "at risk patient." The way in which nurses define the patient ultimately affects the overall assessment of the patient and the type of nursing intervention that is selected.

Clinical manifestations

In general, nurses will adapt their approach and their intervention style depending on the patient's clinical presentation.

Well, it really depends on the person... it depends on how they are presenting when they initially come in... if they are really hostile I am going to proceed with a little more caution (Isabelle: lines 267-270)

For example, a patient who is male, psychotic and has a significant size may be perceived as an increased source of risk. One's interpretation of the clinical manifestations may lead to the immediate deployment of restrictive interventions rather than adherence to regular de-escalation processes.

Q: Are there times where you have been fearful and sort of skip those steps ...?

A: Yes. ...it was this very, very large gentleman... young guy who was in and out of sort of psychosis and ended up probably drug-induced. He was not behaving safely. We needed to provide safety for those around him. We approached him, and he ended in a situation where it went from the approach to an action by him, to an intervention that ended up physical, and the individual was secluded. (Marc: lines 541-559)

Knowing the patient

In addition to clinical manifestations, there is also a clinical relevance to knowing the type of population with which one is working; nurses adapt their approach differently when

dealing with different patients. As this nurse suggests, not to know patients individually (including their diagnosis) can produce anxiety.

If I got pulled to another area and I did not have knowledge of the patients, some of their illnesses, those types of things, and I had to go out..., behaviours were different around me..., I would have some anxiety. (Marc: lines 632-644)

According to the participants, knowledge of the patient is a determining factor in the nurse's comfort level regarding the patient's "potential." There is a certain advantage for the nurse to know the clinical background of the patient in order to assess the baseline of the patient's mental status, and to recognize when it may be changing.

As you get to know the people on more of a personal basis, you get to feel more comfortable. You get to know when they are escalating. You can see the cues. You know how to approach them, how to deal with their problems. (Trevor: lines 54-58)

Given the structure of the institution, the elements of time and space are important factors associated with the element of knowledge. As the patient evolves in his/her treatment plan, they usually move from the assessment unit to the active reintegration unit. Throughout this period of time, the patient accumulates higher levels of privileges, increased trust from the institution, and has usually been stabilized on medication. Therefore, the nurse's evaluation of a patient's potential can be associated with what floor the patient is on (the assessment unit is usually considered more dangerous than the reintegration unit).

Time may also be a factor. Even if the patient is considered to be dangerous (for example, a resident on the long term unit), nurses get to know them and learn how to manage (or at least expect) their behaviours. With time, a level of comfort sets in and the element of risk may decrease. As the following nurse explains, nurses develop a certain type of knowledge over time, whereby they can evaluate when it is appropriate to intervene.

As we get to know people, and as we get to understand them, there is an element when the risk...anxiety and fear would decrease. (Marc: lines 665-667)

Evidently, not knowing the patients increases the perception of risk. In order to deal with the "unknown" factor, certain practices have been developed in nursing to ensure not only that the patient's condition is taken in charge, but also that staff are safe. For example, new admissions are usually placed on modified supervision, where they are monitored every 15 minutes. In some cases, patients are put in a quiet room for observation.

Modified SOR, we call it..., it is like a close. They are being monitored every 15 minutes and charted on every hour for the first 24 hours; that is just because we do not have any idea of what we are dealing with. Generally they would sleep in a quiet room at night... (Julie: lines 410-415)

Knowing the history

A tension exists between the nurses' need to know and understand patients and situations in which knowing certain types of information categorizes the patient as being "at risk." In effect, knowing the patient's history (including their forensic history) may influence how nurses perceive their patients. (This knowledge may become a source of anxiety, because the nurse knows what the potential for violence is.)

I would not be scared so much as nervous, and that is normally with somebody I do not know. If they are becoming out of control... or one of the clients that I have known from years ago and he was in psychiatry, and I know what he can be like when he loses control. (Nathalie: lines 454-458)

As this next participant explains, if a patient's history demonstrates information that threatens staff (a history of violence, for example), then it is likely that a restrictive plan of action will be initiated. However, should a threatening situation arise, the steps that are usually followed to try to assess/de-escalate the patient may not be followed. Ultimately, the nurse's appraisal of the situation and how s/he feels s/he can deal with that situation determines his/her course of action (whether or not the nurse has the necessary resources to deal with the situation).

If he was psychotic and threatening, aggressive and whatnot, he would definitely go into locked seclusion as soon as he got here. And that would be upstairs on the assessment end. We really do not have a locked seclusion room on this unit. ... We do not even really have an open quiet room. (Philip: lines 586-590)

However, the patient's history is only threatening if it is interpreted as such. In other words, perceived threat/risk depends on the nurse's own appraisal of the situation. As many nurses explained, personal experiences may influence the nurse's awareness or cautiousness when dealing with particular patients. Sexual offenders may be more threatening to female staff, while a nurse who has experienced a stabbing in the past may be more aware of patients who have this particular characteristic in their history.

The type of diagnosis

As a general observation, the type of diagnosis often guides the perception of risk and goes hand in hand with the patient's history. In their acute phases, many different patients may be potentially threatening. This threat is, in part, evaluated during the clinical encounter. However, participants and nurses often talked about specific types of patients who evoke a particular risk of deviance (not necessarily assault) that demands vigilance from staff: the psychopath and the Axis II. These patients are a good example of the type of patient who would be construed as being a higher risk. As this next informant explains, there is a difference between the perception of risk evoked from a patient with an Axis I versus an Axis II diagnosis.

I think crimes against children... are the big ones. So if I have a client who has schizophrenia, and they are using indirect community privileges, and they are ten minutes late returning, I do not get as anxious as if I have a client that has an Axis II and is a paedophile and they are ten minutes late returning. ...I tend to have a little bit more concern there. ...it is definitely with the people that do not have an Axis I diagnosis. (Mary: lines 651-662)

This is not to say that a person with an Axis I diagnosis is never perceived as a risk. What this research would suggest is that Axis II patients are much more likely to be perceived

as chronically deviant and manipulative, while Axis I patients tend to show signs of improvement when medicated over time, thus decreasing the perception of risk.

Medicated or not

Another element that nurses identified as a risk for working with patients is whether the patient is medicated or not. When the patient is not medicated, then the risk potential of the patient increases. The symptoms of mental illness are uncontrolled and, therefore, considered threatening.

...When we were getting them from jail or from court..., and sometimes we got patients that weren't medicated, I was a little more scared, because you could tell that they were hallucinating sometimes or... being very, very threatening... threatening your life. (Philip: lines 24-29)

Coupled with the fact that the patient is unknown to the staff and may only be identifiable by his/her forensic history, the non-medicated patient becomes a higher source of potential threat. As a result, nursing interventions seek to regain control of the non-medicated patient by trying to encourage them to take medication.

I have worked the assessment unit and I cannot say I felt safe at all time. ... because you are getting people who are not being treated...they are not on medication and they are there straight from prison to assess. Even before they even medicate, I cannot say I felt safe all the time there..., but I do feel safe here...; they are medicated. (Jordan: lines 211-216)

Within the hospital structure, the non-medicated patient often resides on the assessment floor.

Usually they are stabilized when they come to this unit. ...So usually they are stabilized on medication coming from the floor above us. (Philip: lines 277-279)

The boundless institution

The forensic psychiatric institution is, above all, a secure environment. It is a hospital that is mandated to protect society by creating physical boundaries between patients and the rest of the population. Nurses are aware of these boundaries, and are conscious that these boundaries enable them to create a therapeutic environment. According to the

following nurse, hospitalization, through all of its internal mechanisms of functioning (medical and observational), suppresses the risk posed by patients.

It is an individual style, and some work, some do not. Like, we have had nurses come on and they forget, entirely forget, the security issue. And: "Ah this man has been in hospital for five years without committing any act of...." That is right; he has been confined to the ward for five years, except for brief outings for dentist and that kind of thing. He has had very little opportunity to do anything. (Dustin: lines 244- 249)

Surveillance mechanisms and available resources within the institution create a sense of safety and security needed to work with forensic patients. This became very clear as some nurses explained their unease when boundaries of the institution become less constraining (for example, when the patient is close to being discharged). For some patients (sexual offenders, paedophiles, personality disorders), the clinical scheme of reference that fosters a belief that the patient can be rehabilitated is overpowered by a social scheme of reference (wherein the patient is dangerous). Despite his/her having followed treatment, the patient's history remains a threat.

The hardest part for me is not more here. The hardest for me is, like, seeing them out there, either during their care or after their care. ...Knowing what they have done, knowing what their history is, knowing what they are capable of... and you know, should you have any children. I know myself I have a child. So...just knowing that that person is living in our society, that is the hardest thing for me. ... just hoping that, not to say it the wrong way..., but hoping that they are actually...going to be OK with living in the same community as us and... . (Kristen: lines 94- 107)

In other words, the institution and its boundaries define nurse-patient interactions. Some nurses made it very clear that a differentiation needs to be made between what happens within the institution (professional life) and what happens outside of the institution (personal life).

Not on a daily basis or anything like that. But I just feel that my personal life is my personal life. And I do not want any kind of boundaries getting jumped. I do not want to have a social life with the patients or anything. ...I like to have very distinct boundaries. It is just easier if I only see them here... and then you do not ever have to worry about those boundaries being crossed in the community. (Isabelle: lines 445-453)

Because, you know what, a patient is a patient, will always be a patient to me. I mean, I love to see them progress and things like that, but I really do not want them to be in my neighbourhood. And not to be prejudicial, but I want them to get on with their life. And it is probably better that their life could be actually more fulfilled if they are not living close by to me. You know, because...that would disrupt my personal life, and I would likely be more cautious with my grandkids....But their life is better off away from people that would know them, so they can start a fresh life. Because I already have prejudged notions, and that is never going to go away. (Patricia: lines 692-703)

The difficulty of re-establishing boundaries outside the institution, due to the nurse's knowledge of the patient (history and psychiatric condition) was made evident. This unease can simply be linked to the appropriation of new social dynamics and how nurses interpret them. Some participants explained how they greeted former patients in the community the same as they would any other person. Because of confidentiality issues, others feel like it is the patient's choice to initiate interaction.

What is awkward for me is seeing them on the street and respecting confidentiality. I do not want to look like I am snubbing them, but I think it is up to them to say hi or initiate it first. If they do not, then I am going to assume they do not want to. But that is what...I mean, I have that happen. You make that eye contact, and I am thinking they are waiting for me to say hi, and I am, like, no. So that has been awkward. (Rachelle: 499-505)

The new dynamics that are created when the social arena of the psychiatric institution is removed can also become a source of anxiety for nurses. For example, one participant explained how a patient attempted to contact him at home while he was away on vacation. Despite believing in social reintegration, the nurse experienced a certain anxiety because he knew what the patient was capable of when he decompensates.

I was on vacation last year..., and an individual phoned my house and my son answered the phone. All he wanted to do was to get ahold of me. He was having trouble sleeping. ...And this is a guy that, when he decompensates, becomes very, very dangerous. But the message that I took out of that, in my conversation with him when I returned from my vacation, was that he had nowhere else to turn, and he knew that if he got ahold of me, I would make sure he got help. ...I did have a concern about him phoning my house, and we had a conversation about that. And he hasn't since. ...And the guy only lived two blocks from me, that is the other thing. (Marc: lines 680-699)

What was made evident from the nurse's account was that a patient remains a patient. The goal of humanizing patients that nurses attempt to achieve within the institution becomes difficult to maintain outside these boundaries. The patient/person is never completely dissociated from the illness or the baggage that institutionalization carries. For example, when nurses were asked how they would react to a forensic patient moving close to their home, a certain degree of apprehension was expressed, especially if the patient had committed a horrendous crime. Once the institution and its security apparatus are no longer in place, then the threat of knowing what the patient is capable of becomes tangible. The patient's history is imprinted in the nurses' thinking processes. One can try to dissociate the crime from the patient in a clinical setting, because the structure permits it; it permits nurses to engage and disengage, whereas in the community, patient contact is permanent and lacks boundaries. The risk is virtual, because it is constructed in the nurse's mind, and tangible, because the patient embodies this risk.

I can understand, and I am glad for them. They get better and all that stuff. But yes, there is an invisible line and it would be crossed. ...I mean, I know there are staff in [city name] that have lived in close proximity, but it does not make them feel uncomfortable. I know one staff that moved. It was that disturbing to him. So I guess it is just something on an individual basis that you have to deal with and see how much it would affect you. And if you thought it was having such a negative impact, then you'd have to just leave. ...because it is your personal life. ...And it is just your own mind. The location might be fine, but it is just your ability to be able to cut from one to the other, and if you cannot do it, then it is better to just cut your losses. (Patricia: lines 704-717)

Thus, knowing the patient is a source of contamination for nurses. The nurse's knowledge can create internal tensions. The patient may be well at the moment, but there is always a risk of decompensation, a potential that is always present.

I would like to say that I am open-minded and I would have no problem. But we moved because there were four of our clients within the three-block radius when our children were small. And I know that right now, there is not a risk. But I also know that stress combined with substance use can very rapidly change that risk, and I just was not comfortable. And that was the big thing ...all of our clients had not really done any effective stress management

programs and that there were substance use issues in the past, and those were two risks that were very real. (Mary: lines 696-704)

And it is a different role that you are playing as well. I mean, you can try to appreciate that everybody is re-integrated. You kind of give them the benefit of the doubt. But at the same time, you cannot help but know, know the history, know the rate of recidivism. (Nicole: lines 792-796)

So the psychiatric institution is a site where safety is created by the existence of its structure; it is a site where patients can evolve within a controlled environment. Within this site, nurses can engage with patients in a professional manner, as part of their job. But as this nurse explains, once the structure of the institution is removed, an element of safety is also removed. The patient's criminal history and potential regains tangibility.

I think the only time that I got scared [was when] one of our clients was done their treatment here and had been released out into the community. The home that he moved into happens to be on the same street that I live on, and that made me a little nervous. Because we had a good nurse-client relationship while we were here and then I kind of got worried about.... He has seen me on the streets. He has passed me on the streets. So right away I am worried. ...Is he going to come to my home? How am I going to handle it if he comes to my home? ...But aside from that, here, there is often...seven people on the floor. I am very seldom alone. (Kristen: lines 324-344)

Although decompensation and re-offending are always possible, when patients are discharged from the hospital, they usually remain on disposition orders that continue to link them to the psychiatric structure. For example, out-patient services are in place to extend the institution into the community.

But you know what my thing is? I do not feel somebody is ever 100% rehabilitated. Personally I do not think so. I think the stresses in life.... Like in here, they are living in their own little environment. There is somebody always helping them out or.... ...Putting these people out... I think, it is a concern. And I think there needs to be more in-depth follow-up. ...I think there needs to be better follow-up in the community. (Jordan: lines 486-506)

Such a view re-establishes the notion of management versus curability. Mental illness remains incurable. It is always considered to be a risk that needs management and that justifies ongoing links to the psychiatric facility. From a medico-legal perspective, having a

mental illness and being linked to the forensic psychiatric system is, ideally, a never-ending unity that ensures security/safety in society.

Some thrive once they get out. They really do. I guess I see mental illness as a condition, like diabetes, where you are never cured, but you can live a relatively normal life, productive life. So, once they are out of our doors, are they cured...? Absolutely not. If they do not take their medication...we have seen many bad things happen. They need to be monitored. ...I firmly believe they need to be able to contact. They need the support. (Tracy: lines 534-543)

4.3.2 Internalizing Fear

Although the forensic psychiatric institution may evoke feelings of fear and unease, nurses were generally comfortable working in the environment. As this nurse explains, the psychiatric setting is a controlled environment where patients are usually medicated and monitored, thus decreasing the potential for danger.

I think it is a controlled environment. ...Again, there are people here that are here for very little: harassment and maybe misdemeanours. ...You have situations where murder, but...[...they are either very good at playing the system and nothing you are going to do is ever going to change that... and again, it is mostly a personality or anti-social or psychopath or...there is no medication for that. Personally I do not think this is the environment that I would feel the most vulnerable around somebody like that. Or if they are truly mentally ill with a severe delusion or psychosis, or do not even remember what happened, which would mostly be the case if it was a genuine situation like that. This is a controlled environment, and now they are on medication and being monitored.... (Rachelle: lines 115-128)

As some of the nurses explained, the psychiatric structure is comparably safe to the dangerous, "uncontrolled outside world," where individuals are not necessarily identified as sick, and are not following treatment. When described in such a way, the forensic psychiatric institution seems like a relatively safe place to work. Safety is related, in part, to which unit the nurse works on and how the patients are being treated (assessment and un-medicated patients versus rehabilitation and medicated patients).

I think I am more aware of what is going on. ...I kind of feel safe in this environment. ...You know, if I met somebody on the street or something like that, it is a totally different story. I feel a little more safe here. ...Plus most of them are on medication; they are relatively stable. You know, by the time we

get them here, on this unit, as opposed to upstairs [assessment unit].
(Jordan: lines 176-181)

For nurses, the feeling of security instilled by the psychiatric apparatus is paramount. It creates an environment where fear is not at the forefront of all interactions. This security enables nurses and patients to interact without having to deal with the potential threat of becoming a victim, or at least, it ensures this threat is not as likely. According to this participant, if fear was present, then the nurse-patient interaction would be extremely difficult. Fortunately or unfortunately, the patient's crime is always in the back of the nurse's mind and it must be consciously suppressed during the interaction.

I am here, my goal is to do the best I can for the patients that are here. And I am glad I do not have the fear. ...Because fear stops you from doing things that you need to do. If I was afraid of these guys, I would not go to them; I would not interact with them. There is a new fellow here, that I must admit, I have only met him a couple of times and I did read his history. He slashed his girlfriend's throat not that long ago in a psychotic state. So when we are walking and talking, fortunately or unfortunately, I have that visual image when I am talking to him, but I still try to put it aside, and ask him, "What are your plans? Your disposition only has you on a 1:1." ...I would not go ahead of him up a stairwell. I would stay behind him. But I do that with most of them. Again, it is like when you are out in public. You are not going to walk into a washroom in a mall down a dark hallway without being aware of who's behind you. ... that sort of awareness. That is not really fear; it is just being cautious. (Sylvie: lines 895-914)

In this case, the perception of fear is primarily negative. If fear was present, it would impede day-to-day nursing care. Nurses would try to avoid the threatening patient.

However, a different view of fear was also presented, a view in which fear is considered to be positive. The perception of a threat and the internalization of a fearful sensation enables nurses to heighten their sense of awareness: it not only "keeps you on your toes," but also diminishes the chance that you will become complacent. As comfortable as one can get with the setting, nurses explained that complacency is extremely dangerous. Working in forensic psychiatry means that nurses should always remember where they are, who they are working with, and what the potential of patients is.

I do not care what mix of patients we have, or how long you have been here, or how good the ward has been lately. You should never become comfortable or complacent, because you should always have in the back of your mind, where you are and what the potential is. Because, if you let your guard down, then chances are you are not acting, possibly, in the safest way. ...you should always have a little bit of fear ...Because...if you are fearful, you are going to be safer in what you do. ...heightens your awareness. (Nicole: lines 609- 704)

Although many nurses attest to the positive view of fear as a protective emotion, discussions regarding fear are much less likely to occur sporadically. As this nurse suggests, dealing with a forensic psychiatric population can generate a certain level of anxiety and perhaps fear. However, these emotions may not be acknowledged; instead, the threatening experience is replaced by a discourse of commodity focussed on safety and security. A certain conditioning takes place when nurses are working in a potentially threatening environment, and fear may be present in the nurse's rationalizations, but not necessarily recognized.

I think that there is more fear than the people acknowledge. I think that people become conditioned to working in these environments. I think, especially when you get people that are acutely ill, and you understand their history and potentials, and people say, "Well I worked there anyways... it does not bother me".... I do not know if that is true. I think there is a degree of anxiety in everyone working in these environments. I think that that is a good thing, in that it makes them think of the safety needs of everyone around in the environment and dealing with people that have potential. (Marc: lines 531-539)

The conditioning effect described above is partly explained by another nurse who qualifies the experience of working in forensic psychiatry as being a reconstruction of a nurse's cognitive and behavioural scheme of reference. The forensic environment imposes a certain way of seeing, interpreting and responding to patient behaviours. These responses, which are not necessarily conscious, become internalized, and define a new scheme of reference that is specific to the forensic environment (and possibly others), whereby nurses interpret actions in terms of dangerousness and risk.

Now I had a hard time when I first came over there, if you are talking about fear. Because I would go upstairs early in the morning for report. And about

six or eight of these clients would all rush me at the door. And I had an awful time with that, because, in forensics if you were getting rushed by seven or eight people, you are in serious trouble. ...It took a long time for me to get down from that. So I guess that there were a lot of things that went on that I had just kind of internalized and just did. You know, like my care and security things. (Julie: lines 630-640)

Anticipating fear

According to the participants, specific interactions or situations could be described as fear-inducing. Being fearful is an individual experience that varies depending on the nurse.

I am not afraid of them hurting me. ...it has occurred in my mind that maybe, at some point, that now I really have to be careful walking away, maybe, with my back turned. If I know somebody is angry at a decision that I made, that I am conscious that person could just jump on me one day or do something. But I mean, it is not overwhelming that I cannot conduct my job. (Jordan: lines 191-198)

If you are honest with yourself, you are fearful going into a psychiatric violent episode. You are fearful for yourself. You have got the potential for being injured. You have a potential of over-exerting your restraint and injuring the patient and putting your practice at risk. You are at high risk of criticism by others by your approach because if someone gets injured. It all then turns into investigations and blames, and it gets back to the blame issue. (Marc: lines 826-833)

The relatively closed environment of the forensic psychiatric setting often redefines the rules of interaction between staff and patients, in that specific defence mechanisms can and cannot be deployed in these "fearful" situations. The term *rappport obligé* refers to situations where nurses often do not have all the options of a fight or flight response in the threatening encounter, and must engage in the fearful interaction.

You are always kind of fearful when you are having to put someone into seclusion. Of how it is going to go down. Or when you get a new admission, if we have to go downstairs to the admission and discharge area, and the police take someone out of their cruiser who is in hand cuffs and shackles, and take that off them, and "Here you go." And you have to come up the elevator with that person who you know little about, and most times they are not happy to be here. You would be foolish not to be fearful. I think you have to be fearful in certain situations to be safe. (Nicole: lines 676-684)

In situations that are immediate (such as direct physical assaults) and fear-inducing, the nurse may run, freeze or possibly fight back. However, situations that are based on

anticipated rather than immediate threat may also qualify as fear-inducing. As these two participants exemplify, nurses are often obligated to continue working with individuals who may have threatened or assaulted them in the past. Although the experience may have generated feelings of fear, anger, and the like, nurses described needing to find a way to deal with the situation. Nurses must engage with the patient, regardless of the emotions that the patient provokes.

I remember one of my first episodes. It was a young, very physically fit patient who...had a lot of Axis II problems, and I went and told him that he had to do this and he had to do that...and he literally said, "Well, I am not going to do that"... he took his cigarettes out of his pocket and got in a fire stance, and came right at me. So...afterwards, do you harbour feelings because he knew what he was doing? He physically attacked me. Do I harbour feelings? Yes. You try to re-establish a relationship; yes you do. But is that playing on your mind that at anytime he is allowed to take a poke at you? Yes. (Marc: lines 870-882)

Now, will I have trouble Thursday, when I have to go to that group and that patient may or may not be in that group? I hope I am not afraid. I do not think I will be. ...I think he was just angry. And I am not going to have anyone go with me, so I, you know, I am going to have to do it. (Julie: lines 1230-1235)

Fear can be both immediate and/or anticipated. With the anticipation of a forced, fearful interaction also comes the possibility for one to generate and deploy cognizant, self-protective strategies. Although fear is not always discussed, a threat may always be present. In this particular research project, nurses described a constant variable of potentiality, where there is always the possibility of becoming a victim, because the patients, both sick and deviant, are perceived as risk factors. A lack of immediate threat may bring nurses to discuss different types of self-protecting strategies as part of a therapeutic or safety rationale. These rationales are in place in anticipation of possible adverse events. Anticipated fear is described as a productive force. As a result, nurses have developed interventions to diminish possible threats and control their environment. These interventions can be divided into three sections: interventions directed at the self;

interventions directed towards the patient; and interventions directed towards the environment.

Interventions directed at the self

In anticipation of potential threatening situations, nurses discussed passive and active intervention strategies that could be utilized should a threatening situation arise.

Passive interventions

Passive interventions are a means for nurses to gather information that helps them comprehend and attain a description of the situation/patient. In order to do so, nurses described the need to read a patient's history, listen to the nursing report and discuss with other staff to determine the "here and now": what is the situation on the floor and what is the state of the patients (or future patients)?

Qr: And for you, in these types of situations, what did you do in your practice to sort of counter that?

A: Well you suck it up basically. ...But to help, you would talk to your colleagues; you try to read the charts; you would try to get a sense of the patients. If there is a patient in particular that made you uncomfortable, you would try to get a good understanding of them. ...it is all about your knowledge of that person and how you gain that knowledge. (Marc: lines 646-649—657)

Gathering information also includes making oneself aware of their surroundings. As another nurse explains, nurses grow accustomed to evaluating the risk to themselves and avoiding these risks to stay safe. As such, situations or the environment may be perceived as unsafe, but the nurse has the capability to evaluate the situation, and may deploy active interventions to stay away from or control potential danger.

Q: I asked you if you were scared and you said no, not generally. But you are unsafe. What is the difference between fearful and being unsafe?

A: It comes down to a matter of assessing the risk to your own self. Like, I can come in here, and look around, and say, "This is extremely unsafe in here, but I am going to be okay for the day, because I am going to know to

stay away from this situation." That I am going to know to keep a closer eye on this person. (Dustin: lines 729-737)

When I did have to pass by somebody who I was a little leery of, I would always keep my eye... knowing where they were at all times. (Jordan: lines 260-263)

In this case, a professional language of risk surrounds the threatening situation, which in turn permits clinical discussion regarding potential dangers. Nurses become aware of potential dangers through this ongoing dialogue. Fear is replaced (sanitized) by a clinical language of risk and risk avoidance.

Well, you talk to your team members. I mean, if you feel threatened. I am going to let every team member I work with know. If I feel that there is a chance for physical aggression or violence, I am going to talk about it with the team. ...hopefully we have the history to read, so we know what this person is capable of. (Philip: lines 43-48)

Active interventions

Active interventions can be considered as the subsequent step to passive actions. After assessing a threatening situation, nurses will decide whether to carry out actions directed at minimizing the possibility of becoming a victim. For example, talking in open spaces with potentially violent patients, making themselves aware of the patient's whereabouts, letting colleagues know of their own whereabouts, doing rounds two-by-two, or evaluating patients from a distance (keeping an eye on patients from the nursing office) are all active/interactive actions that nurses have developed and adopted in order to decrease their potential victimization. This may also include changes in monitoring procedures, such as increased monitoring of doors or common areas.

Well, if you were going to talk to him, you talk to him in an open space. ... if you are going into a room like this, bring another staff in, let every staff know where you are going to be; have a staff outside the door. (Philip: lines 552-555)

You kind of stick closer to the office when you know that somebody is in...you kind of look out of the office more frequently. Whether it is over the half door, or you open the half door and you look down the hall, you are just kind of more often keeping an eye on where that person is. (Nathalie: lines 838-845)

And because I knew what he was capable of...when he lost control, then I was very nervous...but certainly very aware of where they were and where I was in relation to him. (Nathalie: lines 817-821)

Other active actions may also include the decision to use protective devices to enhance feelings of security. For example, nurses use personal alarm systems to alert other nurses who may be in a threatening situation.

In brief, passive actions enable the nurse to become aware of the situation, while active actions focus on minimizing the effects of the situation. A certain degree of evaluation takes place so that, somewhere along the way, nurses will assess if s/he has the necessary resources needed to deal with the situation. As the previous examples have illustrated, nurses have recourse to different resources (for example, the use of space, human resources and technology) to deal with all types of threatening situations.

However, there comes a time when the threat is great, and the resources are minimal. One nurse described a situation when a dangerous patient was going to be admitted on the floor. By reading the patient's history, nurses not only felt threatened by the patient, but also worried about their own safety. Discussion surrounding the possible resources available to deal with the patient were initiated, and a protective shield was brought into the unit. By anticipating the dangerous encounter and knowing full well that they would have to deal with this individual, nurses put in place a strategy to protect themselves. Although the strategy seemed irrational, even at the time it was put in place, the fact remains that nurses must make decisions regarding forced, dangerous interactions, and that these situations will be dealt with according to the resources that are available.

The first couple years I worked here, they brought a fellow in. He was about six foot four, 250 pounds, not an ounce of fat on him. In case something happened, they brought the staff up a battle shield, a protective plexiglass shield. And I thought, "If we go to use that shield, he is just going to squish us against the wall with it." (Philip: lines 533-537)

In a sense, interventions that are directed at the self reinforce the nurse's responsibility in ensuring her/his own safety. The nurse must take the steps necessary to ensure that s/he remains safe. As the following nurse suggests, nurses must adopt a particular sensibility, which can be referred to as "being street smart." When a new patient may pose a high risk, nurses must become increasingly aware of their surroundings. Nurses do so by evaluating the situation and deploying self-directed strategies to diminish their chances of being victimized.

You know how you teach your kids to be street smart. I think in a lot ways it is the same thing here on the ward. When you go out on the ward...I think it just sort of becomes something that we do, that maybe we are not aware that we do. ...If you have a new person on the ward who certainly is a high risk, you just use a little bit of extra caution when you go on the ward, knowing where they are...you find out what has their interaction been like. You pay attention to report, what's their affect? What's happened? Have they had a lot of complaints? ...are they mad about something? ...You just kind of stay abreast of what is going on with that person. I try very hard to make it a practice, especially since we moved over here, where we do not have cameras, like we did. I would rarely go out of the office, even if it is just scooting down to the office, that I do not tell somebody else where I am going.... (Nicole: lines 329-344)

Interventions directed towards the patient

In anticipation of potentially threatening situations, nurses discussed direct and indirect actions aimed at containing and controlling threatening patients.

Direct interventions

Nurses follow a mandate that requires them to act in violent and potentially violent situations. Direct actions are forms of control that are aimed at the patient (and his body). Direct interventions can be verbal, physical and/or chemical. On a continuum of restrictive interventions, from least restrictive to most restrictive, participants noted verbal de-escalation, offering a PRN, using physical force and finally chemical force (chemical restraint). Seclusion is a direct method that is used by nurses to control threatening individuals. For example, at the time that this research took place, a high profile rapist was

supposed to be admitted to the assessment unit. In order to protect the female staff, nurses discussed putting the patient into preventive, locked seclusion.

Like this guy, [the patient...] He was the apartment rapist in [city]. He killed a couple of girls and raped a numerous amount, and he is supposed to be coming down. Now, [the psychiatrist] has seen him, and apparently he has our unit on his disposition. [...the psychiatrist] has said that, in the event that he would come, that we will not be able to have females on the unit at that end. And I am thinking, we have all these female staff here. ...So the plan was that he would get locked up every night. He gets locked in his room every night. And to keep everybody safe, that is fine, OK. But then you have the College of Nurses: "You cannot just lock him and not watch him"... so... "Well no, he signed a waiver; we do not have to check on him"... and it is like... I still do not know. ...When you have somebody locked behind a room that usually is not locked, I do not know if the College of Nurses...If he is coming, I would like a camera in his room. I think that is the safest thing, is to be able to monitor this man by somebody. ...He will be out on the ward during the day...how do you protect yourself if he drags you in the bathroom and the door is closed? (Patricia: lines 476-513)

Nurses were aware that the situation described above might raise ethical concerns, which were being explored at the time. However, nurses essentially tried to control the threatening situation by adjusting restrictive interventions directed at the patient.

Indirect interventions

In order to diminish possible threatening situations, nurses could also utilize indirect interventions. Indirect interventions were described in terms of strategies that would discipline either the individual or the group if deviant behaviours were presented. The privilege system is a good example of indirect interventions that are used to control patients. Although the nurses' acts of gratification or sanction are direct, the patient's knowledge that a particular behaviour is linked to a certain outcome becomes a self-disciplining element. This can also be applied to the group, where in-house regulations are put in place to discipline the entire group should deviant behaviour occur.

At the time, it was more dangerous on the admission ward, because there was a lot of security that was in place on the forensic ward. Back in the day, if a patient attacked me ...all of the patients were confined for at least the morning or the afternoon. So they all had a vested interest in not letting anybody get attacked if a fight broke out. (Dustin: lines 39-47)

Interventions directed towards the environment

Finally, in anticipation of a potentially threatening situation, nurses can organize their environment to diminish this potential. The most popular intervention directed at the environment was the use of surveillance technologies such as cameras. However, interventions directed at the environment may also include the addition of nursing bodies on the units. Having more personnel on the units can be considered a change in the environment that creates docility in patients.

Safety in numbers

In this research, nurses drew on the collective notion of the group (safety in numbers) to assure that safety would be maintained. Visibility of staff and organization of space were coupled with a need for social cohesion. Simply put, nurses felt safer as a group.

If I felt uncomfortable with somebody, I would just make sure that there was another staff there. ...I just would not be alone with them. ...There is safety in numbers. (Isabelle: lines 64-68)

At the collective level, sheer numbers impose a certain degree of docility from patients. Nurses believe that the visual effect and presence of staff create this docility. Increased numbers of staff in a potentially violent situation may facilitate verbal de-escalation; should verbal de-escalation not be possible, then adequate support is present to intervene.

Even numbers, whether you are male or female, tend to intimidate. Not intimidate, tend to show that you mean business. And I do not think that staff intentionally means to intimidate a patient but, just by sheer numbers. (Sylvie: lines 352-355)

Definitely, numbers matter when there is a violent patient. I have been where there have been a couple of stand-offs and people attacked and forced into seclusion; and oftentimes when you have two or three people, they are not going to go. But when you have ten people, they, you know...common sense does sink in no matter how psychotic they are. (Mary: lines 431-436)

The group represents the tangible element of visibility and safety. However, the notion of collective safety goes beyond simple numbers; safety, on the one hand, is individual (in that the nurse must learn to take responsibility for what is happening to her), but it is also

collective (in that nurses depend on others to evaluate risks and feel safe). At the individual level, nurses are not only responsible to evaluate personal risks, but also to ensure that they are proficient in their security interventions in order to ascertain that group safety is not compromised (the collective). For example, if one nurse makes a mistake, forgets a detail or does not wand a patient properly, their actions compromise the security of the unit and all of its residents (including the staff).

If you want to go home safe and sound, then you are ultimately responsible for your own safety. You cannot always depend on a co-worker or somebody else to protect you. And I do not want to ever go home in a wheelchair or being immobilized or be dead. ...part of your job is to respect and help out your co-worker, so if you notice something and then you go home that night and you never told anybody and you figure, "Nah, that was not really that important." But later on that night somebody got hurt and all of a sudden you realize, "Oh my God. If I would have said something, maybe that would not have happened." ...But you cannot depend on them always. You have to be your own best security officer and safety officer (Patricia: lines 280-294)

In other words, nurses' safety partly depends on each others' actions. If all staff is performing their duties correctly, then the group is considered safe. Therefore, a lack of group cohesion may lead to an increased perception of threat. In this particular study, some nurses described being set apart from the group, and consequently deprived of this sense of unity.

Twenty years ago when I started, it was made very clear that if you say anything about your colleagues, that the next time somebody is assaulted, if it is you, they may take longer to get to you. (Mary: lines 470-472)

So it is kind of intimidating if you have been told, "Something bad could happen to you, and we would be pretty slow to come." And you are the only person who is on the ward. And you are relying on those people to have your back. ...you just stay in the office where you are safe. (Julie: lines 809-821)

4.3.3 (In)visibility

The concept of (in)visibility is used here to demonstrate both the need to make visible what is invisible (invisibility), as well as the need to be visible (in visibility) to others. It represents the need for staff to see all and be seen by all, not only for therapeutic reasons, but also because of security imperatives. As such, being visible and invisible on the nursing units

were described in terms of the organization of space, how the nurses position themselves in that space, and how surveillance technologies (cameras) have been fused with nursing care to actualize this visibility.

Spaces and bodies

During the interviews, connections were made between the physical layout of the in-patient units and the monitoring and positioning of bodies within these spaces. Nurses described the in-patient units as spaces of division, exclusion and (in)visibility. The position of nurses within these spaces was always defined in relation to others (both patients and staff), and was qualified in terms of relative safety. Being separated from the nursing group created a relatively unsafe situation, because it affected the visibility of and accessibility to other nursing staff. For some nurses, this relative safety is considered a threat to their integrity, while for others, it is more a question of proper functioning. Not being available or accessible to other staff jeopardizes the general safety of the ward.

It is not really safe to get settled at any one end on the ward either, because there is no contact with elsewhere on the ward. And we have fewer staff now. Like they said when we came over here, because we do not have the cameras, "Well that would free up another staff." Where we used to always used to have one staff on the camera. That would free up that staff. Well okay, we do not have one staff that would work the cameras and the doors. Over here; we have a staff to do the doors; we have staff that has to be in the office to answer the phones; we have a staff that has to be available for patients' requests and this kind of thing. ...It just has not worked out ... and I have found, like, I will go get settled at one TV room or the other, and you will be there less than half an hour, when another staff member has to come looking for you because we need you to cover this while we do this, and that kind of thing. (Dustin: lines 131-141)

Being visible and accessible on the in-patient units proved to be an important dimension of nursing care. A certain number of "bodies" (nursing staff) are necessary for the unit to function "safely," in that nurses need to be readily available to "cover" each other when particular situations arise. Not being visible to others and creating a detachment/distance from the hub of the unit (nursing office) diminishes the presence of bodies that is required for safe, overall functioning.

If you remember me telling you, first we had 9 staff with no cameras. Then we went down to 6 with cameras. Now we are at 6 with no cameras. There is about four or five patients that go one-to-one out three times a day. There is two groups of one to four patients that go out three or four times a day. One or two people are spending their entire day taking patients in and out on privileges. So that is going to leave a med nurse, a charge nurse, which you really cannot count, because they are involved in.... so that leaves you two people with locked doors in the middle of the hall, to interact with the patients....(Julie: lines 1061-1071)

The same logic of visibility and safety can be applied when assessing the potential for violence. Because the layout of the unit does not permit direct visibility of common areas, thus creating invisible positions, detachment from the nursing station becomes a safety issue. If something were to happen to staff or patients, it is possible that there would be no witnesses to the event because of the lack of visibility.

I would prefer to have the cameras in the office like we did in the other building. I am not a huge fan of the layouts here. I do not like that the common areas are way down at the end of the hall like that, behind closed doors, because if anything did happen to a staff, for example, nobody would really know unless they went down for their hourly round. And same with patients; if they got into a fight, unless you hear someone screaming, there is not really anything you can do. I do not like that we cannot see the unit anymore. (Isabelle: lines 341-348)

This division and isolation creates a situation that is subsequently viewed with caution. Consequently, nursing actions are determined in terms of the potential for an adverse event to occur.

On nights here, there is four staff. If somebody is off on break, if somebody is busy down on the other end, you cannot be everywhere. If you have got two in the serving area...; you have got somebody answering the phone; you have got somebody pouring meds...; at least one person is down by themselves. If something would have happened. First, you cannot split yourself. (Tracy: lines 128-135)

There is a difficulty associated with the positioning and monitoring of individuals to create safe spaces. The secure environment can actually diminish or increase the potential for a threatening experience for nurses. Having to work with individuals away from the main work unit (nursing office), alone, behind a number of locked doors and hallways, increases the perception of a threat. This is not to say that nurses will be immobilized by terror. On

the contrary, nurses will continue to carry out their nursing duties. However, care will be defined within a frame of reference wherein danger is always more or less present. Unless an imminent threat is felt, nurses will continue on with their regular routine. This next excerpt actually demonstrates how visible division and separation of patients in relation to staff enhances feelings of safety in a situation that is considered potentially dangerous (nursing rounds at night). According to nurses, what makes this situation less dangerous is knowing that each patient occupies a specific space that is observable, and that these patients are kept at a safe distance.

Making rounds at night, some staff will...go in pairs and some staff would not. ...This unit, everyone is in their own room. Over there, there were sometimes two and three people in a dorm with curtains. So...it was kind of unnerving at two o'clock in the morning to have to walk by two curtains in order to see that third person. ...Because you did not know what was on the other side of that curtain. ...Nothing ever happened, but the thoughts were still there. It could be very easy for somebody to clonk you over the head...whereas this setup is much less anxiety-producing, because everybody is in their own room and... you can observe people sleeping without actually entering the room. (Mary: lines 165-180)

The way space is organized and made visible will affect the nurse's sense of control and safety over the environment and the population for whom they care. The removal of cameras and seclusion rooms, for example, has created a sense of loss; some nurses do not feel they have the necessary resources to deal with threatening situations.

It was a different thing before moving here. If there was a situation that built fear, I felt more in control to deal with it. (Tracy: lines 456-457)

Technology and surveillance

The use of surveillance technologies on the forensic psychiatric units was an interesting topic of discussion, because it yielded paradoxical positions; it was described as both a positive and as a destructive force. This sub-category of (in)visibility attests to the difficult relationship that is formed when technology and nursing care, or the ideals of nursing care, are coupled. At the time the research took place, the use of all surveillance technologies such as two way mirrors, monitoring stations and cameras had recently been

removed from the in-patient units. As such, nurses often described the use of technologies in terms of comparisons to old ways of operating, which were generally considered "safer" because of the visibility they created on the ward. Nursing care continued to be exercised, but a language of increased safety (or lack of) was very evident.

One of the reasons for introducing surveillance technologies on the in-patient units was to create a safe distance between staff and potentially violent patients. The use of cameras in seclusion rooms was a recurrent example given by nursing staff. Although this form of surveillance no longer exists on the units, the possibility to monitor from a distance without being subject to physical threats from potentially violent patients was considered to be beneficial for nurses. In light of caring for dangerous individuals, surveillance technologies created a safe zone for nurses by replacing human contact with a distant (safe) observer.

That is just in the space planning, because if he is coming, I would like a camera in his room. I think that is the safest thing, is to be able to monitor this man [a rapist coming from jail] by somebody, and not just sort of leave him in there and not be looked after for the whole night. (Patricia: lines 500-504)

Surveillance technology was not necessarily used for its disciplinary effects, the presence of cameras theoretically diminishing the chances of violence since patients would know that they were being observed. In the following case, the use of cameras was described in terms of its effectiveness to enable quick responses to dangerous situations and its usefulness as a covert method of surveillance and documentation.

I see taking the cameras as taking a very important therapeutic tool and security tool, because there is a lot of behaviours that you would be observed on camera while you were outside the room, that would not be exhibited when you are out on the floor. These people just are not going to be doing these things, and I personally have been in a situation where I was attacked by a patient, and before staff on my own ward knew that there was a problem, we were already getting assistance from another ward that had seen the assault on camera. (Dustin: lines 80-91)

It just seems the layout is, the halls are closer and it is sprawled out more. And with no cameras that we have access to, we cannot keep an eye on things the way we did over on [the other ward]. Like [the old wards] both had monitors in the office and the cameras on the ward. And they could see things starting or the potential for happening before anything got totally out of hand ...You could do the assessment of anybody coming in on assessment. Here, ...they are going to act different if they know you are right there. They are going to act a little different than they would be ...and without the cameras, we cannot catch that. We cannot get to their true behaviours as easily. (Nathalie: lines 314-326)

The use of cameras was perceived by some as useful, because they not only permit nurses to monitor and to react in violent situations, but also to observe behaviours that patients do not necessarily demonstrate when staff is present. Cameras enable nurses to see what the nurse-patient relationship failed to see, or what was usually hidden in daily encounters. This type of observation is valued, therefore, not only for its capacity to evaluate the patient's condition from a distance and to respond to dangerous situations, but also for its ability to ensure a certain degree of social order. In this environment, the patients are considered to be deviant and manipulative in addition to being sick. Cameras were used to see whether order could be maintained.

A lot of times you cannot monitor what is going on, because when staff are actually in there, nothing happens. It is a whole different dynamic than when we walk out of, say, the TV room. Then the real... whatever is going on would happen. ...Plus they have lookouts. I mean, you go to walk down the hall, and they have got somebody watching. As soon as you come, then everything stops. So you do not get a sense of if somebody is getting bullied down there, which has been the case many times. ...And we have no way of knowing that until the client comes to us and complains about it, which then puts them at even more risk. ...many times people were saved because the camera was there. A staff had gone down to do whatever...was attacked, was seen on camera, and helped. The same as a patient can be attacked. It is just a safety feature. (Tracy: lines 135-163)

In addition to the efficiency of cameras as they allow nurses to quickly respond to dangerous situations, the visibility they offer also creates a sense of virtual safety. Although nurses may be alone in a sector of the unit, they nevertheless feel the presence of the group because of the real-time visual supervision; this effect often out-performs that of other safety devices (such as personal alarm systems).

I felt safer on our old unit. ...Because of the monitoring that we were able to do. The camera system that we had in place. ...You could see so much more, and you were aware of what was going on. ...You knew that when you are in the main hallway, staff could see you. You knew that if you went into one of the patient's dorms, or even went into the bathroom, staff saw you going in there. They knew where you were on the ward at all times. (Nicole: lines 635-650)

Plus not having the monitors, like the cameras that we can use. And you just felt that when that was there and your own co-workers were watching, they had your back. Here, without that, it feels like you do not know if anybody has your back or not. (Nathalie: lines 399-405)

Over the years when cameras were used on the units, visibility became extremely important for nurses. However, when nurses recently changed buildings and were deprived of their "visibility," the in-patient units suddenly became unsafe; the change not only increased the chances for nurses to be isolated from the group (virtually and in reality), but also provided less control over deviant behaviours on the floor. Once the implanted cameras were removed, participants reported, their sense of vulnerability was renewed.

When we were out on the ward and we did not have cameras, there was always lots of people. Now you would be out there alone. I mean you have this little PALL," and it is a silent alarm, so you do not even know for sure if you have (run) the thing properly, or if someone is going to be able to come and help you. You are all by yourself to defend yourself. ...Where before, that would have been very visual. That we would have been seen and heard. (Julie: lines 454-483)

In 1996, we had nine staff on days, on one floor with no locked doors in the middle. We had 36 clients, no cameras. So everybody was out, around, hearing, seeing. Then when we were refitted in '91.... They told us we needed less staff because we had cameras. We were in a control booth...And we could see the hallways; we could see the common rooms. ...Now when we moved over here, now we have six. We have double, locked doors separating two units, but we have no cameras to monitor. So people have become even more reluctant to be out and around in the hall. (Julie: lines 432-450)

The question then becomes: Why were these technologies taken away? The paradoxical positions emerge at this point. Some individuals justified the need for cameras because of their surveillance and safety features, while others viewed the use of cameras

as the source of a distant nursing practice. The effects of cameras over time influenced the way nurses actually organized their care. For some, having a monitoring station was believed to have created a centre of surveillance that took nurses off the floors and actually decreased the potential for nurses to use and maintain their psychiatric skills.

Except for in the seclusion room, [cameras] were the biggest mistake they ever made on forensics, because it took nurses out of the ward and into a bubble. And over here, the nurses are still in the bubble. So at any given time, you can walk up to the office, and there is usually three or four people sitting there. ...cameras did not tell you what was going on in the rooms. ...You could not tell a mental status looking through a camera. So it gave them a false sense of security as well. When you were making rounds, you hoped that the person sitting on the cameras was watching. ...Cameras, I think they really allow people to not use their skills in observation and assessment. (Mary: lines 890-919)

The negative attitude toward the use of surveillance technologies essentially represents part of the care ideals promoted by the administration and some staff. This view of care promotes the creation of a dynamic relationship with patients, where human contact replaces technology (in its mechanical sense). That is, human contact is considered a human technology of surveillance, whereby being present on the floor, "watching more" and being "more aware," produces results similar to those of surveillance cameras. However, as explained above, the ideal of human contact is juxtaposed with safety concerns. Although threat is not imminent, and will not necessarily impede nursing actions, most nurses favour increased visibility of their surroundings.

4.4 CATEGORY 4: OTHERING

4.4.1 Demystification

4.4.2 Abjection

Creating a distance

4.4.3 Decriminalization

Minimizing contamination

Working in the moment

Getting accustomed to the histories

4.4.4 Identification and Differentiation

Contextualization

Vulnerability

Perception of control

4.4.5 Potential for recovery

Favoured patients

The fourth category (Othering) that emerged from the data analysis is the core of this investigation, because it is the site of a basic social process, and represents the site where all other categories converge. (Refer to Figure 4.3 for a visual representation of the basic social process.) This section provides a descriptive plan employed in all of the other categories.

The section begins with a description of the nurse's exposure to forensic psychiatry, followed by a description of abjective situations described by the participants.

Next, it explores how nurses attempt to see the patient as a person by de-criminalizing them, and reports the contextual elements that must be put in place to do so (process). Finally, it describes a differentiating classification system for patients who are considered to have no potential for recovery.

4.4.1 Demystification

As many of the participants reported, preconceived notions regarding forensic environment patients were generally negative and ranged from extreme cultural representations of the violent serial killer to the criminal manipulators of the judicial system.

I actually pictured people in cages. Like in cells you know. The way they described it: "Well, you cannot go there," was like... I thought people would be trying to jump on my back and beat me. You know, I thought they were totally insane people that were also criminals. (Julie: lines 29-33)

I kind of got the idea that it was really, really dangerous, and it was Hannibal Lector type of people. I mean, ...there was some pretty bad people that were, you know, you kind of put up in that class. There was a couple guys that were really, like, scary, I guess you would say, or really sick. (Trevor: lines 43-48)

Nurses reported that how they conceptualized forensic practice resulted partly from a socialization process. One nurse, who was warned that forensic psychiatry was a dangerous area of practice, initially conceptualized having to physically defend him/herself. Due to the particularities of the environment and the population being cared for, one's personal integrity/safety could be at risk and could require nurses to engage in self-defence strategies.

When we were students, we were not even allowed to tour that unit, because they said it would be so disruptive to the clients. So I had absolutely no idea where I was going. I went home and told my husband I would have to quit my job, because I was sure I would be killed. I would not survive there at all. I was not a fighter, I was not somebody who could defend myself. And the best advice I got from my geriatrics friends was, "Keep your back to the wall." (Julie: lines 15-22)

This last quote also summarizes a negative, outsider's view of forensics, since forensic professionals often promote a language of fear and safety risks. However, some nurses

have also been encouraged to gain exposure to forensic psychiatry. Notably, recent graduates were presented with an image of forensics as being an interesting field of practice, though they were not entirely aware of what the practice entailed.

Honestly, I did not really know too much about it before I came in. ...I just remember the teacher asking us, "If you had an option as to where you wanted to go?" And I was told that if the teacher asks that question, to make sure that I said forensics, because apparently that was the most interesting ward to work on. So honestly, I did not know too much about it. I did request it at that time. I did not get fortunate enough to work on forensics until actually getting hired on. ...So I did not really know too much about it before going in. Just knowing that it was the most interesting ward to work on and that was it. (Kristen: lines 28-41)

Evidently, "forensic psychiatry" reflects a socially constructed reality and may echo Kent-Wilkinson's (2008) observations regarding the growing popularity of forensic professions, fueled by media attention to the word 'forensics'. Nevertheless, these aforementioned preconceptions were the product of a social scheme of reference that was often fed by vague understandings of what forensic psychiatry actually represents. However, beliefs regarding the population were either reinforced or rejected once the participants actually began working in the environment. Many patients were stabilized on medication, and, as a result, nurses' preconceived stereotypes of troublesome patients, as produced by popular culture, were eradicated. A certain shift took place, wherein the nurse's social scheme of reference became informed and modified by clinical practice.

I discovered that they were probably the more stable psychiatric patients in the system. Nobody was jumping at my back; they were not in cages. My mental image going there was completely evaporated. (Julie: lines 43-46)

I guess, when I very first started here, I thought forensics was full of murderers and paedophiles, that I always had to watch my back. But after working here and developing rapports with the different clients, establishing trust and communication, I knew it was not like that. Once they were stabilized on medication, that is not the case. When these patients were stabilized on medications, I felt totally comfortable being around them. (Philip: lines 18-24)

When I first came, I had heard a lot of horror stories verbatim from other people that had never worked forensics. And so the first six months of my job, probably, was educating myself and not being afraid of talking to a

mentally ill person that was designated as a forensic patient. (Patricia: lines 23-27)

As for physical assault, very few nurses described having been victims of physical violence on the wards. Whether initially or over time, nurses who work at the F.P.T.D. have come to describe the work environment as unique. Though some nurses have developed a certain comfort level within this specialized practice, there remains an element of unease. As this participant clearly summarizes, patients may not present themselves exactly as they were imagined to be, but remain different:

You expect people in straightjackets and bark-at-the-moon-crazy kind of thing. ...you understand on some level that that is not what you are going to find, but at another level, you certainly expect that things are not going to be quite the same here as elsewhere. (Dustin: lines 23- 27)

4.4.2 Abjection

While patients' crimes were not always gruesome, many nurses expressed difficulty working in this field because of their knowledge of the patient's crimes and the way patients conduct themselves in the clinical setting.

I had to manage the constant thought of the crime that this person did; it was horrific, and it was probably one of the worst ones on the unit. And the patient was very, very challenging. He had a challenging past with every single nurse that he came in contact with. Very litigious. So I had to really be careful with.... Just coming into forensics, you know, it was a challenge. (Jordan: lines 46-51)

The gravity of the patient's crime may create a certain dis-ease for nurses who are exposed to them. First-hand knowledge of a patient's offence, and continual interaction with the patient, makes the crime somewhat tangible.

Just knowing that I would be taking care of residents that both had a psychiatric illness and were responsible for some sort of crime. I guess it was a shock to know to what severity the crimes could be.... Like whenever I heard "crime," I was thinking more like shop-lifting or assault or... not realizing to what extreme. (Kristen: lines 46-52)

A few nurses mentioned that working in forensic psychiatry might not be suited for everyone. One is either able to work with patients who have a criminal history or not. Not

being able to work in this environment often corresponds to a difficulty with creating boundaries around the crime. The label "not criminally responsible" loses its meaning, because the crime (the action) takes on greater proportions.

I find staff are either okay with people having a criminal history or not. Like, they are either jaded towards this population or not. If they think, "Oh bloody criminals"... they tend to think the same about patients over here, whether they have been convicted or not. It does not really seem to make a difference in people's opinions. It is their actions. (Isabelle: lines 324-329)

Working with individuals who have committed particularly horrendous crimes affects the nurse at another level, one that reaches beyond a patient's difficult behaviour on the unit. The crime becomes a source of fear and/or disgust embodied by the patient (who, therefore, becomes "difficult").

As nurses are socialized to put aside their judgments, they attempt to set aside the effects of knowledge (the crime) and engage with the patient even if the crime repulses them.

I guess I have to kind of keep my emotions in check, particularly sex offences towards children, just because I have my own... so I just kind of automatically do not like them. But I try not to let that show. (Isabelle: lines 404-407)

Setting aside this knowledge can be difficult, and may even push the nurse to try to ignore the patient. As this nurse recalls, choosing not to deal with a patient's history created a dangerous situation, one that eventually led to the nurse being held hostage by the patient.

Over the time, I have seen some staff who said that to patients. You know, I would like to be able to deal with this, but I cannot, so I will not. And then I have seen them getting into really bad situations, because that information is kind of put into the patient's head. (Julie: lines 109-113)

Creating a distance

Setting aside negative feelings that particular patients evoke is difficult because nurses are constantly in contact with patients. As described by one of the participants, working in forensic psychiatry is mentally challenging, because it can be emotionally draining. The

patient may not represent a physical threat, but, rather, illicit a psychological state that nurses seek to control, contain and to some extent, avoid (distance).

I did not feel physically threatened, but mentally and emotionally threatened, yes, definitely.

Q: What do you mean by that?

...As I said, I did not fear for my safety physically, but, mentally, yes. Because this client was very, very challenging. I mean, in twisting every thing you say into their interpretation. I found that when you are dealing with a psychopath, it was very very difficult. (Jordan: lines 67-87)

The following excerpt illustrates how negative representations can cause nurses to avoid patients. This negative representation involves a justification on the part of the nurse to avoid the patient. However, the following nurse believes that one must overcome negative, even uncomfortable perceptions of patients, and continue to create therapeutic opportunities.

Because his personality is so difficult and it does not seem like he appreciates anything. Nobody seems to get through to him. He is just doing his own thing. He is nice when he needs something; other than that, he just does not talk to you. ...So the fact that I apologize to somebody who is that nasty to me... they just could not understand that. Like, "Why would you do that? Why would you set yourself up for that? Why would you go and talk to him again after he cursed at you last week?" And it is like, "I do not go and figure out why"... he was not born like that. I do not care if you have a psychiatric illness. People are not nasty. They were not born nasty. Something happened. (Sylvie: lines 821-832)

Yet, initiating contact with the difficult or "nasty" patient is not an easy task. As this nurse explains, there is a certain dissociation or differentiation that takes place, wherein nursing care becomes technical and the patient is objectified. In other words, by understanding care for the patients as a technical intervention that is temporary, nurses view the interaction as having an end, and move on to caring for other patients; essentially, they do what is needed and end the interaction.

Like I say, there is nobody here I believe that would deny him anything. If he came to them, and they were the only one standing there, and he asked for something, they would not ignore him. They just do not take that extra step to go... And again, that is human nature. ...I mean, there are some that just

think they can irritate me. And you know, it is not good for them; it is not good for me..., so you know what, there are 32 other people that need your attention... you know... you finish what you are doing and then you go deal with others. (Sylvie: lines 870-878)

Distancing oneself from the patient can be a conscious but difficult decision to make. As this nurse would suggest, difficult patients disrupt what the nurses consider to be proper nursing care. Working with difficult patients challenges their professional values, because nurses cannot provide the care they would like to these particular patients.

It is really hard. I mean there has been patients that I, you know, it is all I can do to be nice or..., I should not say nice, but to be the way I want to be with them. Especially if they turn around and sort of undermine what you have done or are belligerent with you. It is not easy.

Q: Does that affect you at all?

Yes..., it is frustrating. (Nicole: lines 254- 262)

However, nurses believed that being conscious of the distance they create between themselves and the patient is important, because it enables the nurse to examine and change their approach if necessary (including asking another nurse to take over).

Sometimes if you have a really bad day with an individual, you know you can only take so much. And, I think you have to recognize that enough is enough. Anymore interactions, and I am probably not going to be as diplomatic as I would like to be. Or I am going to lose my patience, and it is not going to accomplish anything. It is going to be a negative thing. So you are better off just to back off when you feel like that, and let someone else step in if possible. (Nicole: lines 267-274)

In other words, nurses may want to keep their distance from the patient to the point of significantly diminishing interactions. It is not necessarily that the patient is physically violent, but rather psychologically violent; the patient embodies certain negative attributes (being nasty, difficult, repulsive, etc.), and it is these attributes that are being distanced. For example, this next nurse explains how he consciously avoided a patient, because the patient evoked feelings that would negatively affect the nurse's objective judgment. By acknowledging this repulsion, he took actions to create distance, thus limiting interactions.

I avoided him as much as possible. If he was seeking out my help... luckily... I do not know whether he just sensed something or there was some other reason, but luckily he liked to deal more with the doctors and other professionals, so he would rarely seek me out unless it was something very, very basic. So I was able to keep my distance from him that way. (Dustin: lines 693-698)

The inability to deal with individuals because of what they embody is part of the practice in this forensic psychiatric setting. However, in order to deal with all situations professionally, importance is attributed to identifying situations where nurses begin to distance themselves from patients.

Well, that is probably the part of this environment I had the most difficulty adjusting to. ...sometimes you would have a particular patient: "Oh my God, this just does not work between us"; ...no matter what you do, it does not work. So if you have that kind of situation here. I feel a nurse has to come in and make up their mind that they are going to deal with it professionally. (Rachelle: 171-182)

Everybody has their favourite patients or patients they enjoy working with, and others do not. We have 27 nursing staff here, not even counting the support people, ...so I think you complement one another. You start to identify: "Well, so and so cannot deal with that person. So I will step in and do that"; and you just do it sort of automatically. Just because you do not want to see that person maybe treated harshly or with less respect, because you know so and so just cannot deal with that particular person. So you do complement one another after a while. (Patricia: lines 146-155)

4.4.3 Decriminalization: Seeing the Patient as a Person

Working in forensic psychiatry means that staff will come into contact with individual histories that are both gruesome and troublesome. Despite the fact that nurses must take into account contextual elements of this history for therapeutic reasons (triggers, warning signs, etc.) and for safety reasons (dangerousness), nurses also emphasized the need to separate the crime from the person in order for their interactions to be therapeutic.

I need an awareness of the crime. I need to know what the potential was, what warning signs I might need to look for. But I try to judge that person as a psychiatric client. Who requires some special rehabilitation in order to maintain himself in the community. ...But then you have to put that potential away. (Julie: lines 245-275)

For the most part, the professional value is to see the patient first and foremost, as a human being; this is a characteristic and perspective that nurses must adopt in order to carry out their practice.. As this nurse explains, some patients (in particular child molesters) are treated differently ("the lower on the ladder") because of their crime. When the patient's history cannot be set aside, the background of the patient may affect care, depending on the nurse's appraisal of the situation.

I just think it just sort of came as time went by, and you, you did your job as a nurse and you got talking with them, and dealt with them, and joked with them... you know... and I think I started seeing them as human beings and not just a statistic on a chart with, you know two counts of murder or two counts of rape... and yes, you have to be able to, or you cannot work... you have to be able to get past that. And I still see people, even now that, because somebody has been charged with child molestation, which is probably one of the more offensive of all, that that person sometimes is still, because of the crime... and I suppose it is similar to the correctional... that they are looked at as the lower on the ladder. (Patricia: lines 132-142)

Working in forensic psychiatry is about learning how to manage oneself in this particular setting. It is about learning how to deal with the emotions evoked by the patients' histories. The work involves an accommodation period and a de-sensitization to the patients' histories in order to separate their past from the clinical objectives.

When I first entered the forensic nursing, I was assigned a very challenging, difficult patient... initially, I felt overwhelmed, but I just kind of sat back, did a lot of reading, listened to a lot of people, took a lot of advice, and kind of learned how to manage myself... and manage my thoughts with this person, because when you are dealing with somebody... some of these patient have really horrific backgrounds. You kind of have to separate that from your goals with this person. (Jordan: lines 19-26)

Consequently, nurses have developed ways in which they can try to eliminate the influence of the patient's history, or at least, decrease the effects that the crimes may have on their judgment and practice. In doing so, nurses try to facilitate an identification process (inclusionary othering), where the individual requiring care does not become estranged to a point where care is no longer possible (differentiation). The following is a list of strategies that nurses have developed in order to diminish the possibilities for

differentiation. These strategies are minimizing contamination, working in the moment, and getting accustomed to the histories.

Minimizing contamination

Depending on the nurse, the patient's history may or may not bear the same importance in the conceptualization of care. For example, this nurse explains how she feels she can be a better nurse (non-judgmental) if she decides to meet the patient first and read the file afterwards. In doing so, it is believed that a stereotypical image of the patient (and his crime) will not affect the therapeutic relationship, or at least, affect it to a lesser degree.

I decided before starting in forensics that I would not read the history of a patient before I get to know him a little better, as I thought some of the crimes that some of them had committed would predispose me to maybe treating them not the same as the rest. And I was glad I had made that decision, as some of the other more horrendous crimes would have actually decided me to not really deal with them all that fairly. After working, I found they were just the same as the rest of our psychiatric clientele. They are people. Treat them as such, and you usually get treated the same back. (Nathalie: lines 20-29)

The reason for initiating an interaction and developing a relationship before getting accustomed to the patient's history essentially comes down to the nurse's ability to remain objective. When confronted with the patient's history, it becomes difficult to remain objective and continue to see the patient as a whole person rather than simply a risk factor. Essentially, the patient becomes one-dimensional rather than a complex, whole person.

I would meet the patients first. Get to know them a little bit, then I would go back and look at their history. Because if you do the history on some of these patients you cannot always be objective to meet them first. So that is what I set out for myself. I would spend a couple of weeks working with them, talking to them, doing things with them, then read why they are here. (Sylvie: lines 81-87)

In this case, the inability to remain objective translates into an inability to deal with the patient properly. This nurse describes the effects of the patient's history as creating a distance between the nurse and the patient; the crime predominantly defines the patient's

identity, and/or the nurse comes to personalize the crime (they become a victim of that crime or a potential victim of future violence). Reading a patient's file later in the hospitalization process (post initial interaction with the patient) is believed to enable the nurse to work with the patient and enter the relationship with fewer preconceived notions. It also creates a "real" desensitization of the *person*, as opposed to learning about the individual from a chart that fosters a cognitive interpretation and representation of the *patient/criminal*.

It makes you standoffish and nervous, right? This is a horrible person and it can affect you. I was like: "I am not going to be able to deal with these feelings." It makes you (nervous) even to have a verbal interaction. Until your verbal interactions became more frequent and you got to know the person, then you could see them as they were, and not necessarily just the crime you were reading about on the chart. So...I had to take a break and not read them, because some of them were just so horrific and I just... because, you see, you really cannot empathize if you see your own family as victims... so you cannot do your job properly, (Patricia: lines 997- 1010)

Well, they could not be able to get themselves past what the crime was, because the crime... if you are a woman and the crime happens to be against a woman... some people cannot deal with that. You know they cannot look at that person on a patient-nurse relationship. I think just the crime overwhelms them dealing with the client. (Jordan: lines 149-154)

This approach differs from the one proposed by other nurses, who cannot conceive of consciously refusing to learn the patient's history. Knowing the patient in detail provides a source of comfort and safety, because nurses must be aware of the potential for violence. Knowing the patient's history (including the crime) can help nurses to plan interactions.

Well, you are always conscious of the abilities of the client. I take each one individually. ...There are a lot of people who...worked with the client, not knowing what their crime was, not knowing anything. And...they told me that they prefer not to know that. ...If I am going to deal with a client, I need to read what's going on, and I like to know what the crime was, where this person came from. I like to be well-informed before I go in and deal with somebody. ...It does not really make me afraid, but it makes me aware. ... Knowing what happened and what the potential is, is my safety net. (Jordan: lines 124-141)

Reading or not reading the patients' histories is, therefore, part of the nurses' own experience with the file and how they feel it affects their care. This nurse in particular explains how, at the beginning of her career, she needed to step away from reading the files because it "mortified" her.

I think there is a certain fear factor when they first come here. And the biggest ones to see would be the nursing students. ...I had to stop reading them when I first came, because everything was just so horrible. Even now, every so often, ...the crimes are pretty gruesome. And back then, we had a lot of murderers, and we had a lot of arsons where people died. ...And after you read them for a while, you would just be mortified. It would just be horrible to read this stuff. So I had to go for a period of time with not reading anything and just getting to know the patients. Then, when I saw them as who they were, then I could go back and read about them. But in the beginning, when somebody first comes here, that is the first thing they do is start reading, and, you know, it does not really cloud your judgment, but it sure opens your eyes. I mean, that is how I did it because...I thought I will never deal with these patients properly if I do not put it in the back burner there and just get to know them, and I think that is how everybody does it. (Patricia: lines 964-986)

Choosing when to read the file reflects the personal prerogative of each nurse, which, in itself, reflects an individual approach to care. As one nurse noted, it may very well reflect the professional socialization of nurses at different times throughout history or even in a particular context.

Old school is: you read the chart, you know anything and everything about that person before you provide any care. I know that that was suggested to me before I came in. So I do not know if it is new school, that that is the way that people are doing things, but that is the way that I have done it [read the file later], and I feel that I am able to be a better nurse because of it. You know a lot of people look at me, and they say to me, like, "How can you do that for...?" Not to say it the wrong way, but... they have a hard time understanding...for example, we do have people that we care for that have committed a crime to that extent, and I am still able to sit down with them..., have a conversation with them, spend time with them..., play cards with them..., watch some TV..., read..., or write a letter or whatever it is they want to do..., and just spend time with them one-on-one (Kristen: lines 114-131)

As part of a socialization procedure, some nurses integrate this approach when teaching new nurses how to interact with patients. As mentors, nurses have taken on the

responsibility to pass on the importance of distancing oneself from the chart and getting to know the patients first (nursing ideal of identification).

I remember on our unit before, when we would get part-time staff in, they would hear the word forensic and they would be like (*out of breath noise*)... or when we get students in that were terrified of our clientele, I would ask them to get to know our patients first. Like, be on the ward... talk to them... hello... get to know their faces... that sort of thing. Read the charts later. That way you get a sense of their person rather than their crime. Here [assessment unit] it is a little bit different, because you get them in knowing the crime. You just have to find...some way to connect with... most difficult are probably paedophiles or something like that... and you just have to, kind of have to say, wait a minute... there are many different parts and you just kind of have to block that. (Tracy: lines 194-205)

This socialization is accompanied by messages of caution, informing nurses that they must not blindly approach the patient. Some believe that knowing the type of diagnosis is enough, while others require additional information. Some nurses have developed a hybrid approach to viewing patient charts by not reading the file in detail, but being aware of the patient's potential for violence. By distancing themselves from the gruesome details of the crime, they believe it becomes easier, not only to not personalize the patient's history, but also to remain safe in their practice. For some, the experience of reading the files in detail may "hit close to home," and make it difficult to work with that person.

I have seen behaviours seem to be different with some of the clients as opposed to others. That would lead me to believe that there is a factor involved in that... having read the file before getting to know the person. All I read is what they are here for. I do not read the details of their crime, or how long ago, or what the information with regards to that. I figure that I will get to know them first, and it seems to have worked so far, anyway. (Nathalie: lines 67-74)

Into the files and that, and maybe that crime is hitting too close to home, because maybe you have had some experience in your life that..., you know, is going to put you off of this patient. ...like I say, it is close to home, or it happened to you, or it happened to your relatives or. Because some of the stuff is pretty gruesome, and, I mean, you know that coming in, so that is why I just do not get too far into it. (Trevor: lines 773-778)

Regardless of what floor the patient is on, the chart or the patient history remains a constant variable in the evaluation of risk. Although assessment patients may be qualified as more dangerous and in need of a custodial approach (with cameras, for example), other patients who have gone through the system will still be defined by having a potential to re-enact the crime that has brought them to forensics.

Working in the moment : developing a clinical mode

When working with potentially difficult patients, some of the participants described being able to separate the crime from the person by creating a “clinical mode” – a type of disconnection in which personal opinions and values are set aside, and the task at hand can be carried out without any judgment.

I just have a knack for kind of turning off my personal opinions about things. I might think about it later, but at the time, I kind of get into clinical mode, and kind of shove my personal opinions and values aside, and just deal with the issue at hand. If I am struggling with something, typically I have staff that I can talk with. Like, I can always talk with my co-workers if I need to vent something because it is bothering me.... (Isabelle: lines 413-419)

Definitely there are always some people that are harder to take care of than others. But me, myself, I come down prepared for that. So it would take an awful lot for me to lose my patience in any situation.... (Kristen: lines 181-184)

This clinical mode is further described as a nurse–patient relationship based on empirical observations, in which emphasis is placed on what is happening with the patient in the present (mental status exam), rather than on past behaviours (criminal history). Thus, the patient is described in terms of his/her stability rather than levels of dangerousness based on his/her history.

I do not really think it makes a difference whether they are in here for assault or stealing a loaf of bread. The day to day stuff that does not affect my practice at all. If I think somebody is unstable and they might be a high risk, I might not do things alone with them or go outside alone with them. But really, I do not take their criminal background into consideration all that much. (Isabelle: lines 234-239)

The clinical mode is a temporary adjustment in the nurse's way of thinking and acting in a situation. In light of a particularly difficult nurse-patient interaction (where the patient's crime is hard to understand and where judgments are present), working in the moment or working in the "here and now" enables the nurse to create a certain comfort zone for interacting with the patient, in which past behaviours do not affect (or do not affect as much) the present. A certain preparation takes place when a nurse anticipates working with difficult patients, which allows the nurse to create this temporary distance.

I also try to separate... If I find some of the crimes are particularly difficult to understand I try to say... that was then, this is now; this is what I have to work with. (Julie: lines 255-258)

It is not that you forget this horrible background... it is not my place to judge them. My treatment of them should not be based on whether or not I think what they did was right or wrong or how the legal system played out. I may think that they just had a good lawyer and they should be sitting in jail... however, that is not what's happened. It is not my job; it is not my role; it is not my place to judge how the system has put things in motion; it is my place to deal with the here and now. (Nicole: lines 242-249)

Being able to separate the crime from the person becomes a valued professional ability, which makes it possible for the nurse to create a judgment-free interaction. This approach contrasts those discussed in the previous section, where different ways of using the patients' files are described. Developing a clinical mode or working in the "here and now" literally means that nurses are able to mentally block the criminal history and deal with the patient (not the criminal).

But I think at the time that I am talking to that individual, I can separate it. This is my job; this is professional. We are talking about a client that I am working with. What they did is kind of over, here. I kind of block it. We are dealing with what is going on with the client now, not what happened in the past, and what we are doing to get this person better. You cannot change what has happened. (Philip: lines 198-204)

I kind of take in the total picture and then put aside what I do not need right at the time, and I am still aware of what may or may not be needed, and then have that interaction with the patient. I do not know how else to explain that. (Nathalie: lines 158-166)

Getting accustomed to the histories

Being comfortable with criminal histories and de-emphasizing their place in the nurse–patient interaction was also described in terms of habituation. Continuous exposure to gruesome histories decreases the nurse’s shock or revulsion. Over time, ward nurses grow to distance themselves from the criminal aspect of the patient. Nurses describe being able to “become numb” to the histories.

I think that, when you are green, when you first start, sure, that—like, Holy Cow! It kind of blows your hair back. A lot of stuff blows your hair back when you are new. But as you get going on in your career, a lot of stuff just rolls off. You file it somewhere. It gets easier. (Trevor: lines 310-314)

Time becomes an important factor, taking into account that nurses will interact with the patients, and slowly put the patient’s crime into perspective and see the person as someone with whom they can work.

So, it probably took me six months just to get to know 44 patients. The first couple months, I think I read avidly on histories, and because some of the histories were so violent, that put a lot of fear into me. But I still managed, as time went by, to do my job, and got to know the patients. You always know what their crime was, you always know what they did or what they are charged with. And some of them have been very horrendous. But you are able to put that in the background and keep it in the back of your mind. To keep yourself safe, you have to be aware of that. (Patricia: lines 32-41)

Time essentially enables the nurse to feel that the patient’s chart (the crime) is something that they can dissociate from, something that can be seen as a separate entity.

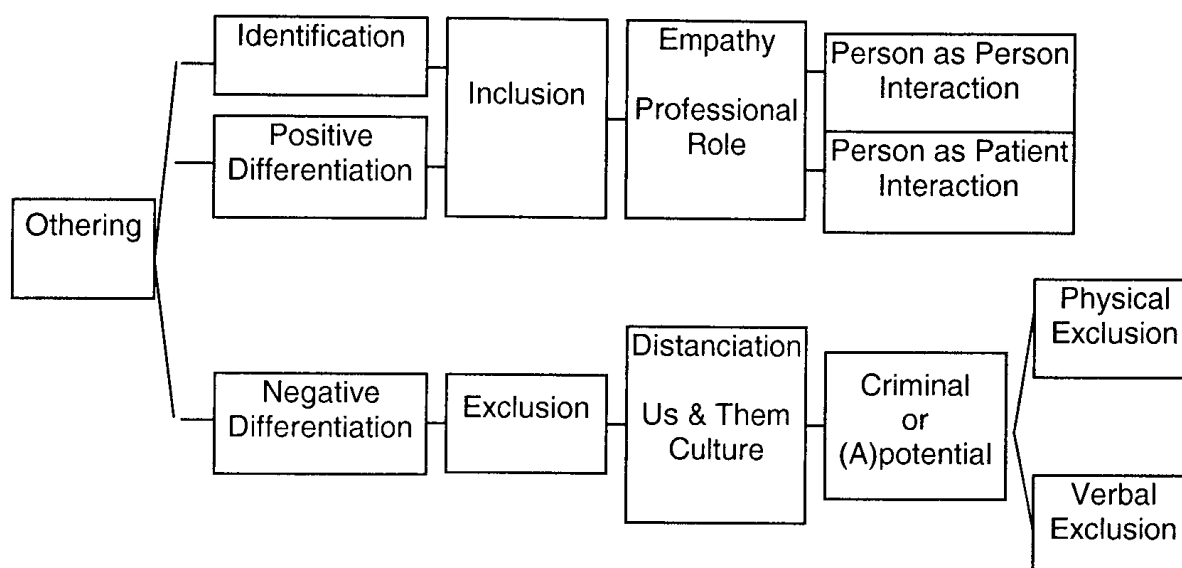
And then, gradually, as I got to know them, I had no problem. ...there are things that still horrify me. But, you know what? Now as you read the horrible, horrible crime that this person’s committed, and... and then I close the chart, and then I can deal with the patient and I know what he has done..., but it is just sort of back there. It does not affect me anymore. Like, it just does not, so I do not know if you become cynical or you just... you are able to: “This is the person here. This is the person I see.” And you do not amalgamate the two (Patricia: lines 1010-1020)

From the participant’s perspective, desensitization enables the nurse to identify with the person rather than try to differentiate themselves from the criminals.

4.4.4 Identification and Differentiation

Figure 8

Basic Social Process



A central element of the participants' accounts revolved around the possibility of either identifying with patients or differentiating themselves from patients. Despite the fact that nurses idealistically seek to create a therapeutic relationship with patients, tensions remain that may hinder this identification process and set the stage for a differentiation process. The identification process essentially refers to the possibility of eliciting an empathetic response from nurses when they are caring for mentally ill offenders. Yet, the identification process may involve a certain degree of differentiation, or what will be referred to as positive differentiation. The patient needs to be labelled as different (sick) in order to create a sense of identification with the nurse, who is then capable of rationalizing behaviours within the realm of "normal" human behaviour. On the other hand, the differentiation process may be referred to as negative differentiation, when the patient is no longer categorized within a medicalized scheme of reference and embodies deviance, difficult behavioural management (no potential) and disgust—characteristics that are deemed socially unacceptable, and that must be distanced. Although these processes are

presented as separate entities, nurses may navigate between them when caring for particular individuals. This dual process of identification versus differentiation should be understood as a fluid process, in that the nurse may move in and out of identification, depending on the context of his/her practice.

Strategies to counter the effects of knowing the patient's crime essentially reflect the deployment of a professional discourse, since nurses are trained to remain composed and in control during nurse-patient interactions (or at least, to develop ways to stay objective and patient-centred). Nurses are morally compelled to try to identify with the patient, which basically translates to the development of empathy. The nurse must put him/herself in the patient's shoes, "where you treat patients like you would like to be treated," thus humanizing care and identifying with the patient's situation.

I think that it is fairly reasonable, because it is the way that I have always done my practice. It is the way that I like to look at clients. I always think of this... this could be me, and you know... after a bad day, this could be me or my brother, or someone... and something can go wrong. (Julie: lines 266-270)

I do not care; it does not matter what program in a psychiatric facility or a general hospital, it just does not matter. I just always keep coming back to that golden rule..., "do onto others, as you would want to be treated if you were in that situation...." (Nicole: lines 233-236)

Most of our nurses are really good communicators. ...Again, you are going to get those few people, who, for example, one patient goes to the door and asks for something: "No, get away".... Those are the corrections-minded people. But that makes the patients stay away from the door. You only have to go up there..., if you went up to the door once, and you get that attitude and you are a patient..., would you go up again? (Julie: lines 839-846)

However, the continual deployment of this professional persona can be challenging and, sometimes, even impossible. In order to identify or differentiate with the patient, nurses described a number of different elements that are crucial to the evolution of this dual process. These elements are contextualization, vulnerability and perception of control.

Contextualization

In order to conceptualize the patient as a person and identify with him or her, a certain rationalization must take place, one that explains the contextual factors that led up to the crime.

If you just concentrate on what their crimes were, I do not think you can set up realistic goals. It always is a concern, but you have to realize what particular factors entered into this person's mind that affected his actions you know, ...there could be drugs involved, there could be physiological things, there could be family dynamics... a lot of different things... social-economic situations. So, I like to look at that type of things..., a person's background, and then kind of build up from there. What I feel our realistic potential would be for this client? And not all the time does it work, but, you know, to challenge, to try to go through with it. (Jordan: lines 27-37)

In other words, nurses are in a position to evaluate the legitimacy of the person's hospitalization. Contextualizing the situation enables the nurse to work from a professional scheme of reference, allowing them to separate the patient's background from their goals with the patient. For example, nurses either try to rationalize the patient's behaviour in terms of psycho-social upbringing, the context in which the crime took place, or more commonly, by acknowledging that the patient was sick at the time the crime was committed. In doing so, nurses are adopting a holistic view of patients as persons, and are rationalizing how their actions were plausible in the specific situations. Through hospitalization, as the patient is medicated and undergoes therapy, there should be a convergence of the nurse's hopes for patient recovery and the patient's presentation, thus emphasizing the need to see the person behind the illness—or at least to try to.

If they have a psychiatric illness, I attribute their behaviour at the time to the illness. Now, when they are stabilized on medications, a lot of the times, they are just like a different person. ...I think I just like to know what they are capable of. (Philip: lines 163-176)

Maybe on the other unit, just getting to know them the other way, because, you know, you might be out for lunch with a murderer, an arsonist, whereas you do not see that.... I truly believe that on medication and with the proper education, they can have close to normal life. I truly believe that what comes in is not necessarily the person you see. Once they are on medication, they

kind of... then you see the personality come through. ...you still have to try and see that person underneath. (Tracy: lines 215-228)

Being able to see the person as sick represents a positive differentiation, in that the nurse is able identify with the patient who is considered to be legitimately sick.

However, difficulty in contextualizing the events that led to the crime may lead to a negative differentiation process, thus causing nurses to re-evaluate whether the patient should be in jail rather than in a hospital.

It depends. Sometimes I see it as an illness, and sometimes I see it as behaviour where there has been instances where I do not think some clients should be labelled NCR. They should probably spend time at the jail, be incarcerated, but still getting treatment. (Philip: lines 284-287)

Although it may not be definitive, the patient's diagnosis largely influences opinions regarding whether they belong in an institution or correctional facility. It has been stated that patients labelled as having personality disorders or being paedophiles are harder to deal with. Nurses generally have difficulty seeing the crime as being the result of an illness, and may not agree with pathologization.

If you are using the paedophile as an example, there is different theories about paedophilia. I mean, some doctors think it can be cured or at least stabilized, and there are other theories that say you cannot cure paedophilia. Even if you chemically castrate them, it's still in their mind, you know. I do not agree with it all the time. And if it is somebody like a murderer, well, it helps to know their history. I mean, did they do it in a psychotic rage or...? (Philip: lines 729-735)

For different reasons, nurses find it harder to understand, rationalize and accept certain of the patients' crimes. Patients evoke abjective feelings that are sometimes recognized, and it is only once these feelings are recognized that the nurse is believed to be able to deal with the situation professionally.

It depends on individual experience, and it depends on the patient's crime. And the perception of that kind of thing. We had a patient who strangled his... I think the boy was seven years old.... I had some real difficulties with that ... this guy, in less than a year..., and he is demanding to have downtown privileges. ...I explained to my supervisor that I will look after the day-to-day stuff..., but I cannot really deal with this case in any kind of depth...and I wondered, because most people I spoke to perceived that,

"Well, this guy is... scammed the system... and it is just not right that he is going to be back on the streets after what he has done." Basically less than two years time for killing a child. That one was hard for me to separate, because of my own personal experience. Luckily that does not come up too often. (Dustin: lines 635-649)

As such, some crimes are more repulsive and difficult to contextualize (crimes against children or crimes that may be personalized, for example). Essentially, the professional scheme of reference (the patient was sick and was not responsible for his crime, and so I can legitimately empathize) may be replaced by a social scheme, also known as negative differentiation (which holds that the person should be punished).

I think that it is difficult for a lot of people. I think maybe it is personality, you know. It is the nurse's own personality and their insight. I know that there is a lot of nurses who, especially, for instance, if we have someone who has molested children. It is very, very difficult for young fathers to put that piece away. And I am just talking in general terms; I am not... but it is more difficult for them to be able see this person as somebody that they want to work with, move forward and return to the community. (Julie: lines 284-291)

As this nurse explains, the way the patient presents him/herself in the clinical setting may perpetuate a punishment mentality if the nurse is unable to see the patient as being sick. Then it becomes difficult to rationalize the patient's situation from a medical perspective. Nurses' clinical and/or professional knowledge becomes disrupted, resulting in difficulty in explaining the clinical reality. This difficulty increases when elements of the nurse's personal life relate to the clinical reality (for example, when a nurse has children and works with a patient who has committed a crime against a child).

This is probably a really, really tough case to understand and wrap your head around. And I think all of us, in some way or another, had a tough time. Some of the ones that we have seen, if they committed this horrific crime..., when they are stabilized, they are aware of what they did, and there is remorse, and they do not want to talk about it, because it is painful. It hurts them to think that they may have killed their son, or they actually did kill their son, and know they have to live with it. ...This one particular gentleman would tell you the "nitty gritty" details of it... time and time again, and say, "I was psychotic when this happened, and I took him to the hotel, I gave him a sedative, but instead of making him tired, it made him agitated, so I smothered him to death with a pillow, and then I cleaned things up, and I showered, and then I called the police." Almost all of us have children, but you just cannot imagine your partner doing that to your son. You try and stay

objective, and you try and stay on the outside. But you cannot help but have more emotional connection to something like that. (Sylvie: lines 1017-1037)

In other words, nurses need to be able to rationalize that the person in front of them is, or was, legitimately sick, in order to explain behaviours in the clinical setting. Otherwise, a negative differentiation takes place—nurses believe that the patient is not sick and is not deserving of care.

Most of the time, there is a major mental disorder, like schizophrenia, that is responsible for the behaviour. So once that is treated, then the person is really no different than you or I. ...There are a couple of people that come in with just Axis II, anti-social personalities, and their crimes have been fairly severe, and I find that I have to be very conscious of how I interact with them so that... to make sure that I am not letting that affect me. (Mary: lines 636-644)

They are people first. They have names, they have families, they have histories. When you learn that the forensic part of their diagnosis is because they were probably in an acute phase of their illness and probably most times off their medication. So when you realize when they are on medication and relatively stable, that they are really no different than...the guy next door. (Sylvie: lines 57-65)

Vulnerability

Following the contextualization of patients' situations, nurses have described the patients in terms of their vulnerability, as a population that is in need of help.

I think I identified early in my career the vulnerability of the patients in this program, and when I talk about forensic patients being vulnerable, I usually get differing opinions from those who do not understand the complexities of the work. (Marc: lines 22-26)

I see... a young population, although it is getting older, who do struggle out there and often..., you know when I think of stigma and the misinterpretations that people have. You know, I really feel that... I feel a calling to wanting to help some of these younger individuals that have often had difficult histories as well. I try to rebuild some of their psychological strength. (Greg: lines 49-60)

This vulnerability is further explained by the "double" stigma that is attached to a person who has psychiatric issues and has crossed paths with the law. The internalization of social values by nurses comes into play where punishment is a central component when a crime is committed.

If you sit back and you watch anyone who has a conflict with the law, society then looks for punishment. Here, we are forensic mental health; all the individuals that we care for here have had conflict with the law. If you think of a sociological point of view, they would say, "Okay..., we need to punish these people." So that is the way it is, and it creates a double stigma. Not only does society stigmatize mental health issues, but now you have someone who has had a conflict with the law. So it puts him at a double whammy against the individuals who care. Therefore making them even more vulnerable than someone who is in a general mental health program. (Marc: lines 30-40)

This nurse also describes how she/he comes to construct the patient as vulnerable, either by attributing the issues of the person to a medical imbalance or to the product of a difficult social background. In other words, the nurse rationalizes that the person, who is considered to be a perpetrator of violence, is actually a victim of either bad health or bad social upbringing.

Yes, it is horrific and stuff, but I kind of find that I can get past that, you know. Say, okay, try to find out what led them up to that. ...it is psychiatry, it is trying to help these people. If they can be helped, they should be helped, whether it be medication, whether it be, you know, intense therapy, psychotherapy or whatever. It is the mind, and the mind is an organ, just like our heart and our liver and everything else, and there is a chemical imbalance, and that is the way I look at it. There is usually some sort of chemical imbalance; usually it is physiological. You know and if they can be helped. I mean a lot of these people come from terrible backgrounds, and they have not had a chance or any opportunity in life. They do not know any other way. And I feel that is what my job is to do. (Jordan: lines 158-170)

By creating this notion of the patient as a victim of illness (as opposed to perpetrator of crime), this nurse explains how one can develop empathy for patients.

Well, I guess, first of all, I naturally do have some empathy for them, which may be a starting point. I am thinking of indexed offences and things, and thinking of some poor schizophrenic who is hearing voices and devils. ...I mean, because of their mental illness and environmental situations, were provoked into terrible things beyond their will. ...Take the blame away and see the person here. (Greg: lines 297-306)

Developing empathy by believing that the hospitalized person is vulnerable is essential to nurses' attempts to identify with patients.

Perception of control

Nurses also described being able to identify or differentiate themselves from patients in terms of self-control. If the nurse perceived the patient to be out of control (ill), then the patient was positioned within a scheme of reference that was acceptable: the patient is sick and, therefore, is deserving of help.

When I look at this group, I think most of them are not dangerous. I think the truly dangerous are those that...are intentionally and wilfully...,and the use of will requires that the need for good reasoning capacity and things. ...I think most of the folks here have legitimate mental illnesses, and are pretty fragile, and are a vulnerable group, and are looking for support, and will befriend you and support you, and actually alert you to problems that are going on, on the floor. As opposed to two or three that are clearly manipulative and trying to undermine things. (Greg: lines 228-239)

As the following nurse illustrates, seeing the person as ill makes it possible for the nurse to rationalize the "irrational" / criminal behaviour that took place.

And sometimes you have to see their illness in full-blown psychosis, and you can then see them doing their crime and not being able to be held responsible for it. (Patricia: lines 42-44)

As exemplified in the next excerpt, depending on the illness, certain behaviours (such as violence) are comprehensible.

But see, they did not see any better. I mean, there you are dealing with Alzheimer... the worst of the worst, you know, and they do not realize you are a nurse.... (Jordan: lines 233-34)

The nurse's perception of the patient as being ill and out of control was also reflected in the distinctions they made between patients. A diagnosis of Axis I enables the nurse to generate a compassionate response to that patient, while he/she might respond differently to a patient considered to be in control of his/her behaviours (Axis II).

I think, generally, people who are Axis II, you tend to think that they had more control over what they were doing. That it was more of a deliberate sort of anti-social movement, than if it is somebody, who, for instance, was having command hallucinations. That they had to kill their children because the devil was going to possess them, and it was the only way to save them. I think that generally... you are more compassionate with somebody who was not in full control of their faculties. Axis II people generally are, are cognitive. (Julie: lines 323-330)

I think it is harder when you know it is a choice. You know it is a behavioural issue rather than something I would consider truly as mentally ill.

Q: Difficult in terms of...?

Like they did not get their way, so somebody-is-going-to-pay kind of behaviour. ... Obviously, it is disappointing, especially if you had a good relationship with them..., but there goes your personality disorders again.... (Rachelle: lines 387-396)

This differentiation often comes with the nurse's ability to see the patients as cognizant individuals who can differentiate right from wrong. Depending on their appraisal, each nurse will adopt a different approach to care, one that may result in minimal interaction with patients.

Q: So again, this whole idea... I am just going to take your opinion on it... because he is nasty, because he is difficult... how do other people interact with them...?

A: Some, minimally. They just do what they have to do. Some will completely ignore him. They will not deal with him, because they feel he has the ability to have manners. They think he knows the difference between right and wrong. He knows that what he is doing is wrong, so they figure he knows, and until he learns that, I will not give him the time of day. They will always take care of his basic needs, you know. He will have his meds, phone calls will be given to him, you know. There is nothing taken away from him. They just will not go an extra mile, and, I mean, that is human nature. I mean, very few people keep going back, and back, and back. What is the definition of insanity? Doing the same thing over and over, but expecting different results. Going to him, and he is just going to... you know, why do you do it? But then, sometimes, you just sort of say, "That is it. I am done. I cannot do it anymore." (Sylvie: lines 838-853)

In forensic psychiatry, some nurses explained that patients are usually "cognitive". In this sense, the patients are considered to be able to think their actions through; they are believed to be able to weigh the consequences of their acts.

They should not accept it. Can they expect that violence occurs? Yes..., but you can expect that in geriatrics. As I say, I guess, you could expect it in any other unit. I do not think that you should expect it anymore than you would in any other psychiatric facility. Our patients have more to lose. So their thought process... they're pretty stable. They hit a nurse, they can lose a year. Like the review board can turn. There is probably actually less violence in forensic.... (Julie: lines 1111-1118)

With forensics I feel more like the clients would have a little bit more control and wherewithall into how they are acting..., how they are behaving..., as opposed to full psychiatry, where so many of them do not have that kind of control when they have what is called a psychotic break, and they just...flip out of control. (Nathalie: lines 467-476)

Nurses described a certain type of population (the Axis II) as opportunistic and difficult to work with, because they disrupt the natural, altruistic nature of the nurse. Nurses now have to look for deviant behaviour (negative differentiation) as opposed to care for sick patients (positive differentiation).

We do a really really good job with people who have Axis I diagnosis. We tend to not do as good of a job with people who have an Axis II, because they are experts at splitting, splitting teams, creating...creating opportunities for themselves, and... I guess, because we are nurses, we do not always look for the deviant pieces...; you know, we are more involved in trying to help them here, but we forget that they have a motive going on over there. Two or three of those, and the ward is just bouncing. (Julie: lines 335-343)

So when I look at forensics, I do not really look at the individuals as the murderer, or the paedophile, the arsonist. ...Yes, it is important to know their history and have a bit of insight into their potential for violence and self-harm and all that type of thing. But day-in day-out interaction, if I am going to have a weakness, it is going to be tolerance with personality disorders. It is not going to be the true Axis I, which is always my focus. (Rachelle: lines 36-44)

According to nurses' experiences working with this type of population (patients with personality disorders), often interactions result in the creation of mistrustful environment:

I think your observation has to be a lot more astute. I tend to have a very mistrusting feeling about them, mainly because most personality disorders... you know, you are looking at some of the sociopath or a conduct disorder... and they tend often to be nothing but trouble, and you have to be so very careful how you verbalize with them, because they are so good at twisting your words and trying to team split, and you just... you have to really go in with your heads up.... (Nicole: lines 101-108)

Consequently, nurses begin to distance the possibility that the patient is "not criminally responsible." Here, the "personality disorder" embodies the notion of "being cognitive" and "in control" of his/her action, as opposed to being "ill" and "out of control."

Not because they are in assessment...and, in all likelihood, being a personality disorder, the offence was not committed because they were suffering from a mental disorder.... (Nicole: lines 90-92)

There are consequences to this type of thinking, because if a nurse considers someone to be sick, then the choice of intervention will be different than if the patient is considered to be in control of his behaviour and thus not deserving of punishment; patients in control will be punished, while patients considered to be ill, should not.

When it is behaviour...,yes...,we usually give them choices with consequences...; when it is behaviour....

Q: Like?

Well like.... I am trying to think of an example.... Let's say one guy is picking on a more vulnerable guy, play-fighting.... We can tell him, "If you continue this, you will either be...a) put in locked seclusion or confined to the unit. So it is your choice. If you are going to keep doing this, you are going to lose something." Whereas, if it was a schizophrenic who is truly sick, giving them choice with consequences is pointless. They are legitimately sick. Where if somebody is in control of their own thoughts, they can make a better choice than a sick schizophrenic. (Philip: lines 302-316)

If it is somebody who I do not think is mentally ill.... I am less tolerant of some of the childish behaviours and that kind of thing. If it is somebody that is truly mentally ill, you can be blind to a lot of social kind of things. It is funny, because you can actually watch. Somebody will come in, and different staff, as they get to know that individual, will come to the determination that he is not mentally ill. He is scamming. And it is interesting, because you see a staff member, and on their first day with the guy...they are bustling around and: "Oh, can I help you with this... and can I help you with that"... , and then, of course, when they get taken advantage of, they... " That guy is not... he is...." Well, that guy is going to have a rough couple of days for the next couple of shifts. (Dustin: lines 617-629)

4.4.5 Potential for Recovery

Establishing that a patient has the potential to get better and eventually be re-integrated into society was described as an essential element for nurses to create a therapeutic relationship with patients. Patient "potential" motivates nurses to invest themselves in this therapeutic relationship.

I see that there is potential. You have to see the potential. That is what makes you want to work with them and try and develop a relationship and help move them along. People do get re-integrated in the community. (Greg: lines 309-312)

Being able to see potential in all patients is particularly difficult, because different patients evoke distinct beliefs and expectations regarding their recovery. The long-term setting in which this study took place exemplifies this point well, because patients are not expected to show signs of progress in a short period of time, nor may they show any significant clinical improvement at all. As some of the participants explained, a continuous belief that something can be done, and that something will be done, to engage patients in a therapeutic process must be maintained. For example, rather than dismissing personality disorders (Axis II) as untreatable, nurses will try to ultimately change their thought process by creating therapeutic opportunities (groups, for example).

This ideal of care does not prove to be the case in every situation. The notion of patients without any potential exists. As this nurse explains, some patients who have been institutionalized for long periods of time (chronic risk) may begin to evoke an understanding that care is useless (no goals can be achieved); interventions are bound to fail. In this case, nurses go through an evaluation process based on "realistic" expectations. As these two excerpts demonstrate, expectations regarding recovery can vary greatly depending on the nurse and the patient.

Like my prime patient that I have had, he has been institutionalized for about 32 years. His offence was murder at age fourteen...so a lot of people that knew him back then said, "He will never be able to do this... or because of frontal lobe damage, he will never be able to." You do not say that to me.... I have to be careful not to be naïve, but I also cannot be pessimistic. And...I believe anybody can change. I believe, given the right things, the right circumstances, people will succeed, to the point you and I will... I mean who is to say they have to succeed to the level that we do? So this young man was discharged to the community. He is working in the community. First time in 32 years. And some had maintained he should not be in the community; he would never be in the community again. But he is there and he is doing very well. (Sylvie: lines 172-187)

I just do not think it is realistic to expect a major turnaround in a very short period of time. I think it is unrealistic to expect them to. There is one patient they moved downstairs a couple of weeks ago...and maybe he will succeed, maybe he will not. But maybe the expectations are too high in a shorter period of time. Maybe there will be some healing; maybe there will not. (Rachelle: lines 431-447)

This sense of realism is part of the profession's thinking process. Nurses must evaluate the patient's strengths and the characteristics that need improvement, in order to create clinical objectives. Throughout this evaluation, nurses categorize patients based on their potential for improvement. This separation is not necessarily ill-intentioned, but results from working with different patients in a context that inevitably imposes such differentiations. In a long-term forensic psychiatric facility, there are patients who are relatively stable, but remain at risk to the community, and practically are destined to remain in the system. As this nurse explains, it may become difficult to compare a patient who is on the verge of leaving the institution to a patient who has realistically achieved his highest level of functioning, but will remain hospitalized.

I do not know if you know any of the patients that have been around, but... what you might achieve with [Jack] versus what you might achieve with somebody who is ready to leave downstairs, like [Jim] or somebody..., that is going to be two different things. (Rachelle: lines 519-523)

The inability to see any patient potential is a reality that may partly be explained by an experiential process. Not witnessing a repeat of bad behaviour enables nurses to see potential that others have ruled out. This situation has been described (not exclusively) in terms of time spent in the system. Less experienced nurses may be more inclined to embody nursing ideals of care (non-judgmental approach), while more experienced nurses may be less excited to try to initiate new interventions with patients who are believed to have little potential to succeed.

But then, there are ones that have a lot of history.... That they have seen, you know, maybe 100 patients come and go. And they have seen that there is a repeat in their behaviour or what they are going to do. Whereas, I do not know them, so I am going to give them the benefit of the doubt. Again, I put that information on the back burner, and take it into consideration after I form my own views and see the patient. (Sylvie: lines 158-164)

Unless experienced nurses have consciously decided to continue working with individuals who continuously fail to produce the desired clinical outcomes, a negative

differentiation process may take place. Nurses openly discuss becoming jaded towards some patients over time. They no longer see any potential, because they know the patient, and have seen their failure to succeed in the past.

...people that have been here for a long time. Maybe too long..., I am not saying everybody, but...somebody that has been here for a long time, they get to a point where they are just not going to do anything for that person, and they do not understand how you can do anything for that person. They do not feel like that person merits any time for anything. (Kristen: 149-158)

Q: What about... I will use this word... I am not sure if it is the right word but... jaded... do you become jaded?

Oh yes. Particularly with certain circumstances. Like my prime patient..., he has been here thirty years. ...he is on forensics for a crime he committed while being a patient here. He attacked and stabbed a staff member. His illness, as most mental illnesses, is cyclical. So anybody that has been here twenty, thirty years knows the cycle. And we have people coming in and saying, "Oh, he is ready to do this." Well, no he is not. Give him another month or two. "Well, you need to back that up"... and I am, like, "Well, it is this guy. I do not even know how to back that up. That is just the way it has been for twenty-five years." "Well, I have not seen that in my two years." (Dustin: lines 582-596)

It can be quite easy to dismiss the potential of some patients, either because they are failing to produce clinical outcomes, or because they are just unpleasant to work with day-in and day-out. This dismissal can be reinforced by a certain group mentality that labels a patient as unpleasant or incapable of progress. The nurse who attempts to work with the individual will, therefore, be subjected to negative comments from the group.

I think a lot of people have different views. You know, I have heard people say, you know... "Well what are you wasting your time for?"... or, "They do not belong here; you cannot help them."...you know, I have two prime patients right now who I think basically the whole ward has given up on. They say "[Jordan], how can you do it?" And you just have to say to yourself, "They need somebody, too." Like you and I need somebody. And I will not give up until I feel I cannot do anything else. And I still feel that I can do something. You know, if I get to the point where I lose my patience and cannot deal with it anymore, then I would say to my team leader or whatever, you know, "That is it; I have had it. I find that I am not dealing with this non-judgmentally. And it is not fair for me or fair for the patients." (Jordan: lines 548-560)

Ultimately, the belief that a patient may not have any potential may create an internal tension for nurses. As this nurse explains, some patients will recover, some will return (revolving door), and some will simply stay in psychiatry for an undetermined amount of time. These patients, who are essentially hospitalized for life, generate tension within the unit, because although nurses cannot ignore their presence, they are powerless to help them. Nurses must create the illusion that therapy is happening to show the patient that s/he has not been "written off," even though this may actually be the case. Basic needs may be fulfilled and trivial objectives determined, but nursing care essentially loses its meaning. The work resembles "indefinite babysitting."

I think you have to accept the fact that some of them will get better, and move on, and probably do well. There are others that, you know from their history, may do well, may get out...chances are they are going to become non-compliant, and it is going to be a revolving door for them.... And there are others that you would like to see them get well, but chances are they are not In some ways, like, you are family for them. ... So I guess you tend to develop a long-term relationship with them. And I guess, even though you know sort of the prognosis, you cannot really...let the patient know that you just kind of wrote them off. Like, you always have to be trying to get them to do better than they are. Like, it may only mean getting them to be better about their hygiene, but if that gets better for three months, you have done something kind of thing. You have either made them feel better about themselves, or they have had that small accomplishment. Like you have to give them some sort of hope in some aspect of their life. (Nicole: lines 510-535)

The tension created by individuals who may have no potential disrupts the normal nursing trajectories, because it is difficult to find interventions that work with the individual. Reflecting on "no potential" individuals, this nurse explains how the situation can be rationalized in a positive way. Even if there is no potential, the experience of being hospitalized is better than its negative alternative (for example, being in jail). By adopting this perspective, the nurse is positively contributing to his caring experience by conceptualizing the hospitalization as something that is good, rather than focusing on a lack of possibilities for the patient.

Your role changes to trying to provide some maintenance, quality of life for a fellow human being...who again...,because they were not blessed with the strength of mind and support system that some of us have, and never are going to be able to cope out there. We have to look after these people. I mean, what kind of society do we live in, and what kind of society will it become if we just either dump everybody out on the street or lock them up in jails, all the mentally. ...You look at the alternative, and you say, "Boy, is that what you want to reflect here?" (Greg: lines 324-333)

Despite nurses' good intentions, this sort of situation may prove to create more tensions than positive outcomes. A lack of potential for select patients ultimately produces inconsistent nursing expectations. Nursing actions start losing their significance if inconsistency settles in. Insignificant care then becomes irrational care, which in turn creates inaction.

Things are not going to change just because I am here today. ...I do not know what it is about nurses. Sometimes they feel that if they can do that, that they are making a significant improvement, and it is not necessarily an improvement if it is something that cannot be consistent.... Then why do it? (Rachelle: lines 55-59)

Working with individuals who may not demonstrate potential creates an environment in which staff expect that "nothing" will happen and that their actions may not have any particular impact. Little importance is given to everyday nursing interventions, because they are not necessarily valued anymore.

You have to realize that you cannot do everything. I mean, you can do what you can to help, but I mean...some people are just really sick..., but if you think you are going to come in and change the world, you may not be able to. (Trevor: lines 811-816)

Working in an environment that has been described as increasingly "custodial" disrupts the nurses' sense of identity, or at least, their conceptualization of nursing. As one of the participants explains, inaction produces a "diluted" nursing identity, because there is little glorification or gratification that comes out of work that is stripped of tangible intervention.

There is the odd thing that comes up that you least expect, somebody that you have never seen going off and upset. You know, all of a sudden, in that state, or a medical emergency, or... that it is like, "Oh wow..."; "Oh, ya we are the nurses, we have to do something"..., but you know..., you just do not see that much out here. (Rachelle: lines 605-609)

Evidently, care that has no therapeutic impact puts the nurse in a situation where the work itself becomes meaningless. Having had difficulty finding significance in the long-term vision of care, which may be synonymous to a medicalized custodial practice, nurses attempt to define care in terms of concrete actions that re-situate their practice as being useful and well-intentioned. The following nurse discusses how she considers the impact of her immediate, daily actions in order to give meaning to nursing interventions. For example, giving out medication is seen as an immediate positive action for the patient: by providing patients with medication, she is helping them get better today. It is concrete.

Well, that can vary from day to day. So I would have to say if I got up in the morning, and thought that what I was doing or what I was coming to work and how I spent my time was not impacting somebody in the long-term way, I do not think I could get up in the morning. I have to look at it as day to day. Will I make somebody's day, you know... better today, kind of thing. ...being med nurse 99% of the time or whatever..., if it is..., it has got to be day to day.... I cannot look at it long term.... (Rachelle: lines 420-427)

Just as other staff focus on the tasks they are given for the day, these nurses emphasize the tasks' completion, and not necessarily the patient's progress. Nurses must feel as though they are "accomplishing something," and, rather than an observable change in the patient, it is the completion of the action that is believed to be therapeutic and altruistic.

Favoured patients

The fact that some patients have potential and others do not can also lead to the favouring of some patients over others. Although this favouring process is individual to each nurse (and perhaps unintentional), generally speaking, nurses prefer to deal with an Axis I patient rather than an Axis II patient.

I would much rather deal with a schizophrenic patient than a personality disorder. I find schizophrenics, their medication really takes hold a lot better. Like PDs, how do you really medicate them? I think they're more of just behavioural. You say "no" to them, and it could be that simple, and they could lash out. Whereas a schizophrenic, I mean..., when they are taking their medication and stuff, they seem to have a little more direction, and they are more down to earth. (Trevor: lines 285-293)

As this next nurse suggests, some patients may not evoke as much human compassion as others, a condition that will affect the way these patients are (negatively) treated, distanced and differentiated.

And so, maybe human compassion and stuff... does not necessarily come into play for some people. ...they might be treated differently, a little bit more harshly than others. Because people cannot get past that, and I think that is just human nature, no matter what the field is. ...Everybody has their favourite patients or patients they enjoy working with, and others do not. (Patricia: lines 142-146)

This notion of favourite patients on the units precedes the notion of preferential treatment, where some patients are treated differently than others based on the emotions they evoke in staff. One informant provided the example that one patient gets secluded and the other does not, even though the context demands that both patients be secluded. For some staff, it is very clear that favouring takes place.

4.5 SUMMARY OF RESULTS

The forensic psychiatric setting where the study took place had been vested with the mandate to care for mentally ill offenders requiring longer lengths of stay as well as to assure the detention of these individuals. This dual mandate of care and custody was, described, however, as being in perpetual re-conceptualization. As a result of a change in governance and the evaluation of services, the F.P.T.D. was forced to relocate its physical structure to a modernized building, and to change the way nursing care was exercised shortly before the research began in 2008. This change was marked, in part, by the introduction of correctional officers to provide perimeter security, the withdrawal of surveillance technologies (cameras) used by nurses, the reduction in the number of seclusion rooms, the creation of individual rooms for patients, and a renewed interest in the implementation of a new philosophy of care (TIDAL nursing conceptual model).

The forensic psychiatric environment is defined both by its therapeutic role and by its use as a method of social control (managing societal risk). Working with risk rather than

with length of incarceration fosters a therapeutic rationale of rehabilitation and social reintegration on the basis of risk management. Indefinite hospitalization defines the outcome of patients being declared not criminally responsible, and bears the difficult task of diminishing these risks in order to reintegrate patients into society.

In this research, correctional officers provided perimeter security to manage the risk posed by the in-patient population. However, the responsibility for the safety of those within the secured perimeter was assumed by nursing staff. As a result, a certain discursive field has been created, where a language of safety is in place to talk about patients and their actions. Nursing interventions become justifiable from a therapeutic standpoint, but also from a need for social control. If nurses in a hospital carry out actions similar to those of peace officers, such actions are nonetheless considered to be different, because they are rationalized under a therapeutic language of safety.

The structure of nursing as a professional group was officially organized as a hierarchy composed of official leaders who seek to govern practice. A distinct collective element defined the group, with autonomy often being replaced by organized routines of care and with decisions based on group consensus. The research further noted that unofficial figures of authority also influenced group dynamics in terms of assuring conformity through fear.

Forensic psychiatric care was described as being hierarchically structured, task-oriented and spatially divided. At any given time, each nurse must be in a specific location in order to fulfill a specific assigned task that is often at the intersection between nursing care, institutional functioning and custody. More often than not, this triad was described in its binary form of care versus custody. Very briefly, nurses described that being security-minded is a central element to forensic psychiatric nursing. Security and nursing care not only coexist, but one needs to be present for the other to take place. If the perception of security cannot be achieved, then nursing care becomes difficult to exercise. It is within

this framework of care, custody and institutional functioning that a marginal type of nursing practice was described. Nurses have to create opportunities to interact with patients while carrying out tasks that may not necessarily be considered "nursing." With the integration of security routines into nursing care, a new therapeutic rationale is constructed around functional and custodial practices.

In parallel, nursing care was described on a continuum between passive and active approaches to care. Generally speaking, some staff will be out on the floor seeking interactions, while others will tend to congregate in the office, and wait for patients to "seek them out." These attitudes are, in part, the result of a rigid framework imposed by the environment, where opportunities to create interactions are described as being restricted. However, the "consumerism" (passive) approach is rationalized in terms of its altruistic benefits as nurses meet patients on their terms, a reality that was paradoxically described as accentuating the exclusion of patients by some nurses, rather than creating opportunities for interactions.

Nevertheless, participants also described a set of characteristics, competencies and skills that were expected in their line of practice. *Communication*, *trust* and *ethics* are the professional elements that nurses described in their conceptualization of nursing care. In most cases, *communication* skills were associated with the ability to avoid physical interventions within a preventive framework of early intervention. However, effective communication often revolves around the nurses' capability to adjust their *approach*. Communication was as much about the immediacy of nurse-patient interactions as it was about nurses reflecting on the way to engage with each patient (evaluating verbal and non-verbal ways of interacting). In effect, a clinical cycle of mutual observation and interpretation occurs and shapes the way nurses approach (or avoid) patients.

Communication skills were further described as a means for developing a rapport and establishing *trust* with patients. By creating a trusting relationship, and subsequently

encouraging personal disclosure, nurses believed they were more inclined to access valuable information, influence behaviour and ultimately encourage patients to see the altruistic partnership created within the psychiatric institution. For nurses, establishing trust with patients required them to actively seek out elements within the relationship that would facilitate the development of a connection (*trying to relate*); but it also required them to show some *vulnerability*, distance themselves from the rigid representation of forensics, and give patients some control over their actions. However, given particular circumstances (such as an assault), trust may only represent an ideal. As the research results suggest, some patients will be described as being more or less appropriate for nursing attempts to establish trust, thus creating exclusionary classification criteria for patients who are not (*trust*)worthy.

Subsequently, nurses also described ethical elements that needed to be taken into consideration when caring for mentally-ill offenders. Nurses need to be accountable, competent, respectful and non-judgmental. *Accountability* was described in terms of the responsibility that nurses have towards patients, and the importance of acknowledging the patients' concerns. Then again, the fact that some patients are categorized as not deserving of the same rapport provides interesting insight into the clinical reality of accountability and exclusion of ethical constructs. *Competence* was described in clinical terms, in that nurses need to be able to demonstrate this quality to patients by the way they act and the way they handle themselves in the workplace. Forensic psychiatric competence was described as being more clinically induced (mentoring, peer influences) than theoretically deducted (academic). *Respect* referred to a dynamic concept influenced by a jailhouse mentality in which "if you want respect, you have to give respect," a way of being and acting whereby nurses treat others as they would like to be treated. *Being non-judgmental* was often highlighted because of the patient's criminal history; professional standards require detachment from the judgments that patient history may evoke in order

for nurses to engage objectively with patients. These professional constructs were contextualized, however, within a casual framework, and further positioned within the exclusivity of the nurse-patient relationship. The hospital was often described as a home for patients, and some participants reported the muddling of consumer/provider boundaries and, to some extent, de-professionalization of nursing care.

On a different note, nurses also talked about the notion of control in the clinical setting. Nurses often described having to ignore a flight response and engaging with individuals who may be considered immediate and/or virtual (due to criminal history) threats. In these situations, nurses exhibit a distinct identity that is formed and valued around the control of emotions as well as around the control of the unstable situation. This control necessitates that certain emotions (such as fear) be hidden, that a particular "front" be presented, and that various degrees of authority be used to deal with disrupting situations. Despite this need for control, nurses believe the authoritative figure they present must be moderated with a certain degree of flexibility. Nurses must learn to navigate within the rules of the units so they will know when to offer choices and when to be strict, a decision that is often contextually driven, based on various rationales of safety and also influenced by the group.

In addition, institutional psychiatry revolves around a system of authority commonly known as the "privilege system." The privilege system is in itself a way to make the patient appreciate the consequences of actions and to create a sense of responsibility through rewards and punishments. This *feedback loop* may position the nurse to communicate authority and force immediate compliance to in-house rules. However, this process may not be overtly confrontational, in that nurses may use subtle disciplinary strategies to redirect patients.

Finally, nursing care in forensic psychiatry was described as being masculine. The imagery and mental representation of a nurse being strong and forthcoming were situated

in a context that nurses described as the centre of a strong male culture, and that resulted in a form of masculinization of staff.

In addition, certain gender dynamics exist within the forensic psychiatric structure, wherein a distinct affinity for male presence as a form of authority, protection and role-modelling was described and valued, and was contrasted to female attributes that complement this authoritative figure with a soft/maternal presence. This division of roles is not necessarily discussed within the group, but has become an assumed expectation that serves mutual support in the work environment.

The milieu of forensic psychiatry is defined by the potentiality of its dangers and the need for nurses to assimilate (learn) potential threats. Participants described their practice in terms of gradual and socialized risk awareness a right of passage from being naïve to becoming guarded. Nurses are socialized to develop a new clinical scheme of reference that consists of a heightened sense of awareness, suspicion and mistrust. Socialized risk awareness is partly acquired through experience, but it is also embedded in practice and part of an oral history. In effect, the threatening experience does not have to have been lived for nurses to assimilate its precautionary effects. Nurses are made aware of potential risks by the meanings attributed to their routine activities and by the oral transmission of threat that happens almost ritually between nurses. The recollection of past events and their applicability in everyday practice warrants the need to be guarded and to avoid feelings of complacency. The nurse must always remember where s/he is, who s/he is working with, and what the risk potential is.

Despite the presence of a risk discourse, the security that is produced through the psychiatric structure makes the forensic psychiatric institution a relatively safe place to work, so that the notion of fear was often described in positive terms (a heightened sense of awareness). Although many nurses attest to the positive view of fear as a safety-inducing emotion, discussions regarding fear are much less likely to occur spontaneously

in environments where the threatening experience is replaced by a discourse of commodity. A certain conditioning takes place when nurses work in a potentially threatening environment, where fear is present in the nurse's rationalizations and actions, but not necessarily recognized as such. The forensic environment imposes a certain way of seeing patients, and interpreting and responding to their behaviours. These responses become internalized and define this new scheme of reference, in which one interprets actions in terms of dangerousness and risk.

In this research, participants described fear as both immediate and/or anticipated. Fear that results from an immediate situation may force the nurse to try to deploy reactive, self-defence strategies. On the other hand, with the anticipation of a forced fearful interaction comes the possibility to generate and deploy cognizant, self-protective strategies. Participants described *interventions directed at the self, the patient and the environment* to diminish possible threat and to control their surroundings. *Interventions directed at the self* generally refer to gathering information in order to grasp the elements of an upcoming situation (reading the patient's history, for example). After assessing the situation, nurses will actively develop interventions directed at minimizing the possibility of becoming a victim, interventions such as talking in open spaces, doing rounds two-by-two, and so on. On the other hand, *interventions directed towards the patient* are interventions aimed at controlling the patient. These interventions are usually positioned on a continuum of restrictive interventions such as verbal de-escalation, offering extra medication (PRN), using physical force (restraints and seclusion) and chemical force (chemical restraint). However, indirect strategies were also described—disciplining strategies that would sanction either the individual or the group. Finally, *interventions directed towards the environment* refer to the organization of the environment to diminish potential victimization. One of the most discussed interventions was the use of technologies of surveillance such as cameras.

To some extent, the notion of risk (potential for violence) is present with all psychiatric populations and is often heightened in different areas of practice (assessment units, for instance). In this research, nurses have defined specific instances where being guarded is particularly important. By doing so, nurses have developed a clinical conceptualization of the "at risk patient." Certain *clinical manifestations*, the *history of the patients* (including the forensic history), as well as *the diagnosis and level of stability* (whether patients are medicated or not) are general elements that help define an "at risk patient."

The notion of risk was further contextualized in the participants' accounts regarding space, bodies, technology and surveillance. During the interviews, connections were made between the physical layouts of the in-patient units as well as the monitoring and positioning of bodies within these spaces. Nurses described the in-patient units as spaces of division, exclusion and (in)visibility. The position of nurses within spaces was always defined in relation to others (both patients and staff), and was qualified in terms of relative safety. Being separated from the nursing group by walls, locked doors and sheer distance created a relatively unsafe situation for nurses, because it affected the visibility of, and the accessibility to, other nursing staff.

As such, the concept of visibility was extremely important and brought nurses to discuss the intimate relationship between technologies of surveillance and nursing care. Although cameras no longer exist on the units, their use was valued for its capacity to monitor patients from a safe distance (seclusion), to respond to dangerous situations (ward visibility), to create a virtual sense of safety (real-time supervision and group presence), to see behaviours that patients would not show in presence of staff, and finally, to ensure a certain degree of social order through covert supervision of deviant behaviour.

However, discussion of the use of cameras yielded paradoxical positions. Although valued for their surveillance and safety features, cameras were also described as the

source of a distant nursing practice. The ideals of care promoted by the administration favour the creation of a dynamic relationship with patients, in which human contact replaces technology (in its mechanical sense). Human contact is considered as a human technology of surveillance, therefore, whereby nurses being present on the floor, "watching more" and being "more aware," would have similar effects to that of cameras. However, human contact is juxtaposed to safety concerns, since lack of visibility increases a sense of vulnerability.

Nevertheless, the notion of risk is particularly fluid and highly contextual. Mechanisms of surveillance and resources available within the institution usually create the sense of safety and security needed by staff to work with patients. Once these boundaries are removed, the nurses' attempts to humanize the patient within the institution become difficult. The patient/person is never completely dissociated from the illness or the baggage that institutionalization carries. Once the institution and its security apparatus are no longer in place to create a safety net, then the threat of knowing what the patient is *capable of* becomes tangible. Dissociating the crime from the patient in a clinical setting is possible because the physical and social structures permit it; they permit staff to engage and disengage, whereas outside the institution, contact is ongoing and lacks boundaries. The risk is virtual because it is constructed in the nurse's mind, and tangible because the patient embodies a threat that is very real.

The way nurses conceived of forensics prior to entering the milieu was frequently described in stereotypical representations. Preconceptions were the product of a social scheme of reference that was often fed by vague understandings of forensic psychiatry. Participants described a process of *demystification* once they actually worked in the environment. The nurse's social scheme of reference became informed and modified by clinical practice. Nevertheless, normalization of the patient population (seeing the patient as a person) remained difficult. Although patients may not have matched the stereotypes

held by nurses, these individuals were still considered different. We posit that it is within the concept of *difference* that nurses engage in a dual process of othering: inclusionary othering (identification with patients), and exclusionary othering (differentiation from patients).

In this research, participants explained that some patients would be labelled difficult because of their behaviour on the units, but also because of the crimes they have committed. Particularly horrendous crimes affect the nurse differently; the crime becomes a source of fear and/or disgust embodied by the patient, who is deemed, therefore, difficult. The patients may not represent a physical threat, but, rather, a psychological state that nurses seek to control, contain and, to some extent, avoid (distance). As such, negative representations of the patient resulting from the way they present themselves (behaviours and appearance) or from the way they are presented (history) may justify distancing practices such as avoidance (exclusionary othering).

Creating a distance from patients can be a conscious strategy that is difficult to choose. Working with difficult patients challenges the conceptualization of nursing, because nurses cannot live up to their professional ideals of how a nurse should "be" with a patient. However, being conscious of this distance was also believed to be important, because it enabled the nurse to self-examine and to change their approach if necessary (including asking another nurse to take over in a situation).

Nevertheless, trying to see the patient as a human being, regardless of the feelings that patient might evoke, was a professional value described by the participants. In fact, it is an element that was believed to be necessary "or else you cannot work" with these individuals. When the patient's history cannot be set aside, nurses are much more likely to take a different approach with them. Thus, working in forensic psychiatry was described as learning how to deal with the emotions evoked by the patients' backgrounds and to attempt to separate the past from clinical objectives. Consequently, nurses have

developed ways in which they can try to eliminate the influence of the patient's history, or at least, to decrease the effects that knowledge of the crimes may have on their judgment and practice. By doing so, nurses try to facilitate an identification process (including positive differentiation), wherein the individual requiring care does not become estranged to a point where care is no longer possible (negative differentiation).

One strategy adopted by nurses to diminish the effects of the patients' background was to meet the patients first and read the file afterwards: "a way not to get contaminated by the history." By doing so, it is believed that a *real* desensitization takes place, a process in which a stereotypical image of the patient (and his crime) will not affect the therapeutic relationship. (The nurse remains objective.) As part of a socialization process, some nurses integrated this approach to teaching new nurses how to interact with patients. But this socialization comes with its message of caution that one must not blindly approach the patient. Some believe that knowing the type of diagnosis is enough, while others need to know more. Some nurses have developed a hybrid approach to the charts by not reading the file in detail, but being aware of the patient's background. Nurses considered naïve other staff who blindly approached patients whose potential dangerousness warranted an awareness of the chart (in detail or not). The chart, and the history it contains, represents a constant variable in the evaluation of risk.

Another strategy developed by nurses was to separate the crime from the person by creating a "clinical mode"—a type of disconnection in which personal opinions and values are set aside, and where the task at hand can be handled without any judgment. Emphasis is placed on what is going on with the patient *now*, rather than on past behaviours. The patient is described in terms of his/her stability as opposed to levels of dangerousness based on the history. The *clinical mode* is a temporary, anticipated adjustment in the nurse's way of thinking and acting in a situation. In light of a particularly difficult nurse–patient interaction (in which the patient's crime is difficult to understand, and

judgments are present), *working in the moment* enables the nurse to create a certain comfort zone in which to interact with the patient. For some, this strategy is realized by an objectification and technicalization of care. By viewing patient care as a technical intervention that is temporary, nurses can anticipate the interaction as having an end, at which point they will move on to care for other patients: "do what you have to do and get out."

The final strategy described by nurses was somewhat incidental. Being comfortable with criminal histories and de-emphasizing their place in the nurse-patient interaction was also described in terms of habituation. Previous or continuous exposure (time spent on the ward) to criminal/gruesome histories decreases their shock-effect. With time spent on the wards, nurses believe they grow to distance themselves from the criminal aspect of the patient, as evidenced by some participants who reported "becoming numb" to patients' histories.

The development of strategies to counter the effects of the crime on the nurse-patient interactions essentially reflect the deployment of a professional discourse in which nurses are trained to be composed and in control during the caring situation, or to develop ways to remain objective and patient-centred, at the very least. Nurses are compelled ethically to try to identify with the patient, which basically translates to the necessity to develop empathy. However, the continued deployment of this professional persona can be challenging. In order to identify or differentiate with the patient, nurses described a number of different elements that are crucial in the evolution of this dual process.

In order to conceptualize the patient as a person and identify with him or her, a certain rationalization needed to take place, one that would explain the contextual factors that led up to the crime. Contextualizing the situation enabled the nurse to work from a professional scheme of reference whereby it became possible to separate the patient's background from their clinical goals. As such, the nurse needed to see the patient as

different and to rationalize this difference in order to create a therapeutic relationship (positive differentiation). However, some patients have committed crimes that are harder for nurses to understand, rationalize and accept. A patient's diagnosis of personality disorder or pedophilia were cited as being more difficult to deal with, for example. The nurse struggles with understanding the crime as being the result of an illness, and may not agree with pathologization. Thus, some crimes are more repulsive and difficult to contextualize (crimes against children, for example), so the professional scheme of reference that fosters empathy (identification) may be replaced by a social scheme of reference that encourages punishment (negative differentiation).

Following the contextualization of the patient's situation, nurses are in a position to conceptualize the patients in terms of their vulnerability. As opposed to the internalization of social values, of which punishment is a central component when a crime is committed, the nurse may be in a position to see the person (who is considered to be a perpetrator) as a victim of either unfortunate sickness or poor social upbringing. By creating this notion of victim (as opposed to perpetrator), nurses may use the notion of difference to facilitate empathy (positive differentiation).

Finally, contextualization and subsequent conceptualization of the patient as vulnerable may be reinforced by the notion of self-control. If the nurse perceived the patient to be out of control (ill), then the patient was positioned within a scheme of reference that was acceptable: the patient is sick and, therefore, is deserving of help. Seeing the person as ill makes it possible for the nurse to rationalize the "irrational" / criminal behaviour that took place. Having a legitimate Axis I diagnosis enables the nurse to generate a compassionate response, as opposed to how the same nurse might respond to someone considered to have control of his/her behaviours (Axis II). Here, the "personality disorder" embodies the notion of "being cognitive" and "in control" of his/her action as opposed to being "ill" and "out of control." There are consequences to this type of

thinking. If a nurse considers someone to be sick, then his/her choice of intervention will be different than if s/he considers the patient to be in control of his behaviour; intervention in the latter case will most likely have a punitive rationale. This is also true of general ward dynamics.

In parallel with the effects of the patients' criminal histories on nursing care, nurses also described the importance of seeing potential for recovery in patients. Having "potential" creates an opportunity to motivate nurses to invest themselves in this therapeutic relationship. However, this ideal of care does not prove to be the case in every situation. The notion of lacking any potential exists. Some patients who have been institutionalized for long periods of time (chronic risk) may evoke an anticipation by staff that care is useless (no goals can be achieved) and interventions are bound to fail.

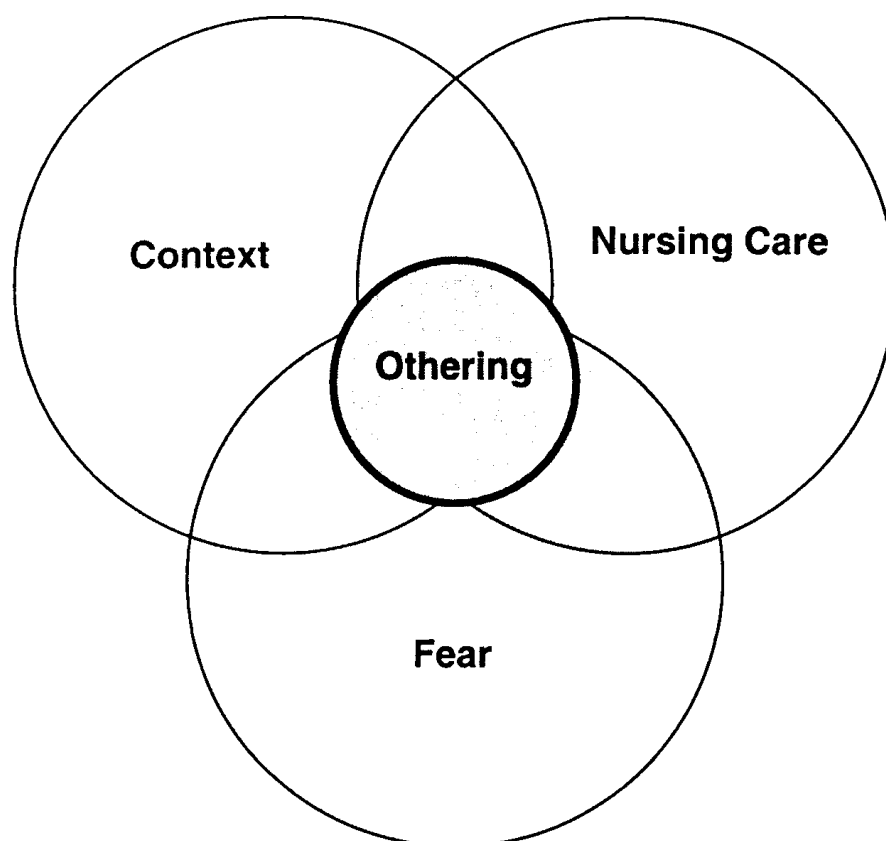
Not being able to see any potential is a reality that may partly be explained by an experiential process. Not having observed repetition in negative behaviour enables nurses to see potential that others have ruled out. This situation has been described (not exclusively) in terms of time spent in the system, wherein less experienced nurses may be more inclined to embody nursing ideals of care (a non-judgmental approach), while more experienced nurses may be less eager to initiate interventions with patients whom they believe have little potential to succeed. It can be quite easy to dismiss the potential of some patients, either because they are failing to produce clinical outcomes, or because they are simply unpleasant to work with day-in and day-out. This dismissal can be reinforced by a certain group mentality that labels a patient as unpleasant or incapable of progress. The nurse who does attempt to work with the individual, therefore, will be subjected to negative comments from the group.

Ultimately, the belief that a patient may not have any potential may create an internal tension for nurses who must create an illusion of therapy to show the patient that he/she has not been "written off," even though this actually may be the case. Basic needs

may be fulfilled and trivial objectives created, but nursing care essentially loses its meaning. Insignificant care then becomes irrational care, which, in turn, may create inaction. Working with individuals who may not demonstrate potential creates an environment in which it is expected that "nothing" will happen and actions may not have any particular impact. Evidently, care that has become meaningless puts the nurse in a difficult situation in which the work itself becomes meaningless. In light of not having a positive vision of care, some nurses described the need for concrete actions that resituates their practice as good and well-intentioned. For example, giving out medication was seen as an immediate positive action for the patient: "I do medication, therefore I am helping patients to get better today." Similarly, other staff will focus on the tasks they are given for the day, emphasizing not necessarily the patient's progress, but the completion of the tasks.

Figure 9

Model



The goal of integration is to link categories and compare them to one another according to their properties. These comparisons will eventually lead to the identification of the phenomenon of interest. In this research, four descriptive categories were produced, where the fourth category (othering) was identified as the site of a basic social process and primary conceptual element (core category) where all other categories converged. Although each category could be explored in isolation from the other categories (mutual exclusion), there remains a certain dynamic connectivity between all four categories.

The first link: context and nursing care

By comparing categories and identifying their relative positioning between one another, a connection was made between the *Context* and *Nursing Care*. In effect, the specificity of the context as an institution of detention and therapy inevitably (re)defines what is considered to be nursing care. Psychiatric care is supplemented with judicial demands and regulations. Nurses must navigate in this new role in order to create opportunities to interact, evaluate and intervene with mentally-ill offenders.

The second link: fear

The association between the *Context* and *Nursing Care* produced an outcome that is considered to be an integration of risk discourse by nurses. Fear of the other (patient) is the result of a specific practice (nursing care) in a specific setting (context), where patients are defined by the potential (risk) violence they embody. As such, nurses must deploy a number of different strategies to assure that safety is maintained (positive effects of fear).

The third link: Othering

Finally, the product of all three categories enabled the identification of the fourth category as the site of a basic social process. In light of working with an "at risk" population who may evoke such feelings as fear and disgust, nurses undergo a constant process of identification and differentiation (othering). That is, nurses constantly attempt to avoid contamination from the patient's history in order to engage objectively in the therapeutic

relationship. However, when nurses are unable to contextualize the crime, to see the patient as vulnerable and to see a potential for recovery, then nurses are likely to distance themselves from patients and disengage from therapeutic ideals.

CHAPTER 5

DISCUSSION

This chapter presents a discussion of the major findings revealed in the analytical portion of this project, Chapter 4, which will be compared and contrasted to existing theoretical frameworks and the current literature on the subject. The discussion will revolve around six headings that are representative of nursing care in forensic psychiatric settings, and answers the research questions presented at the start of this project. The discussion, therefore, will revolve around the following headings: ① *Nurses as Objects of Power*; ② *Incorporating the Male Standard*; ③ *The Architecture of Fear*; ④ *The Productive Effects of Fear*; ⑤ *The Mentally-Ill Offender as Other*; ⑥ *The (A)potential Patient*. The final portion of the discussion will address the limitations of the study as well as the implications of results for practice, research and education in nursing.

① Nurses as Objects of Power

An in-depth analysis of the research data suggests that nurses find themselves enmeshed in a matrix of power relations forcing them to assimilate institutional roles and discourses. Nurses are objects of power to the extent that nursing practice is constrained by the regulations of the institution and that representations of the patient population are reconfigured according to an overriding risk discourse. As such, the results from this research would suggest that the "objectification" of nurses prevents the possibility of defining nursing practice outside of the specific context in which it is exercised and the population that is being cared for. Working with a threatening population within a secured facility will inevitably create new power dynamics between groups; these dynamics need to be described in order to understand how they affect the conceptualization and provision of nursing care.

Revisiting the disciplinary institution

Many authors have described the difficult articulation of therapy and security imperatives associated with nursing care in forensic psychiatry (Burrow, 1998; Holmes, 2001a; Holmes & Federman, 2003; Mason, 2002; Peternej-Taylor & Johnson, 1995; Peternej-Taylor, 2004). As this research confirmed, such a difficulty is often associated with the overriding need to assure security in order to facilitate nursing care. Consequently, many of these authors associate the constraints of care to security imperatives; and this may very well be the case. However, the results from this research also indicate that security imperatives are actually part of much larger functions associated with the disciplinary institution. On this subject, the research results are congruent with St-Pierre's and Holmes' (2008) parallel between healthcare institutions and machines. Influenced by the works of Foucault (1995) on disciplinary institutions, these authors situate nurses within a disciplinary system that operates on them as objects as well as instruments of its exercise (St-Pierre & Holmes, 2008). "Health institutions act as machines when they aim to transform and control their employees to achieve greater efficacy, hence the need for employees to be amenable and accommodating (docile)" (St-Pierre & Holmes, 2008, p. 354). If a relationship can be made between the forensic psychiatric hospital under study and healthcare institutions as machines, it is in the way nurses are strategically disciplined in adopting new ways to practice. In the name of efficiency and proper ward functioning, nurses have become the pivotal peons of the institution by playing the card of "versatility." As a result, nurses find themselves trying to incorporate nursing practice within the rigid demands of the institution (including those associated with security). *À défaut* of applying disciplinary strategies to create a docile patient population, nurses are themselves being disciplined.

To exemplify this point, one disciplinary strategy described by Foucault (1995) is particularly relevant for this research: the art of distributions. In effect, nurses who organize

the patients' division in time and space also become objects of discipline. As the participants described, each nurse is assigned to a particular place on the nursing units to ensure a balanced allocation of people and the monitoring of individuals. Although distributions may invoke security rationales, it is the concept behind the specific art of distributions that is important. Nurses are disciplined in the sense that they are given a functional site on the unit for a particular amount of time, and that these functions are not always nursing-oriented. For example, one nurse must remain at the locked door to monitor patients coming in and out of the unit, as well as wandering them for contraband. The specific position of the nurse who is attributed a specific function for a certain amount of time resembles all too clearly the structure of disciplinary institutions.

Within this rigid framework, nurses described the incorporation of their care. Despite not being able to have prolonged interactions with patients because of this distribution, nurses use the brief interaction that takes place in the task they are given to create a therapeutic opportunity. Much like the nurse who is responsible for the distribution of medication, the nurse who is at the door may take advantage of their brief interactions with patients to do an assessment. While wandering patients and monitoring the door remain institutional and security-oriented tasks, nurses have reorganized their approach to the situation in order to give it a therapeutic connotation. They have developed a way to rationalize and integrate institutional demands into their nursing routines. This amalgamation of roles and adaptation in practice is interesting, because although the technical task remains the same regardless of the person who is executing it, the rationale given by the nurse will make it an appropriate nursing intervention. Thus, nurses have appropriated to themselves the everyday management of the unit and its security while giving it a therapeutic rationale. Though nurses only touched on the subject of their practice as being different from other areas of health care, they are nonetheless involved in a therapeutic machinery that changes/governs the way they can practice. What is

dangerous in this process is the institutionalized managerial function attributed to them. The triad of care, custody and institutional functioning defines nursing care and delineates new ways of understanding how it is practiced. The risks associated with an enlarged scope of practice based on institutional demands creates a dilemma in which nursing practice is not defined by nurses, but rather by the institution.

Revisiting the total institution: incorporating a risk discourse

In addition to the disciplinary enterprise that is shaping nursing practice are the discourses of risk that permeate the forensic psychiatric settings and affect the way nursing care is provided. Once again, nurses are objects of power to the extent that patients have the capacity to evoke a fearful response (Whittington & Balsamo, 1998). From this perspective, the patient is no longer a passive recipient of care or simple bystander in the nurse-patient interaction. By the way they present themselves or the way they are presented (their history), patients affect the way care is conceptualized and provided by nurses. According to the participants, re-conceptualization of care in forensic psychiatry revolves around the incorporation of risk as an element in defining the patient population as threatening.

In light of the research results, the incorporation of a risk discourse into the nursing practice fostered parallels between the forensic psychiatric hospital and "total institutions" (Goffman, 1990). Characterized by their internal modes of functioning and normalizing attributes, total institutions can be defined as sites of self-modification. Those who become captives of these institutions will be submitted to a similar process that seeks to reconfigure behaviours, thoughts and motivations according to a predetermined set of institutional norms. If this process has originally been attributed to the experiential progression of mentally-ill individuals in asylums, Holmes (2005) suggests that self-modification processes also affect nursing staff working in forensic psychiatric environments, a reality corroborated by the results of this research.

According to Goffman (1990), each individual enters a total institution with an imported or domestic culture, one that is shaped by different life experiences and different social structures. At any point in time, this culture is what constitutes the frame of reference that consolidates the individual's identity (Goffman, 1990). However, even with the best intentions (therapeutic rationale), the total institution will not substitute its own culture with each individual's presenting culture. The total institution somewhat suppresses previously consolidated external identity, and imposes its own internal frame of reference. Therefore, previously defined social representations of the self are stripped upon entrance to the total institution, and are replaced by this internal culture. As the research results suggest, once nurses enter the forensic psychiatric environment, they are immersed in a culture of risk (potentially dangerous patients). If all nurses did not fully internalize this culture, it is nonetheless a dominant characteristic of the group, and safety and security rationales are often reported to be at the forefront of nursing interventions.

Participants in this research described how a certain attention was drawn towards the need to become aware of potential dangers. Over time, nurses developed a new clinical scheme of reference that was rooted in suspicion and the subsequent need for a heightened sense of awareness. This new clinical scheme of reference essentially represents a distancing from original concepts of care (domestic culture) to a concept that is coloured with mistrust and apprehension. As part of what *Goffman (2002)* describes as "embrigadement," nurses are constantly reminded by other staff of the risks involved in working with mentally-ill offenders. As the research results indicate, nurses are summoned to assimilate a culture of risk and to incorporate this notion into their practice ("having your guard up").

However, it is important to differentiate the notion of generalized risk that defines a population and the empirical individuality of risk that was described by participants. If all patients do not embody the same level of risk (individuality), there is nonetheless a

potential that is present in everyone (generalizability). It is this general attribute of *potential* that was at the forefront of the participants' accounts. As Ewald (1993) suggests, once a "population is identified as at risk, everything within it tends to become—necessarily becomes—just that" (p. 221). In this sense, defining the patient population as being "at risk" is a static element that nurses are socialized to incorporate into their care. In forensic psychiatry, the potential for violence that some patients carry is enough to redefine nurse–patient interactions. As such, the assessment of risk that implies continuous day-to-day evaluations (mental exam status), comes to be overshadowed by the conceptualization of risk as a constant, rather than a variable. Perhaps, then, in forensic psychiatry, the notion of the monstrous has returned (Rose, 1998). This class of "monsters" (sex offenders, serial killers, paedophiles, personality disorders, etc.), who are dangerous on account of what they are, remain (potentially) dangerous regardless of treatment, and so taint the general ward atmosphere with a negative aura. In other words, the heightened awareness and suspicions that a few patients may evoke comes to affect care on a much larger scale (the whole nursing unit).

In this research, socializing other nurses to the possible risks that exist is very much part of an oral history. As such, nurses do not need to experience a threatening encounter to be aware of the possible dangers associated with their job. The intellection of the patient population that is created through this verbal history shapes the way care is conceptualized and provided. These mental representations demonstrate the human capacity of interpretation, whereby relationships between individuals are strongly contextualized rather than rooted in an immediate situation (Mannoni, 1998). Due to their cognitive capacity, humans are able to detach themselves from an immediate world and live in a sub-reality of perceptions, a universe that may be physically absent, but psychologically present (Mannoni, 1998). At any given time, mental representations

usually correspond to a group's point of view. Thus, individuals who work in similar environments will share common symbols of representations (Holmes & Federman, 2003).

In this research, the collective history of adverse events (what has happened in the past) becomes a source of information and apprehension that fosters a group conception of risk and how it should be avoided. As Sunstein (2005) suggests, "when people use the availability of heuristics, they assess the magnitude of risks by whether examples can readily come to mind. If people can easily think of such examples, they are far more likely to be frightened than if they cannot" (p. 36). The verbal history, as well as the prolonged work experience in forensic psychiatry, creates the effect of familiarity that affects the availability of these examples and the deployment of precautionary strategies. As Sunstein (2005) warns, heuristics can lead to serious errors in assessments, in terms of both excessive fear and neglect. However, one cannot remain blind to experience. Such is the dilemma portrayed in this study: nurses build a repertoire of experiences that will inevitably affect the precautions deployed with patients, while nurses who have not yet seen or experienced these events may not feel the need for the same guarded approach to patients. Nevertheless, the forensic milieu is shaped by the events that have happened and will happen in the future. Decisions regarding the patient population are formulated according to the awareness of past clinical events as well as the patient's history. By doing so, nurses work in the potentiality of events (what could happen) based on a collective history and the availability of adverse examples.

At the clinical level, the type of risk (potential) that the patient population embodies confirms Ewald's (1993) beliefs concerning the application of risk in practice. Knowing the risk does not eliminate the problem of having to choose whether or not to accept it. "The idea of an objective measure of risk has no meaning here; everything depends on the shared values of the threatened group. They are what gives the risk its effective existence" (Ewald, 1993, p. 225). More importantly, defining something or someone as being "at risk"

will depend on the availability of information that creates this risk (Sunstein, 2005). As the research shows, the definition of some patients as being "at risk" is produced by a particular relationship between the patient population being cared for and the nursing personnel. As a central concept driven by fear, anxiety and uncertainty, this notion of risk has come to take an important and dependent place in decision-making processes regarding the control of risky populations (Bourque, 2006; Lupton, 1999). As Rose (1998) suggests, risk thinking "generates and exacerbates the very fears it claims to secure against: a population suffused with fears about the 'the risk of risk'" (p. 181).

@ Incorporating the Male Standard

Throughout the research, participants highlighted the presence of gender dynamics and social norms that implicitly and explicitly governed work divisions and the presentation of the self in the forensic psychiatric units. Throughout their verbatim, control and authority were described as masculine standards that permeated the research setting and influenced nurse-patient interactions. In this respect, the results from this research concur with Morrison's (1990) conclusions regarding the frequently observed and documented development of macho cultures in psychiatric settings. This type of culture, as Stobbe (2005) proposes, is intrinsically linked to masculinity, with both sexes routinely reproducing the male standard. Forensic psychiatry is a milieu that promotes the "virilization" of nursing care, in which feminine attributes are somewhat repressed (Bourdieu, 1998), or at least, only considered useful in specific situations.

In this research, the question of fear was of primary interest. As many participants explained, a fearful reaction often must be masked. The notion of control as both a clinical obligation and a way to present oneself was an important aspect of nursing practice in the forensic psychiatric environment. Because it is a closed environment, and nurses are responsible for providing safety, they are forced to intervene regardless of their feelings. Nurses must often ignore a flight response, and engage with individuals who may be

considered threatening. As a result, nurses described having to control internal emotions as well as to control the threatening situation. These notions of control are valued psychiatric skills; nurses have a distinct identity that revolves around the control of the self (calm and controlled) as well as the control of the unstable situation. In other words, nurses reject their own sensibilities about the threatening situation in favour of a professional persona or "front" (Jacob, Gagnon & Holmes, 2009).

As reflected in the research findings, not showing fear could be considered to be the result of a macho culture (Mason, 2002), where the need to be in control in threatening situations is a valued skill (Morrison, 1990). In this case, not showing fear is the result of a power struggle between nurses and patient. This type of "masculinization" fits well with Bourdieu's (1998) description of institutional ways of doing that are enacted to officialize the domination of one group (nurses) over another (patients). Nurses described having to adopt an authoritarian image that ranged from being firm, strong and "telling it how it is," to standing up to a violent patient. These qualities associated to a masculine (but not necessarily negative) presentation of the self according to the male standard, or, as some of the participants argued, a masculinization of nursing care.

In parallel with the presentation of a professional persona (masculine front) are the practices that evolve from a culture that is highly influenced by the presence of a male workforce, the need for security on the unit, and the predominance of a male patient population. For the most part, male and female nurses fulfilled a number of prescribed roles that were presented in the form of "taken for granted" assumptions. This can be interpreted as an accurate reflection of "natural differences" that are rationalized in terms of a necessity (Stobbe, 2005). As the results indicate, the affinity of male nurses for work in forensic psychiatry revolves around their gender attributes of providing authority and protection as well as role-modelling. In such cases, it is the "natural differences" between men and women that are evoked in the exercise of power. Being masculine is not

presented in relation to dominance over women, but, rather, as dominance in general (Stobbe, 2005). By embodying authority, male nurses are believed to create a degree of docility on the units.

The price men pay for this social representation is the rebound effect of resistance (Foucault, 1995). According to the participants, men are more likely to be the targets of violent acts, because, as authority figures, they embody a threat for patients. In such cases, participants believe complicity exists between the roles men and women play on the units. Unlike Holmes (2001a), whose results indicate that maternal attributes may be seen as weak and devalued in a correctional setting, the participants in this research suggest that there is much to gain from having women on the workforce. Maternal attributes, in some cases, are seen as less threatening by patients, and may enable nurses to avoid physical interventions. As such, being a man or a woman in forensic psychiatry is unique, because the gender of the caregiver creates different responses from different male patients. Regardless of a professional unity, male and female nurses may actually have something different to bring to the table, simply because of their gender, which serves mutually supporting roles. However, as Stobbe (2005) suggests,

Shaping a sexual division of labour is an active process, but most actions are characterized by a routine way of doing things. ...Machismo is very much internalized and therefore structures power processes quite implicitly. Men and women interpret, internalize and use machismo actively, yet, more often than not, they do this routinely. So change is possible but bounded.... (p. 111)

In other words, the internalization of gendered roles is difficult to undo. It is very likely that men will continue to feel they have a gendered obligation to intervene in violent situations, and, in some cases, to take on the role of protector. In such cases, the participants' accounts concur with Lawoko, Soares and Nolan (2004), who conclude that "it is plausible that males are often approached to attend situations in which violence is likely to occur. This may explain why male nurses are more often subjected to violence than other personnel" (p. 51). The role of security (physical confrontations) on the units is "naturally"

attributed to men, a role that male nurses are not always comfortable with, but usually must accept. Though the institution forbids official reference to gendered roles, the clinical reality proves to be much different.

③ The Architecture of Fear

According to Ellin (1997), "the insecurities incited by the transition from feudalism to capitalism led to new proposals for buildings. In the same year that the French Revolution began, the English philosopher Jeremy Bentham conceived the Panopticon (Greek for everything, place of sight, or all-seeing) ..." (p. 16), an idealistic architectural design whose optic effects permitted continuous surveillance and control over its captive population. Ellin (1997) continues, "This building was conceived explicitly to carry out the task of enlightenment" (p. 16). With this development, architecture became the ideal structure "that would operate to transform individuals; to act on those it shelters, to provide a hold on their conduct, to carry out the effects of power right to them, to make it possible to know them, to alter them" (Foucault, 1995, p. 172). The forensic psychiatric hospital is no exception to this architectural phenomenon, as panopticism became the underlying principle in the construction of many institutions including asylums, prisons, schools, factories and workhouses (Ellin, 1997; Foucault, 1995). More importantly, the transformative power attributed to the panoptic architecture justified the use of confinement as an acceptable method of exclusion for individuals whose behaviour qualified as dangerous or disturbing in regard to social order and morality (Russ, 1979). Institutionalization became the "therapeutic" solution to identifiable social burdens.

As the research results suggest, the institutional form of panopticism is very present in the participants' ideals of nursing practice, because it permits a constant evaluation of patients. Though lacking a Benthamian architecture, the forensic psychiatric hospital under study remains a site of panoptic surveillance for security, safety, and

therapy. The results from this research reinforce the well-known dynamic Foucauldian association between power and knowledge that are facilitated within the examination.

The examination combines the techniques of an observing hierarchy and those of a normalizing judgement. It is a normalizing gaze, a surveillance that makes it possible to qualify, to classify and to punish. It establishes over individuals a visibility through which one differentiates them and judges them. That is why, in all the mechanisms of discipline, the examination is highly ritualized. In it are combined the ceremony of power and the form of the experiment, the deployment of force and the establishment of truth. At the heart of the procedures of discipline, it manifests the subjection of those who are perceived as objects and the objectification of those who are subjected. The superimposition of the power relations and knowledge relations assumes in the examination all its visible brilliance. (Foucault, 1995, p. 184)

As part of a therapeutic regime, the concept of panopticism, or complete visibility, is a key element in the historical objectification of madness (Foucault, 2005). Since Pinel's famous liberation of the mentally ill in the nineteenth century, the psychiatric hospital has become a site where madness can be *seen* in its denuded reality. What the positivistic (read "visible") accounts of individual behaviour could objectively identify was the foundation of a psychiatric nosology. Today, nurses and other healthcare professionals still engage in visual identification, documentation and categorization of behaviours to identify pathological processes. As the results from this research suggest, there is a discernable advantage in rendering patients completely visible to nursing staff. Participants described total visibility (notably through the use of cameras) as an ideal condition to identify abnormal behaviours (self-mutilation, social interactions, assaults, etc.) that are not always discernable in daily encounters and to enable quick interventions.

In addition, the therapeutic rationale of a complete visibility in forensic psychiatry also relates to the institution's mandate of assessment, that is, evaluating whether a person is either mad or bad. Echoing the works of Goffman (1959), social interactions in this research setting may be conceptualized under the metaphorical framework of theatrical performance. Each person in a social encounter will attempt to guide and control others' impressions of him or her. The person is, therefore, a "strategic manipulator of

impressions," who may present a particular "front" in order to sustain a social performance (Lemert & Branaman, 1997). In this regard, nurses are asked to see and document behaviours that will ultimately differentiate those who are sick from those who are not. The nurses' gaze must pierce through the "veneer of normality" (Stevenson & Cutcliffe, 2006, p. 715) presented during social interactions, and must seek other ways of observing patients' behaviours. In this case, participants explained how cameras had enabled them to access behaviours that patients were able to mask in daily encounters. A visual connection that required no physical presence on the floor permitted this form of documentation so that strategic manipulation of the self could be interpreted and differentiated as either the product of a psychological disturbance (illness) or of a malevolent mind (criminality).

Nevertheless, making patients subjects of constant visibility was not necessarily rationalized for its therapeutic objectives, but rather for its purpose in fulfilling safe and secure spaces. As part of safety and security rationales, discussions regarding panopticism went beyond therapeutic goals to include the use of cameras as a disciplinary and self-protective tool.

Under the guise of complete visibility lies the disciplinary function of surveillance and its subsequent power over individuals (Foucault, 1995). According to Foucault (1995), panopticism refers to an ideal architectural configuration enabling "a state of conscious and permanent visibility that assures the automatic functioning of power" (p. 201). As such, panopticism is a crucial aspect for the constitution and functioning of disciplinary power, that is, the "methods, which made possible the meticulous control of operations of the body, which assures the constant subjection of its forces and imposed upon them a relation of docility-utility" (Foucault, 1995, p. 137). This concept finds its efficiency in its capacity to induce self-surveillance and self-regulation under a single, invisible, unverifiable gaze. The relation that exists between the observer and the one being

observed is founded in the economy of power, whereby the architectural configuration enables one guard (or nurse) to supervise masses without being identified. What is most important in this disciplinary technique is that the one being observed knows himself to be observed even if no guard (or nurse) is visible. Visibility, therefore, is conceptualized as a trap. This definition of visibility fits well with what participants described as their ideal practice, one that allows constant interventions on the patient population. Complete visibility of patients enables direct intervention and correction of deviant behaviour. In the long run, visibility is believed to ensure a "docilization" (Holmes, 2001b) of patients, who know that they are being watched and will not engage in behaviours that are considered unacceptable.

Despite the values attributed to both the therapeutic and the disciplinary effects of the patients' complete visibility, there were no cameras in the research setting. As some participants explained, the use of cameras on the units had created an undesirable effect of distancing. If sociological studies already documented that nurses congregate at the nursing station to avoid working in close proximity to patients (Handsley & Stocks, 2009), then cameras further enabled this process. Holmes (2001b) questioned the denaturation of nursing care through the use of surveillance technologies; the results from this research partially answer his concerns. From some of the participants' points of view, replacing human resources with technology had justified the removal of nursing positions on the wards and favoured a distant nursing body, one that observed and reacted.

Evidently, removing the cameras from this milieu has created a void that is slowly being filled. Nurses must now re-think the way they handle themselves on the wards and must diminish the distance that had been created by the use of cameras.

The results from this study concur with Hamilton and Manias' (2008) suggestion regarding surveillance. The skills of observation can only be affirmed when they are combined with activities of interviewing, listening and engaging with patients (Hamilton &

Manias, 2008). Despite ensuring docility, the use of surveillance technologies without human relationship becomes purely custodial. This particular point reflects well the contextualization of psychiatry in the age of virtual reality. As one of the most influential theorists in psychiatric nursing, Peplau (1997) cautioned nurses into adopting new technologies of surveillance at the expense of interpersonal contact. By addressing the link between the new apparatus of surveillance and the emergence of a subtle type of power (disciplinary power), this research also concurs with Holmes' (2001b) conclusion that "mechanical surveillance does not permit the respect of others so powerfully espoused by the nursing profession. It threatens human dignity under the guise of care and security" (Holmes, 2001b, p. 12). If the relationship between nurses and patients cannot go beyond shallow observation as a form of "under-involvement" (Peternelj-Taylor, 2008), nurses are at risk of becoming an extension of the panoptic and disciplinary apparatus, and losing the benefits of interpersonal care.

In this research, participants expressed conflicting views regarding the positive and negative effects of cameras on the units. This conflict primarily revolved around a state of permanent insecurity that encouraged the consumption of products that offer probabilistic security (i.e., cameras) (Massumi, 1993). The forensic psychiatric institution as a space of fear (where the patient population threatens individual and collective security) is, in fact, an ideal site for technological intervention. As the history of the research setting attests, cameras had been used because of their safety inducing features. Nurses could observe dangerous/unstable patients from a distance without having their personal security threatened. In time, the removal of surveillance technologies that had been present throughout the nursing units revealed new dynamics between architecture, (in)visibility, risk and fear. In effect, the removal of surveillance technologies roughly fifteen years after their introduction on the nursing units produced feelings of division, exclusion and (in)visibility by participants. As a result, the position of nurses on the wards was always

defined in relation to others (both patients and staff), and was qualified in terms of relative safety. Not being visible on the units affected both the proper functioning of the units and the general perception of safety.

As the research results suggest, the panoptic effects of visibility seem to have been internalized by nurses. The conscious registration of being observed is what the panoptic apparatus tries to achieve. In the Foucauldian sense, this consciousness induces in the subject the disciplining of his/her own conduct (Yar, 2003). However, the effect of visibility on nurses is not one of discipline, but rather, a feeling of relative safety. Under the gaze of others, nurses described a sense of unity despite physical separation from the group. This unity, described as "knowing that they have your back," or the consciousness of each other's visibility, was considered important for nurses because of the potentially dangerous patients with whom they were working. Visibility then fulfilled an important role in securing boundaries between individuals, as well as providing a sense of safety. The real-time, visual connection between the nurse who is observed and the nurse who is the observer creates a comfort that surpasses other defensive mechanisms (personal alarm systems, for example). In this situation, the disciplinary effects of visibility collapse. It could be suggested that an opposite disciplinary effect may be in motion. Knowing that they are no longer watched forces nurses to be diligent and to deploy other strategies to create a sense of safety. It remains to be seen, however, if the perceived insecurity affects the actual nurse-patient interactions (which were not observed in this study).

④ The Productive Effects of Fear

Overwhelming feelings of fear did not permeate the participants' accounts regarding their work experience in forensic psychiatry. Most nurses found that the security provided by the psychiatric institution enabled them to interact with patients. The use of medication, surveillance, physical boundaries, rules and human resources (staff) created a relatively safe environment. However, as some of the participants explained, there may be a certain

type of conditioning that takes place over time that reorganizes the nurse's cognitive and behavioural scheme of reference. The forensic environment imposes a certain way of seeing patients, interpreting and responding to their behaviours. These responses, which are not necessarily conscious, become internalized and define this new scheme of reference that is specific to the forensic environment (and possibly others), such that one interprets actions in terms of dangerousness and risk.

In the research setting, it may be difficult to access the fear-motivated rationale behind certain interventions. This difficulty is attributable, in part, to a risk discourse that is used by health professionals, and that justifies most of the interventions in threatening situations. As such, fear may be at the forefront of the nurse's rationalization, but will not necessarily be recognized. As Moyland (1996) suggests, "when a fear response is not reorganized (whether a real threat is or is not present) and dealt with appropriately, a negative effect on patient care can result" (p. 28). More importantly, fear is especially problematic when it is experienced, not as a response to an immediate threat, but as a reaction to patients who may not be immediately assaultive (Moyland, 1996). In such situations, Moyland (1996) argues that physical restraints may be used to neutralize the potential threat before other ways of managing the situation have been explored.

In effect, nurses who are socialized in a language of risk also learn how to deal with these risks, a process that is often influenced by peers and the culture of the institution (Holmes, Perron & Guimond, 2007). As the results from this study indicate, nurses have developed a variety of interventions to face these risks and to avoid being victimized. In response to the threat of violence, nurses produce interventions, and it is these interventions that are of interest for this research.

According to Mason (1999), violence and its effects can be interpreted as oppressive mechanisms that seek to constrain those who experience it. Seen from this perspective, violence is the exercise of power in its traditional repressive forms (Perron,

Fluet, Holmes, 2004). However, exploring the concept of power from a Foucauldian perspective enables the researcher to explore how the exercise of power between individuals and groups can have productive effects (Perron, Fluet & Holmes, 2004). In this research, the patients' potential for violence was a powerful motivator for nurses in the development of strategies to avoid victimization and enable safe interactions. The perceived risk of violence that participants described did create continuous negotiations between physical safety and the ways nurses managed themselves. "In this way, the perceived risk of violence exerts a subtle governing influence over those who directly experience it, and those who believe they might." (Mason, 1999, p. 122). However, the negotiation between physical safety and management of the self was not described in terms of its oppressive effects, but rather in the way it justified and created interventions to counter possible victimization. The threat of violence that patients embodied forced participants to produce interventions to contain and control this threat. Such innovation, therefore, can help re-conceptualize the threatening and fearful experience as a powerful stimulant for change.

As a general statement, the internalization of fear is a process that results from individual appraisals, and varies from one person to another (Lazarus & Folkman, 1984). Depending on the appraisal of a situation, the feeling of threat or challenge will foster the deployment of a variety of coping strategies to manage this situation. In forensic psychiatry, the individualized process of stress, appraisal and coping has already been theorized (see Whittington & Balsamo, 1998). What must be remembered from this theory is the reciprocal nature of observations, appraisal and actions between nurses and patients. More importantly, this appraisal often includes self-preservation rationales, wherein interventions are no longer deployed in the patient's best interest, but rather for the nurse's own well-being. This component proves to be a pivotal concept in this

research, because self-preservation interventions will ultimately change the way care is provided.

As Bourke (2006) suggests, fear becomes an emotion through which certain aspects of life are administered. When an individual experiences fear and recognizes it as such, that experience justifies cautionary or pre-emptive action. In this research, the threat/fear that some patients evoked (although it was not identified in those terms) may become part of larger systems of safety that seek to prevent future possibilities of victimization. Many of the participants described an anxiety or nervousness that some patients provoked in them. The capacity to define the source of this anxiety (making the subjective objective) serves a distinct function and represents a particular process, wherein making a threat tangible enables the fearful individual to control the disruptive object by various means (neutralizing the threat) (Bourke, 2006). Working in an environment where there is the possibility of an adverse event enables the nurse to try to avoid threatening situations. In this case, the works of Lazarus and Folkman (1984) regarding stress, appraisal and coping are useful in the understanding of strategies deployed by nurses to try to deal with (potentially) threatening situations.

As explained in the literature review, "the basic idea of Lazarus and Folkman's (1984) approach is (1) that the emotions we experience are partly a function of our cognitive appraisal of a situation and (2) that such appraisal is a function of our evaluation of the significance of an encounter for our well-being (Primary appraisal: Am I in danger now?) and our awareness of possessing appropriate coping resources (Secondary appraisal : What can I do about it?)" (Whittington & Balsamo, 1998, p. 75). To cope with a situation essentially refers to an attempt to control it. In response to the fear of violence, psychiatric nursing has always instituted rituals of protection such as removing personal articles and ward searches (Goffman, 1990; Morrison, 1990). By thinking in terms of prevention, nurses then limit chances of violence, but also act on situations that have not

yet happened. In this research, nurses defined three ways in which the threatening situation could be controlled:

1.) Interventions directed at the self: gathering information about the patient and/or situation, and subsequently taking action to minimize victimization (talking in open spaces, doing rounds two-by-two, evaluating patients from a distance, etc.).

2.) Interventions directed at the patient: forms of control that are aimed at the patient (and his body), such as verbal de-escalation, PRN medication, using physical force, developing a privilege system, etc.

3.) Interventions directed at the environment: forms of control that seek to rearrange the environment to avoid victimization, such as the use of cameras, controlling what is allowed on the units, staffing, etc.

These interventions will depend, however, on the nurse's appraisal of possible outcomes and his/her capacity to manage the situation (Lazarus & Folkman, 1984). In this process, nurses will also evaluate the consequences of using certain coping strategies over others, which will vary depending on the relationship between the individual, the context and the available resources (Lazarus & Folkman, 1984). In this research, a salient contextual consideration was evident; that is, nurses are highly influenced by the context in which they practice. This context will influence the strategies deployed in potentially threatening situations. In effect, nurses will deploy interventions directed at the self and at the environment to the extent that they evaluate the situation as manageable. Once a patient or a situation escalates, then nurses need to control the disruptive object (patient) in order to neutralize the threat. This is done on a continuum of restrictive interventions (de-escalation to physical force). In this case, nurses "pathologize" (where potential violence becomes a symptom that can be dealt with under medical authority) to the extent that the language of risk is used to justify controlling behaviours. However, the

dangerousness associated with some patients forces nurses to take precautionary repressive measures to ensure the overall safety of the units (including their own safety).

The stories which participants shared regarding the future admission of a serial rapist on the unit attest to this contextual consideration. At the time the research took place, nurses were planning a preventive seclusion intervention to protect female nurses on the units from the possible admission of a high profile, serial rapist. As a result of a fearful anticipation, a collective understanding developed as to how this situation should be handled. Despite not having met with the patient, nurses discussed the risk that he posed to staff, and came to the conclusion that this potential risk needed to be contained. In this case, seclusion was considered to be the best possible solution to ensure safety. It is important to note that this discussion took place in relation to recent environmental changes on the nursing units. A minimal number of seclusion rooms were available to staff, and technological surveillance (cameras) had been removed. As such, a new negotiation between threatening encounters and how to handle them was taking place. By changing the environment, there was an administrative incentive to foster prevention through human interaction; however, many of the participants remained in uncertainty as to what resources were available to deal with potentially dangerous individuals safely.

In this situation, the patient's history became a tool of evaluation that was used in the planning of an intervention. The threat that the patient posed to the staff was not the result of clinical manifestations, nor was the planned intervention therapeutic. As the participants explained, in this type of situation, seclusion was considered the best available resource, because it enabled nurses to stay safe by neutralizing the threat, a threat that was the product of virtual construction of the patient as an "at risk" individual. In light of this particular example, the participants' verbatims indicate that the cognitive appraisal of threatening situations must, therefore, be taken out of the moments that precede an

assault, and must take into account larger contextual factors that influence nursing interventions.

Nevertheless, this example also reinforces how participants need to create a safe environment in order to practice. If a threat is not considered to be manageable by reorganizing the way nurses handle themselves or the environment, then it is much more likely that the intervention will be directed, with a safety rationale, at the patient. In some cases, the fearful response evoked by patients encouraged nurses to be diligent and aware of their surroundings. However, when less intrusive actions cannot neutralize the fearful emotions evoked by patients, then nursing care takes on the form of control. In effect, due to their mandate for safety on the units, nurses who are threatened will most likely want to "take action" to neutralize this threat. The threat presented by those who are feared or defined as "at risk" will be neutralized according to the available resources on the nursing units (use of the seclusion room, for example).

⑤ *The Mentally-Ill Offender as Other*

One of the major research findings that resulted from this project is the identification of a process that explains how nurses engage with mentally-ill offenders. To understand this process, the theoretical framework on "Othering" proposed by Canales (2000) proves to be of utmost importance because of its inclusive and exclusive properties. In this research, the balance between inclusion and exclusion of patients was conceptualized in terms of processes of identification and differentiation. In a complex analysis of differences, negative representations evoked by patients constantly threatened nurses' ability to identify with them. In effect, while representations of patients may open the door to therapeutic opportunities, they may also generate exclusionary practices. As other researchers have suggested in the past, the results from this study indicate that representations of the patient population influence practices, and, likewise, that practices will influence representations (Holmes, 2001a; Goffman, 1963). Keeping in mind the

unique contextual factors that position the research setting at the crossroads between the prison and the hospital, the findings from this research attest to the difficult association of these two environments. This was noted in the participants' accounts of the internal conflict that exists between the representations of the patients as both sick (medical representation) and deviant (criminal representation).

In Chapter Four, the descriptive categories revealed the presence of a professional nursing discourse within the medico-legal institution. Nurses described ethical obligations towards patients whose condition fostered an empathetic response. According to Handsley and Stocks (2009), given the significantly longer period of time that staff spend in direct personal contact with patients, "it is perhaps essential that their 'performances' are seen to embrace empathic elements that demonstrate and foster commitment and 'active' involvement" (p. 30). Thus, in the present study, being able to understand the patient was presented as the ethos of professional nursing care and the foundation for an identification process to take place. As the participants explained, attempting to identify with patients, to relate with their situation and to create an alliance were believed to be important parts of their practice. Being able to "identify with" and "relate to" patients in order to create this alliance was a process based on the premise that the patient/offender being cared for is above all, a person. In other words, being able to identify with patients and being able to relate with their situation was the result of a connection between the carer and the cared for, one that was based on shared humanness and its possible flaws (being sick). Nurses could relate to patients, either because they were able to understand the patient's situation (being sick), or because they could imagine themselves in that situation (this could be me, my brother, my friend, etc.). As a result of this rationalization, the reason for mandatory detention becomes secondary to the conceptualization of the patient as a vulnerable being. Participants explained how a shift took place in their minds, one that reconfigured the patient as a victim of sickness rather than the perpetrator of deviant acts.

The process of identification is rooted, therefore, in the understanding of difference. By casting the patient in the role of the "Other"—the individual who is different from the self on account of mental illness—nurses are in a position to foster therapeutic opportunities, because they can relate to the patient's situation. According to Canales (2000), this type of practice falls within the realm of "Inclusionary Othering." The nurse's ability to view and understand the world from the Other's perspective enables the creation of a therapeutic alliance and a possibility to utilize power within the relationship in a positive way (transformation). "When nurses are able to take the role of the other, however that Other is defined, and begin to see the world from the other's perspective, their own actions can be directed according to perceived individual and group attributes, rather than prejudice and stereotypes" (Canales, 2000, p. 25). Being able to identify with patients and go beyond representations of deviant behaviour enables the nurse to connect through difference. In this research, it is through this connection or alliance that nurses explained how power could be exercised within their relationship with patients. In effect, by creating a trusting relationship, and by encouraging disclosure, nurses described being more likely to access valuable information and influence the patient's behaviour.

The power that can be exercised in a positive (transformative) way by casting the patient in the role of the Other essentially refers to what Holmes (2002) describes as pastoral power (nurses as subjects of power). Issuing from Christian thought, this form of power requires that a person (the nurse) serve as a guide for another (sick or vulnerable) individual. As part of a larger governing structure, this individualized form of power seeks to penetrate the soul, act upon it and, ultimately, direct it (Foucault, 1994). As Holmes (2002, 2005) suggests, this form of power is regularly used by nursing staff as a control mechanism over patients. However, in order to access the patient's thoughts and foster true, open dialogue (uncensored disclosure), establishing trust (or a good rapport) is a requirement that was repeatedly asserted by research participants as being essential.

Once trust has been established, then confession becomes an important element in the governance of patients (Crowe & Carlyle, 2003; Foucault, 1994).

This research shows how nurses use such power as a self-awareness technique to re-socialize patients into adopting "normalized" behaviours. Through a patient's confession, nurses are able to access the patient's deepest secrets and difficulties, and redirect them accordingly. According to the participants, this form of power also assures conformity to treatment plans. In addition, confession can be corroborated by technology to assure that the patient is telling the truth (random drug testing, for example). When the objective evidence (a positive urine test, for example) contradicts the confession, the nurse knows the patient is not yet self-governing. In brief, pastoral power becomes a technique of micro-discipline whereby nurses use their connection with a patient to attain clinical objectives (social reinsertion). However, as the participants acknowledged, establishing or even keeping trust can be extremely difficult, and may create situations that render pastoral power ineffective. Similar to what Holmes (2002) has asserted, nurses who must ensure safety/security on the units are forced to take on the role of a correctional officer, which, in some cases, breaks down the foundations of a trusting relationship.

Nevertheless, the positive conceptualization of the Other presented above is somewhat different than traditional negative views on the subject (see Johnson et al., 2004 and MaCallum, 2002) in which defining the patient as Other is commonly associated with less than optimal care (Jacob, Gagnon & Holmes, 2009). In these circumstances, the nurses' positive use of differentiating attributes (their ability to identify with patients and capitalize on opportunities to influence behaviour through interaction) can be overpowered by the use of such attributes to exclude the Other. If a nurse experiences an internal conflict between the representations of the patient as both sick and deviant, it is through exclusionary practices that this tension is most evident.

In the forensic psychiatric nursing literature, the representation that nurses make of their patients is a distinct variable that will affect care (Holmes, 2005; Holmes & Federman, 2003; Mason, Richman & Mercer, 2006). According to Canales (2000), "when a person fails to take the role of others, or resist role-taking opportunities, they are often unable to interact, or they interact based on misconceptions or stereotypes" (p. 19). As the research results suggest, this type of superficial/stereotypical representation of patients may very well be the result of a particular socialization. The construction of the patient population as being either manipulative, mischievous and/or dangerous is a good example of a socialized group ideology. At any given time, these labels that are attributed to patients represent the group's point of view regarding certain subjects (Mannoni, 1998) and will be used in the professional socialization of other nurses (Holmes, 2001a). As explained earlier, the results of the research indicate a progressive attention to risk in forensic psychiatric settings. As time goes by, nurses are summoned to integrate a belief that the patient population is dangerous, and a safe distance needs to be created. When dealing with a practical discipline such as nursing, it is important to understand that the way nurses conceptualize the patient population may be the result of conditioning (Mannoni, 1998). Therefore, negative mental representations that inevitably lead to negative stereotyping will affect the way that patients are viewed, and will influence the course and outcome of interactions.

What Canales (2000) describes as "Exclusionary Othering" is a practice that is founded on the use of differences to identify, label and exclude the Other based on the negative mental representations that they may evoke. It is a theoretical approach that is based on the works of Goffman (1963) and the concept of "stigma." Those who are labelled as being different carry the burden of a spoiled identity, and, as a result, will be distanced by those who embody "normal" attributes. In this research, the possibilities of Exclusionary Othering (a negative differentiation process) were described as being

influenced by the patient's troubling and threatening history. In effect, the patient's history replaces the visible signs of stigma that are usually associated with the body and that codify patients as Other (stigmatized). In forensic psychiatry, the patient cannot hide the negative attributes that define him/her as Other. The history becomes the vehicle of representations and inevitably influences those who come in contact with it.

In this research, the patient's criminal history was described as a determining factor in the way nurses could/would handle each patient. Depending on the nurse and the patient's particular crime, some patients were deemed harder to deal with than others. For example, some of the participants described having difficulty working with patients whose crimes involved children. This difficulty was associated, in part, with disgust and the complexity revolving around the separation of the nurse's social status (parent) from their professional role (nurse). In this case, some participants were more inclined to identify with the victim of the crime rather than the perpetrator. As a result, the difficulty in working with particular patients because of their specific crime was also associated with a difficulty in accepting and understanding the pathologization of the deviant behaviour. It is precisely at this moment—when it becomes difficult for nurses to rationalize what the patient has done within a medical framework (seeing the patient as sick)—that nurses described a need to create a separation between the patient and themselves. In other words, the separation, which is not always a literal physical separation, does not necessarily happen because of the patient's actions on the floor. Rather, the patient's troubling history becomes a marker of deviance that defines him/her and, in some cases, influences nurses in adopting strategies to avoid dealing with the troubling images that he/she may evoke. The forensic marker of deviance with which some patients are labelled generates a negative differentiation wherein the patient is distanced (physically and/or psychologically) by his/her caregiver.

In general, most nurses needed to cast the patient in a "sick role" to distance themselves from the "criminal" and engage with the "patient" on medical terms. Despite humanizing patients and constantly reminding themselves that each patient is a person, nurses needed to define the "patient-as-an-illness." Seeing the "patient-as-an-illness" enabled therapeutic interactions to take place, because the behaviours that brought patients to forensics could be explained under a medical framework. As such, these research results concur with Mason, Richman and Mercer's (2006) conclusions regarding the use of "Evil" as a clinical term to define the patient in forensic psychiatry. This type of labelling practice that constructs the patient outside of a medical framework, and, consequently, outside the matrix of care and cure, may influence care and base its provision on the illegitimate representation of the patient within in the therapeutic institution.

The results from this research indicate that nurses needed to differentiate patients within a medical framework (patient as sick and out of control) to understand that illness was the main reason for their admission into the forensic psychiatric facility. Nurses' inability to conceptualize the patient as ill (out of control) or to make sense of the criminal behaviour may result in both conscious and unconscious mechanisms to try to create a distance (differentiation) from these patients. For example, the use of pejorative vocabulary (i.e., inmate, monster, evil or murderer) as well as the use of quasi-legitimate medical terminology (i.e., psychopath or borderline) to define some patients are ways that have been described in the literature as well as in this research to create exclusion within relationship and differentiate the patient from the nurse (Holmes & Federman, 2003; Holmes, Perron & O'Byrne, 2006; Peternelj-Taylor, 2004). In part, this exclusion and differentiation is explained by the nurses' experiential knowledge developed during their contact with forensic psychiatric patients. Such a perspective reinforces Goffman's (1990)

beliefs regarding the constructed identities of patients and the role they play in the justification of treatments.

The translation of inmate behaviour into moralistic terms suited to the institution's avowed perspective will necessarily contain some broad presuppositions as to the character of human beings. Given the inmates of whom they have charge, and the processing that must be done to them, the staff tend to evolve what may be thought of as a theory of human nature. As an implicit part of institutional perspective, this theory rationalizes activity, provides subtle means of maintaining social distance from inmates and a stereotyped view of them, and justifies the treatment accorded them (p. 87).

Patients who seem in control and are believed to be able to understand right from wrong do not always evoke the belief that they are sick, and on that account, will fuel different responses from nurses. Once again, this corresponds to Mason and colleagues (2006), who found that, when the perpetrator of criminal acts was viewed as knowing right from wrong and could rationalize action according to good and bad, "there was a perception that this constituted a cold and callous position, which was beyond the treatment sphere and considered 'pure bad'. This lay outside the sickness model" (p. 349). As a result, not attributing the behaviour to illness, and seeing the motivation for actions in daily encounters force nurses to conceptualize the patient as a responsible/criminal being.

Understanding the conscious mechanisms that produce boundaries between mentally-ill individuals and the "normal" population has been described by many authors (for example, see the classical works *Asylums* by Goffman (1990) and *Histoire de la folie à l'âge classique* by Foucault (2005)). However, recognition of unconscious mechanisms that produce boundaries (physical and psychological) between patients and nurses is only starting to emerge in the forensic psychiatric nursing literature (see Holmes, Perron & O'Byrne, 2006 and Jacob, Gagnon & Holmes, 2009). In both articles, the work of Julia Kristeva on abjection is extremely helpful in making theoretical links regarding the nature of contamination from the abject (defined here as the forensic psychiatric patient) and the way in which nurses attempt to minimize this contamination in order to create a safe-zone

from which they can work. "As the abject, the mentally ill offender possesses the power to contaminate and thus poses a risk for those who come in contact with him and his criminal history" (Jacob, Gagnon & Holmes, 2009, p. 157).

In this research, participants described how they would "secure boundaries" between themselves and patients by "working in the here and now." Most participants explained how they would set aside (albeit not completely) the patient's history, and focus on what is happening in the clinical moment. By doing so, nurses described being able to set aside their judgments and work objectively with each patient in a specific moment. Working in the here and now also permitted participants to contain feelings of abjection within time and space; that is, nurses could see the contact with the abject (forensic psychiatric patient) as something temporary.

However, being able to set aside the knowledge of the patient's history, as well as the feelings and thoughts that it may evoke, is not always possible. In effect, most nurses would argue that exposure to gruesome criminal acts evoked feelings of fear, anger or disgust that made engaging with patients extremely difficult. As a result, nurses developed certain clinical practices to minimize contamination from the patients' histories, the feelings these evoked, and their subsequent reluctance to interact with those patients. For one, nurses debated whether to approach a patient without reading the history. Such an approach—trying to interact with the person rather than the criminal—was believed to be helpful in engaging with patients objectively. However, this perspective was considered by some as being at odds with personal and collective safety. An omnipresent discourse of risk is embodied by the patient population; nurses are socialized to acknowledge this, and, to some extent, become accustomed to it and incorporate it into their nursing assessments. A lack of awareness of the patient's history, and the accompanying risks of this ignorance, become a professional incompetency. As a result, nurses are obliged to be

contaminated indirectly by the patient whose history must be reviewed for a complete, comprehensive assessment.

In the face of the abject, Holmes, Perron and O'Byrne (2006) argue that negative labelling of patients (as inmate, monster, liar, etc.) is a way for nurses to create a psychological distance between nurses (Us) and the patient population (Them). As in Mason, Richman and Mercer's (2006) work, it is the conceptualization of the patient outside medical rationalizations that becomes problematic. Holmes, Perron and O'Byrne (2006), however, explain that negative labelling refers to a practice that seeks to de-humanize patients who then take the form of a radical being. Thus, negative labelling becomes the vehicle to discursively (and practically) separate nurses and patients. In effect, once the patient becomes less human, then it is much easier for staff to justify the need to create a distance from him/her (Lupton, 1999).

According to some of the participants in the study, recognizing the negative feelings and thoughts that patients and their histories evoke was believed to be necessary if nurses wished to be professional. Nurses actually made it very clear that only when such abjective feelings are recognized can their feelings, as well as their patients, be dealt with professionally. Likewise, some participants explained that abjection cannot always be contained, and there are times when it is best to avoid contact with patients. In such cases, they suggested that patient allocation could be redistributed among nurses to physically distance the abject.

@ The "(A)potential" Patient

During the course of this study, a number of issues were underlined by participants regarding their work in forensic psychiatry. As with Handsley and Stocks (2009), participants in this study attest to the difficulty of working in mental health nursing, which "can induce a strain, which staff unwittingly fail to recognize, but which can significantly affect patient care" (p. 30). As the research results suggest, close proximity for significant

periods of time with patients can induce a sort of mental exhaustion such that nurses "can go home feeling skinned alive." In some cases, nurses retreated to the nursing office to create a distance from patients. In other circumstances, this *distanciation* was a way to purposely avoid patients and discourage further patient contact with nursing staff (misuses of the consumerist mentality).

However, participants also touched on an issue that is much more sensitive and reveals the difficulty associated with long-term forensic psychiatric care: the question of potential for recovery. Demonstrating "potential" was described as an essential motivator for nurses to invest themselves in therapeutic relationships. So, what happens to nursing care when patients do not demonstrate this potential? The final section of the discussion will briefly attempt to explore the concept of (a)potential individuals in light of the research results.

In the early 1990s, Mason and Chandley (1990) demonstrated the difficult association between societal values of protection and the therapeutic enterprise. In the forensic psychiatric hospital, the patient's progress "can proceed only to the limit of the resources available to the nursing role. At this juncture, frustration occurs and the 'superficial' role of patient is shed and the core role of the detained person is re-adopted" (p. 670). In other words, the patient is only a patient, and nursing care is only nursing care as long as therapeutic interventions can be envisioned. This is the paradox underlined by Mason and Chandley (1990): some patients don't necessarily benefit from therapy, but must remain detained under judicial disposition. In these circumstances, patients remain indefinite prisoners of the medico-legal institution, and create new meanings regarding therapeutic ideals for those who provide care. The present study reveals a unique nurse-patient dynamic that revolves around the notion of long-term hospitalization.

According to Hellzén, Kristiansen and Norbergh (2003), there appears "to be a tendency for long work experience to have a negative effect on nurses' attitudes towards

residents" (p. 616). In this study, some participants openly discussed becoming jaded towards patients, because they have experienced the repeated failures of patients to reach clinical objectives. This experiential knowledge may evoke an understanding that care is useless (no goals can be achieved) and that interventions are bound for failure, a perception that is not always shared by those who haven't had a prolonged (long-term) exposure to the individuals in question. Much like the experience of working with a difficult patient (someone who is verbally abusive, for example), the nurse who attempts to work with or accommodate the (a)potential patient may come under criticism from the group.

Nevertheless, nurses experience an internal tension that is generated from working with (a)potential individuals; that is, there is a disconnect between the ends (clinical objectives) and the means to achieve these clinical objectives. As a result, nurses described having to create an illusion of therapy to show the patient that he/she has not been "written off," even though this may be the case. Basic needs may be fulfilled and trivial objectives created, but nursing care essentially loses its meaning. Such work resembles what Castel (2002) defined as a specialization in custodial work. The functional (read "productive") definition of the psychiatric institution given by Goffman (1990) is not relevant in this case. If a patient has no expectation of being released, being "on the inside" loses its significance in relation to "the outside" (getting out) (Goffman, 1990). This is reflected in the reports by a number of participants who conceptualized the institution as a laid-back, family environment. This is their understanding of what (a)potential patients have to look forward to.

The tension generated by individuals who may have no potential disrupts the normal nursing trajectories, because nurses have difficulty in finding interventions to work with the individual. The lack of potential creates inconsistent nursing expectations. Nursing actions start losing their significance, and insignificant care then becomes irrational care, which in turns creates inaction. Working with individuals who may not

demonstrate potential creates an environment where it is expected that "nothing" will happen and that actions may not have any particular impact. Little importance is given to everyday nursing interventions, because they are not necessarily valued anymore. According to Hellzén and colleagues (2004), "if the nurse experiences the patient as defective or having a meaningless life there is a risk that nurses will view his/her action as a meaningless activity" (p. 3). As participants reported, caring for (a)potential individuals puts the nurse in a difficult situation where the work itself becomes meaningless. Having difficulty finding significance in the long-term vision of care (that may be synonymous to a medicalized custodial practice) forces them to find other ways to conceptualize their practice as good and well-intentioned. From examples given by the participants, there is danger in reducing the patient to an object, a "thing" from which nurses can distance themselves, focusing rather on the completion of a task than on evaluating observable changes with the patient.

LIMITATIONS OF THE STUDY

As with all research, limitations that imposed restrictions on the results occurred within the study. In this case, limitations could be regrouped under three themes: methodological, empirical and theoretical.

Methodological: The interview process may have created limitations, because it excluded from the data collection individuals who did not feel confident regarding issues of confidentiality. Thus, only individuals who felt they would not be jeopardized by the research finding may have participated. In addition, the tensions that existed between some staff and the administration may have given the research project a negative connotation. Prospective participants may have seen the interview process and its lack of anonymity as a professional threat, regarding the interviews as being more like an investigation of them (performance evaluation). Also, the interview process itself may have limitations. During face-to-face interactions, those who decided to participate may have

reported what they felt the researcher wanted to hear rather than expressing what they actually felt (social desirability bias).

In addition, the choice of vocabulary to describe the research (notably the reference to fear) may have also excluded from the data collection individuals who did not internalize the threat posed by the patient population. As it was indicated in the literature, as well as in the results from this research, fear is not openly discussed in these environments, and proves to be a difficult concept to explore.

It is important to note that the results from this research may not reflect the beliefs and experiences of all nursing staff working at the forensic hospital, and that the ensuing findings represent the researcher's interpretation.

Empirical: Limitations regarding the research setting may have also influenced the outcome of this project. First, the entire forensic psychiatric nursing personnel had recently relocated and was adapting to their new environment. During informal discussions with nursing staff, the researcher was made aware of ongoing internal investigations that took place in the research setting. For the past few years, nurses had been participating in surveys regarding their work conditions with little feedback as to what the results were or how it would affect their practice. Coupled with the recent move, frustrations with the research process might have produced a general disinterest in this research project.

Theoretical: Although the choice of method (grounded theory) allowed theoretical works to be added as dictated by the data collection, the analysis remains limited to the researcher's theoretical position. In other words, the results were mediated by the researcher's values, clinical experiences and theoretical influences. These elements constitute limitations to the extent that they influenced the interpretation of the data as well as the selection of specific interview excerpts to create the descriptive categories.

IMPLICATIONS FOR PRACTICE, RESEARCH AND EDUCATION

Implications for Practice

The findings for this research project are relevant for nurses who provide direct clinical care to individuals in psychiatric settings, as well as for other areas of practice where patients may be considered to pose a threat to the individual or collective body.

First, working with a threatening population proves to be extremely difficult in that healthcare professionals have the means to justify controlling interventions on the basis of risk. In these situations, where the patients may be controlled for preventive reasons (both individual and collective), nurses engage in actions that may be clinically relevant (securing the environment) but also ethically challenging. Nurses working in such environments must recognize the ethical implications of working with such a patient population. They need to be consciously aware of their actions, and must not perpetuate a status quo. It is by discussing the difficulties encountered in practice that nurses may find other ways to act in threatening situations.

In addition, the findings presented in this research show that remaining non-judgmental when dealing with marginal populations (paedophiles, murderers, sex offenders, personality disorders, etc.) can be difficult. Nurses must be aware of an unspoken type of violence in the healthcare setting; knowledge of the patient's history may result in the nurse's being psychologically violated. As the participants clearly noted, it is important to clarify personal values in order to act professionally. This may include removing oneself from clinical interactions and letting others deal with the situation/patient.

Lastly, nurses working with individuals who pose a risk to the collective body (society) may have to work in institutions where therapeutic ideals become one with institutional functioning; that is, nurses may be responding to a social need (care to mentally-ill offenders), but may also be required to fulfil roles congruent with the institution's mandate (including security imperatives). In the case of forensic psychiatry,

the social need for care forced the development of a particular institutional practice before guiding principles (disciplinary knowledge) could be developed. As a result, there need to be ongoing discussions between the clinical and the academic settings to adapt the type of knowledge required to provide a service for patients (social need) rather than to fulfil only an institutional role. Given the detailed contextual descriptions, this research could be transferable to other areas of nursing practice where the threat of violence influences nurse–patient interactions (emergency settings for example).

Implications for Research

From a research perspective, the findings from this project highlight the ways in which threat produces certain types of nursing interventions. Instead of looking only at the repressive effects of violence, it is important that researchers begin to look at its effects in the clinical setting (how nurses internalize this threat and produce nursing interventions to neutralize this threat).

Moreover, this research also indicated a troubling reality for nurses working in long-term settings, where nursing care seems to lose meaning. Thus, future research might explore what the implications for nursing practice are when care is provided to a population defined as being a “chronic risk.”

Implications for Education

The understanding of power that is presented in this project attests to its diffuse and dynamic properties. It is important that future nurses be educated and made aware of these dynamics as contextually situated. In this regard, education for nurses needs to incorporate the politics of care (including institutional functioning and agendas) that directly affect its practice. Also, nurses and future nurses must be conscious of patients’ potential to affect the provision of nursing care. Nursing under threat may all too easily justify certain types of interventions (such as over-medication or the use of seclusion) to the detriment of the nurse–patient relationship.

CHAPTER SIX

CONCLUSION

The body of work that is available in forensic psychiatric nursing attests to the ongoing interest in defining this area of research according to the population being cared for and the environment in which nursing care takes place. Of particular importance to this project is the paradoxical situation wherein nurses attempt to fulfil professional standards of care (provision of care) in an environment where personal integrity is threatened (Whittington & Baslamo, 1998). In hopes of expanding on the depth of previous studies, the attempts of this project to describe, comprehend and explain how fear influences nurse–patient interactions in forensic psychiatry constitute one more step in the development of this growing nursing specialty.

As a starting point for this qualitative undertaking, this research project was based on an exploratory research design (grounded theory) with the expectation of producing comprehensive insights into a nursing phenomenon that has been relatively unexplored. Many authors have described forensic psychiatric settings as potentially violent or extreme work environments. Yet, very few have touched on the subject of fear and its effects on nursing care. In addressing the implications of fear in the provision of care to mentally-ill offenders, it is essential that a re-conceptualization of power dynamics occurs to overcome the unchallenged assumption that nursing care can be defined without specific contextual considerations. In effect, the findings presented in this research project reveal that nurse–patient interactions are based on, and modified by, the context as well as the patient population being cared for.

The results from this research indicate that the environment in which nurses practice is as constraining for nursing staff as it is for patients. If the risk patients pose to society is contained by means of institutionalization, this process also creates a highly regimented area of practice for those who are asked to work with them. The role nurses

hold within the institution regulates their distribution in time and spaces, thus allowing little flexibility in the provision of care. As a result, the imperatives of the institution come to define how care is provided, and nurses must navigate within this structure to facilitate therapeutic interventions.

Nurses are socialized to incorporate representations of the patient population as being potentially dangerous, and, as a result, distance themselves from idealistic conceptions of care. In effect, the heightened awareness and suspicion that a few patients may evoke come to affect care on a much larger scale (the whole nursing unit). The constant awareness that some patients may have hidden motives for their actions creates an environment in which trust is difficult to develop. This is particularly true of areas of practice (assessment unit) where patients are considered to be more dangerous/less stable.

The use of the panoptic metaphor was used in the discussion to exemplify the participants' accounts regarding the need to "see" the patient in order to adapt nursing interventions. In effect, rendering the patient population completely visible to staff through the use of cameras was considered to be an ideal, as it permits a direct and continuous method of intervention and evaluation. Nevertheless, the predominant rationalization for making the patients subjects of constant visibility was not necessarily therapeutic, but rather had its purpose in fulfilling safe and secure spaces. Interestingly, the disciplinary effects that cameras may have had on patients in the past may also have changed the way nursing care is being provided (distant and reactive), fostering new dynamics between space, bodies and security.

The constant negotiation between space, bodies and security has, in part, created certain practices to counter the effects of potentially threatening situations. To some extent, nursing under threat may force nurses to scrutinize their actions (self-discipline) in order to avoid becoming a victim. However, if a threat is not considered to be manageable

by reorganizing the way nurses handle themselves in the environment, then it is much more likely that the intervention will be directed at the patient, and that this intervention will have a safety rationale. As participants described in the study, security inevitably needs to be present in order for care to be provided. If the environment is considered to be unsafe, then interventions to secure the space are inevitable.

In parallel to the conceptualization of the patient population as being "at risk" is the possibility of casting the patient in the role of the "Other." In this research, participants described how being able to identify with patients enabled positive (read "therapeutic") interventions to take place. Casting the patient in the role of the other (sick and/or vulnerable) enabled the nurse to create a rapport with the patient and to use the relationship in a transformative way (self-governance). However, exposure to the patient's criminal history, as well as the inability to rationalize the patient's behaviours within a sickness model, fostered a negative differentiation process wherein nurse-patient interactions became difficult. As the participants explained, it is important for nurses to recognize these responses if they wish to engage with patients in a professional manner.

Demonstrating "potential" was described as an essential motivator for nurses to invest themselves in therapeutic relationships. In some cases, experiential knowledge may evoke an understanding that care is useless (no goals can be achieved) and that interventions are bound for failure, a perception that is not always shared by those who haven't had a prolonged (long-term) exposure to the individuals in question. The tension generated by (a)potential individuals disrupts the normal nursing process, because nurses experience difficulty in finding meaning in nursing care. As Hellzén and colleagues (2004) suggest, "if the nurse experiences the patient as defective or having a meaningless life, there is a risk that nurses will view his/her action as a meaningless activity" (p. 3).

Participants also highlighted the presence of gender dynamics and social norms that implicitly and explicitly governed work divisions and the presentation of the self in the

forensic psychiatric units. Incorporating the masculine standards (being fearless) was seen as a socially desirable attribute. In parallel, male and female nurses fulfilled a number of prescribed roles that were presented in the form of "taken for granted" assumptions. For example, men were often called upon to deal with violent patients because of their size. However, unlike Holmes (2001a), the participants in this research suggested that there is much to gain from having a "maternal" presence on the workforce. In effect, women can be viewed as being less threatening than men in certain situations, and may enable nurses to avoid physical interventions.

In brief, the results from this research attest to the difficult situation in which nurses find themselves when confronted with threatening individuals. Guiding principles of the profession seek to conceptualize the nurse–patient relationship as a site for therapeutic opportunities. However, the need for safety (both at the individual and collective levels) will always cast a dark shadow over the ideals of care. When nurses feel threatened, security will take precedent over care.

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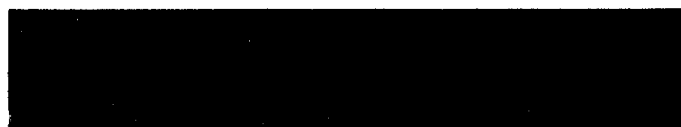
APPENDIX A

Consent Form

Researcher: Jean Daniel Jacob, RN., BScN, PhD(C)
School of Nursing
Faculty of Health Sciences
University of Ottawa

Supervisor:

Affiliated Contact:



Project Title: *Fear and Power in Forensic Psychiatry: Nurse-Patient Interactions in a Secure Environment*

Funding Agency: Social Sciences and Humanities Research Council of Canada

Research Objective

This research project seeks to explore and situate nursing practice where opposing professional roles converge: providing care and social control. The main objective of the study is to describe and comprehend how fear, as a dynamic process, influences nursing interactions with patients in a forensic psychiatric setting.

Participation

If you wish to participate to the study, you will be scheduled to meet with the main researcher on an individual basis in order to answer a broad, open-ended question regarding your experience at the forensic psychiatric unit [REDACTED]. Only one interview will be scheduled and should last approximately 60 minutes. The interview will be audio-taped unless you are opposed to it. If you do not wish to be recorded, notes will be taken during the interview to capture your verbal account. At no time will your physical integrity be at risk. The interview will take place during working hours in the principal researcher's office at the [REDACTED]. Other meeting sites or hours can be arranged if the predetermined arrangements limit your chance to participate in the study.

Criteria for participation:

- 18 years of age or older
- Work at the [REDACTED] a nurse (RN or RPN)

Prior to conducting each interview, you are asked to fill out a short demographic questionnaire to enrich the analysis and interpretation of results.

Risk

You could find it difficult to talk about your experience as a nurse working at the [REDACTED]. You can choose not to answer some questions if they create a discomfort for you and you will not have to justify why you do not choose to answer them. If you felt anxious or stressed regarding the content of our discussion, you will be oriented toward the necessary resources (Employee Assistance Program). Your Employee Assistance Program is provided by the [REDACTED]. This service provides confidential counselling for any personal problems. Confidentiality is respected at all times. No one at [REDACTED] facility or any one else receives information from the EAP without the written, informed and voluntary consent from the consumer. Costs for this service are paid for by the [REDACTED] days [REDACTED].

The data obtained during interviews and direct observation will not be used for evaluative purposes because it is not the goal of this research. None of the data collected will be used for disciplinary actions.

Personal Advantages

There are no direct advantages for participating to the study and you will not be remunerated for your participation. However, with your participation, you are contributing to the development of knowledge in a highly specialized field of nursing practice.

Additional Information

We will answer to any question you may have regarding the research project.

Confidentiality and Anonymity

The nature and content of your statements which will be audio-taped during the interview, as well as the nature of your behavior observed during the data collection period will remain confidential at all times. Your name will not be present on any of the audio-tapes, transcriptions or research results. You will be given an alphanumerical code that will enable you to keep your anonymity against any form of identification in future dissemination of results. All material that could potentially lead to the identification of patients, nursing staff and or the institution will be eliminated in order to respect confidentiality. All data (audio-tapes, transcriptions, journals, [REDACTED]) will be kept in a locked cabinet in the main researcher's supervisor's office at the University of Ottawa.

All audio-taped interviews will be transcribed by the main researcher (Jean Daniel Jacob). Only the main researcher and his supervisor (Dr Dave Holmes) will have access to the data. Information regarding the process and findings of the study will be shared with the thesis committee. However, these members will not have access to the transcriptions or audio-tapes.

The data collected will be kept for a period of 5 years in order to be analyzed, after which they will be destroyed (transcriptions will be shredded and audio-tapes demagnetized).

Given the qualitative nature of the study within a closed institution, anonymity cannot be guaranteed - you will be known by the researcher and possibly other staff members that are working within the institution. However, confidentiality will be guaranteed in future dissemination of results as described above.

Authorization for the Utilization of Research Results

You are accepting that the data collected during the interviews will be used for the conclusion of this research and could be used for scientific and professional publications, as well as educational purposes. It is possible that your statements be cited in publications and/or presentations. However, it is assured that the confidentiality will be respected for both the participants and the establishment where the research takes place.

Withdrawal from the Research

It is clear that your participation to this project is done on a voluntary basis. You can choose not to answer certain questions. It is also clear that you can withdrawal from the research at anytime, without having to justify why you chose to do so. The content of the interviews will be destroyed if you chose to withdraw from the study.

Questions Regarding the Study

If you have any questions regarding the study, feel free to communicate at any time with
Jean Daniel Jacob, RN, BScN, PhD
or with Dr. Dave Holmes, PhD.

Ethics

If you have any questions regarding the ethical conduct of this study, you may contact the
Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550
Cumberland Street, Room 159, Ottawa, ON K1N 6N5, tel.: (613) 562-5841, email:
ethics@uottawa.ca

or



Consent

I, _____, have read and understood the terms presented in this form.

I accept to be audio-taped: yes ☐ no ☐

I accept to be cited in future publications: yes ☐ no ☐

I consent to participate to the study. There are two copies of the consent form, one of which is mine to keep.

Participant

Researcher

Signed at _____, _____ 2008.

APPENDIX B

Observation Grid (adapted from Peretz, 2004)

General Categories	Elements
FPTD Characteristics	• Mapping the geographical site of the FPTD. • Mapping the history of the FPTD. • Identifying the nature of the site. • Accessibility (control office).
Physical appearances / objects / setting	• Physical barriers (locked doors, two way mirrors) • Cameras (numbers, site, how are they used) • Security apparatus (roles and who is associates with it) • Architecture and environmental design (how the work space is organized, hallways, visibility, etc.) • Poster, decorations, etc.
FPTD procedures and politics	• In house rules (regarding patients whereabouts and circulation, interactions modalities between staff and patients, procedure manuals, emergency procedures, etc.) • Politics and procedures regarding ethical interventions.
Actors/Groups	• Authoritative "invisible presence" (ex : memos)

APPENDIX C



Université d'Ottawa University of Ottawa

March 28, 2008

Dave Holmes
School of Nursing
Faculty of Health Sciences
University of Ottawa

RE: Fear and Power in Forensic Psychiatry: Nurse-Patient Interactions in Secure Environments. (H 02-08-02)

Dear Fr. Holmes and Mr. Jacob,

You will find enclosed the Health Sciences and Science REB ethical clearance for the abovementioned study.

During the course of the study, any modifications to the protocol or forms may not be initiated without prior written approval from the REB. You must also promptly notify the REB of any adverse events that may occur.

This certificate of ethical clearance is valid until March 28, 2009. Please submit an annual status report to the Protocol Officer in March 2009 to either close the file or request a renewal of ethics approval. This document can be found at

http://web2.uottawa.ca/services/ressrc/ethics/application_dwn.asp

A copy of this approval will be sent to research services, if necessary.

If you have any questions, you may contact the undersigned at the number

Sincerely yours,

Germain Zongo
Protocol Officer for Ethics in Research
For Dr. Daniel Lagarec, Chair of the Health Sciences and Science REB



Université d'Ottawa University of Ottawa

HEALTH SCIENCES AND SCIENCE RESEARCH ETHICS BOARD

CERTIFICATE OF ETHICAL APPROVAL

This is to certify that the University of Ottawa Health Sciences and Science Research Ethics Board has examined the application for ethical approval of the research project entitled **Fear and Power in Forensic Psychiatry: Nurse-Patient Interactions in Secure Environments**. (H 02-08-02) submitted by Pr. Dave Holmes of the School of Nursing at the University of Ottawa and his doctoral student Mr. Jean Daniel Jacob. The Board found that this research project met appropriate ethical standards as outlined in the Tri-Council Policy Statement and in the Procedures of the University of Ottawa Research Ethics Boards, and accordingly gave it a Category 1a (approval). This certification is valid one year from the date indicated below.

 Germain Zongo
 Protocol Officer for Ethics in Research
 For Dr. Daniel Lagarec, Chair of the
 Health Sciences and Science REB

March 28, 2008

Date

APPENDIX D

RESEARCH ETHICS BOARD

June 17, 2008
Jean Daniel Jacob, RN, PhD Cand.
Principal Investigator

Re: REB# 2008013
Fear and Power in Forensic Psychiatry: Nurse-Patient Interactions In
Secure Environments

Dear Mr. Jacob,

This letter is to acknowledge receipt of your letter (dated June 10, 2008) in which you include a revised Protocol and Consent Form in which you address points expressed to you in our letter (dated June 5, 2008) for the above-titled protocol.

Your responses to questions regarding the Protocol have been reviewed and your protocol has now received approval for the period of one (1) year from the date of this letter.

This approval is contingent upon maintaining adherence to the normal approval process, namely,

- Reporting to the Board any adverse events of the project in progress
- Seeking prior approval from the Board of any direct use of public media to recruit research participants

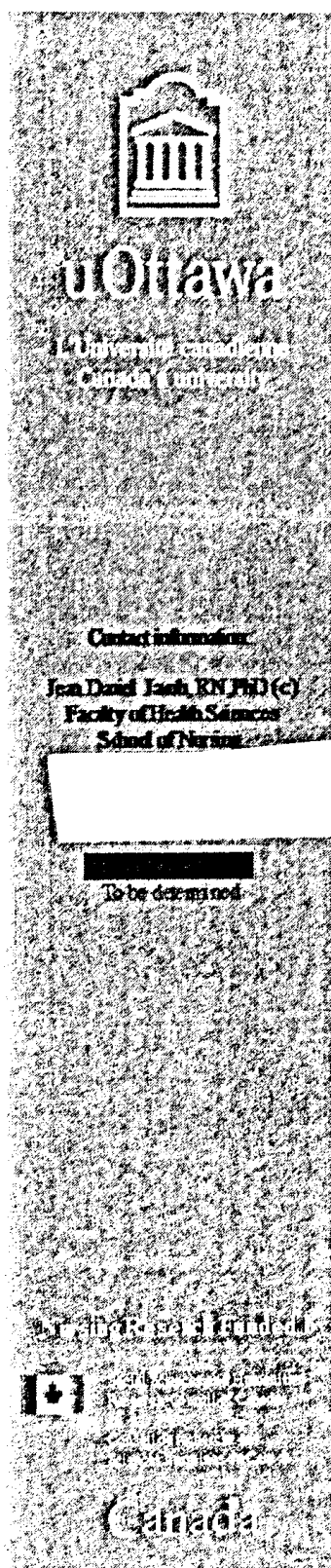
Approval will be reconsidered if Hospital/Institutional resources are used beyond those specified on the Checklist of Resources or the Impact on Hospital resources and/or if Grant funding applied for is not received. However, in either case the protocol can be re-submitted with revised Checklist information and will be reconsidered.

Annual progress reports must be submitted to the Board for continuation of Research Ethics approval. A termination report is required at the conclusion of the study.

Sincerely, on behalf of the Board,



APPENDIX E



Research Information Session

Project Title:

*Fear and Power in Forensic
Psychiatry: Nurse-Patient
Interactions a Secure
Environment*

When:

14th & 15th of July 2008

@

10:00 /16:00/22:00

Where:

Boardroom (first floor)

* Presentations last approximately 15minutes.



Fear and Power in Forensic Psychiatry: Nurse-Patient Interactions in a Secure Environment



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Canada's university

Jean Daniel Jacob, RN, PhD(C)
University of Ottawa
Faculty of Health Sciences
School of Nursing

Université d'Ottawa | University of Ottawa



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Nursing in Forensic Psychiatry

- Crossing of two distinct disciplinary fields: nursing care and criminology (social control).
- Multiples responsibilities regarding both fields: nursing care and maintenance of security.
- Forensic psychiatric environments are settings where violence continues to be a problem where the need for self preservation on the part of nurses becomes a perceptible variable that influences nurse-patient interactions.
- Ethical dilemma: nurses seek to fulfill professional moral standards while concurrently wishing to safeguard and maintain their own right to safety.
- In response to fear of violence, nurses are driven to redefine their interactions and interventions with patients.
- However, fear is not a topic that has been openly discussed in forensic psychiatry and remains under-theorized.

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Research Goals

- The main objective of the study is to describe and comprehend how fear influences nursing interactions with patients in a forensic psychiatric setting.
- Effects of a perceived threat on nurses day-to-day care:
 - Spatial organization
 - Nursing care organization
 - Representation of the patient population
 - Nursing roles



Type of Study

- Grounded theory:
 - Inductive research method
 - The theoretical conclusions from the fieldwork are empirically grounded.
 - The theoretical categories have a direct relation to the realities of nursing practice and are accessible to practitioners who are the intended beneficiaries of these results (reduce the theory-practice gap)
- Objective: Identifying a basic social process
 - Violence in the workplace influences the nursing care
 - Identifying a basic social process seeks to explore how nurses deal with the issue of violence in the workplace.
 - Explore the notion of a perceived threat (fear) and describe how it influences nurses' perception of patients and how nurses organize their care.



Participation

- 18 years +
- Working at [REDACTED]
- Registered Nurse (RN) or Registered Practical Nurse (RPN)
- One individual interview (60 minutes) where a broad, open-ended question will be asked regarding work in forensic psychiatry.
- Main researcher only
- The interview will be audio-taped unless you are opposed to it.
- The interview will take place in the main researcher's office at the [REDACTED]



Confidentiality

- The interview is strictly confidential. Your name will never appear in the research results. You will be given an alpha-numerical code in order to keep your statements confidential.
- All data (audiotapes, transcriptions, journals, [REDACTED]) will be kept in a locked cabinet in the main researcher's office at the University of Ottawa. Only the main researcher and his supervisor (DR. Dave Holmes) will have access to the data.
- The data collected will be kept for a period of 5 years (Ottawa University politics) in order to be analyzed, after which they will be destroyed (shredded/demagnetized).



Dissemination of Research Results

- Research results will be used for scientific publications, professional and educational ends.
- It is possible that quotes from interviews will be cited in publications and presentations: protection of anonymity.
- All material that could potentially lead to the identification of patients, nursing staff and or the institution will be eliminated in order to respect the confidentiality of participants.



Rights of the Participants

- This is an independent project, meaning that it has not been mandated by your institution or any other organization that nurses may report to.
- This study does not seek to evaluate nursing practice - the goal of this research is to describe and understand how fear influences nursing interactions.
- Participation is entirely voluntary:
 - You have the right not to answer questions
 - At any time the participants can ask to withdraw from the study without any prejudice. The motive for your withdrawal does not have to be shared with the main researcher.



Risks

- Psychological or emotional:
 - You could find it difficult to talk about your experience as a nurse at the [REDACTED]
- Minimizing risk:
 - If you felt anxious or stressed regarding the content of the interview, you will be oriented towards the necessary resources (Employee Assistance Program).



Why participate?

- There are no direct benefits for each participant. However, by participating to this study nurses have the chance to influence our understanding of their experience in forensic psychiatry and how care can be provided in potentially violent environments. Given the qualitative nature of this study, nurses will be given the chance to voice their opinion regarding their practice. By expanding nursing knowledge in highly secure environments, nurses will eventually be able to work in a context that is both safe and ethical.



Questions / Comments / Contacts

Jean Daniel Jacob, RN, PhD (c)
Faculty of Health Sciences
School of Nursing

Room XXX





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