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Poststructuralism and the construction of subjectivities in forensic mental health: Opportunities for resistance

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Abstract

Nurses working in correctional and forensic mental health settings face unique challenges in the provision of care to patients within custodial settings. The subjectivities of both patients and nurses are subject to the power relations, discourses and abjection encountered within these practice milieus. Using a poststructuralist approach using the work of Foucault, Kristeva, and Deleuze and Guattari, this paper explores how both patient and nurse subjectivities are produced within the carceral logic of this apparatus of capture. Recognizing that subjectivities are fluid and dynamic, and capable of change, Deleuze and Guattari's concept of deterritorialization will illustrate opportunities for resistance, where nurses can begin to practice outside the dominant carceral logic (and restrictions) of the system.

KEYWORDS

deterritorialization, forensic nursing, poststructuralism, psychiatry, resistance, subjectivity

1 | INTRODUCTION

Nurses working in forensic mental health settings (including but not limited to corrections) face significant challenges in providing therapeutic care to patients within a highly restrictive and punitive milieu. This paradox of custody and caring can affect not only how nurses perceive and provide care for patients but also the subjectivities of nurses themselves. The necessity for nurses to engage in discipline and punishment presents a cognitive dissonance in their role as care providers, and results not only in the production of noncompliant patients as deviant, but entrenches the nurses within the highly masculine and punitive carceral logic of the setting.

This paper intends to explore the production of both patient and nurse subjectivities within forensic mental health settings through the lens of poststructuralism. Mobilizing Foucault's (1977, 1978) conceptions of power and discourse, as well as Kristeva's (1982) concept of abjection, we will illustrate that subjectivity is fluid and dynamic, and, subsequently, subject to both changes and resistance. Using Deleuze and Guattari's (1987) concept of deterritorialization, we argue that nurses have the capacity to step outside of the 'carceral logic' that defines patients based on their crimes and their (mis)behaviours and instead produce patient subjectivities on a more nuanced understanding of patients' experiences. This deterritorialization might allow nurses to reconstruct their own subjectivities outside the

custodial expectations of professionals working within forensic psychiatric milieus.

2 | CARE AND CUSTODY

Forensic mental health nursing is a unique field of nursing practice (Vincze et al., 2015) in settings unlike those of traditional nursing practice. The primary locations where forensic mental health nurses practice are correctional settings and high-security forensic psychiatric hospitals, both of which carry a mandate of excluding those who have been convicted of crimes for the purpose of healthcare, rehabilitation and public safety. In Canada those arrested or convicted of crimes may be placed in specialized mental health units within provincial or federal correctional facilities if they are diagnosed or perceived to be mentally disordered. Those found not criminally responsible on account of mental disorder (NCRMD; *Criminal Code*, 1985) for crimes committed are placed in forensic hospitals under the authority of provincial review boards, and remain until deemed to pose a low risk to society (Latimer & Lawrence, 2006). In Canada, as in many other jurisdictions, this unique legal status permits significant and indeterminant restrictions on the lives of its subjects. Those who fail to meet the criteria for low risk may languish in forensic settings for decades without release.

Within these facilities nurses are the primary providers of care, addressing the biomedical and psychiatric needs of their incarcerated patients. However, this care is provided within highly restrictive facilities, in which nurses carry out a dual role: acting as both agents of care and agents of social control. For instance, in Canadian federal penitentiaries, nurses are officially designated as peace officers (Perron & Holmes, 2011). In addition to the provision of conventional nursing care, nurses are also tasked with the surveillance of their patients, ensuring institutional roles are followed, reporting behaviours that violate these rules and enacting consequences of patient misbehaviours (Holmes, 2005; Holmes & Federman, 2006; McKeown et al., 2016).

This dual mandate creates a paradox of custody and caring for nurses (Holmes, 2002; Peternelj-Taylor, 1999). This is not unique to forensic nursing; for example, work by Foth (2013) on nurses working under the Nazi regime, or Rafferty and Solano (2007) on British colonial nurses highlights historical instances, though, in reality, the need for custody and surveillance of patients exists across multiple areas of practice (Jenkins et al., 2020, 2022). We encourage readers to consider how these tensions exist in other practice settings. In forensic settings, however, such a mandate for custody is laid most bare, and its combination with the need to provide care represents the 'central dilemma for nurses' (Mason, 2002, p. 515). These competing priorities create role tension for nurses, who traditionally view their role in the provision of care as primarily therapeutic. Many nurses struggle with the realities of a practice setting that prioritizes security over therapy. Clare and Walsh (2009) described the tension and competing priorities of this role as a form of significant emotional labour. Jacob (2012) described the cognitive dissonance that occurs when nurses, conventionally tasked with the provision of therapeutic care, are required to perform tasks that conflict with their professional roles, such as the surveillance and punishment of patients. To decrease this cognitive dissonance, nurses adopt two strategies. The first is to reconceptualize 'the way nurses provide care to align disciplinary/punitive interventions within a rational medical framework' (pp. 181–182). This reconceptualization aligns with the concept of carceral humanism described by Kilgore (2014) and further explored by Ben-Moshe (2020). Carceral humanism shifts the discourse of correctional institutions, such as prisons and forensic hospitals, from one of security to one of welfare. Under this logic, forms of punishment are repackaged as service provisions (Kilgore, 2014). The ultimately punitive services provided by nurses and other professions within these institutions are viewed as being therapeutic, as being what is best for the patients. The second strategy (Jacob, 2012) nurses utilize to minimize the cognitive dissonance that occurs with correctional settings is to reconceptualize 'how they view patients to justify punitive interventions within a correctional framework' (p. 182). It is the latter strategy that is the focus of this paper: the production of patient subjectivities by nurses in forensic mental health settings. The poststructuralist works of Michel Foucault (1978) and Julia Kristeva (1982) will inform this analysis, with the work of Deleuze and Guattari (1987) providing insight into opportunities for transformation.

3 | UNDERSTANDING SUBJECTIVITY: A POSTSTRUCTURALIST PERSPECTIVE

The poststructuralist definition of subjectivity stands in contrast to the Enlightenment conception of the subject as a rational, free and autonomous individual (Mansfield, 2000). This individuality is perceived as unique and inherent to the self; an essential and stable identity that pre-exists any contact with the world. In contrast, the poststructuralist concept of subjectivity, according to Mansfield (2000), posits that 'the subject is constructed, made within the world, not born into it already formed' (p. 11). There is no pre-existing inherent and stable self that goes out and encounters the world; instead, subjectivity is produced. According to McGushin (2011), 'subjectivity is not something we are, it is an activity that we do' (p. 134). To Foucault (1978), subjectivity is the product of power relations; to Kristeva (1982), subjectivity is enacted through the psychoanalytic process of abjection. Though power relations and abjection may appear at odds in subjectivity formation, both figure prominently in forensic mental health settings (Holmes, 2002, 2005; Holmes & Federman, 2006; Jacob, 2012; Jacob & Holmes, 2011; Jacob et al., 2009; Perron & Holmes, 2011).

Within forensic mental health settings, discourse plays an integral role in the production of patient subjectivities, and the subsequent nursing practices associated with these patients. According to Perron and Holmes (2011), 'discourses shape the way nurse-patient relationships emerge and produce effects. In Foucault's view, discourses, like power, are productive because they make possible

the creation of social categories and social practices' (p. 193). These authors studied the construction of patient subjectivities in a mental health unit in a Canadian penitentiary through nursing documentation. Nurses constructed different categories of patients based on their behaviours, conduct and adherence to institutional rules and expectations. These categories were rooted within the highly restrictive rules and expectations of the institution; those who failed to adhere to expectations were constructed as deviant and subsequently subjected to disciplinary action. Pejorative terms exist within forensic settings to describe patients who fail to meet the expectations of the carceral culture. In a study of American prison mental health units, Cloyes (2007) identified the term 'ding' as a description of the patient who fails to meet not only the expectations of the institutional staff but those of their fellow patients. This seemingly irrational patient 'cannot effectively participate in the social order of the unit' (p. 208). Cloyes (2007) concluded that the subjectivities of patients were created by the discourse of the mental health control units. Not only did these discourses shape the subjectivities of patients they also shape nursing practices. More custodial approaches are adopted for patients constructed as deviant or challenging (Jacob, 2012). The solution for the patient who engages in misbehaviours and fails to meet unit expectations is disciplinary action, such as loss of privileges, use of seclusion or chemical restraint. They become marked as 'challenging' or 'treatment resistant', and new disciplinary measures are created to manage their misbehaviours (Johansson, 2020). Berring et al. (2015) reached a similar conclusion in an analysis of nursing records of patient aggression. Those who engaged in aggression were constructed as deviant or dangerous and were subject to disciplinary measures. Within the highly restrictive correctional or forensic setting, power relations and discourses work in tandem to construct patient subjectivities. As Ben-Moshe (2020) noted, 'when disability or madness is present, it is conceived of as a deficit, something in need of correction, medically/psychiatrically or by the correction industry, but not as a nuanced identity' (p. 1). A logic of control and discipline dominates forensic settings (Johansson, 2020). The care provided to patients is rooted in the discourses and power relations of this carceral logic.

4 | SUBJECTIVITY AND ABJECTION

Julia Kristeva brings a psychoanalytic perspective to poststructuralism and the construction of subjectivity, specifically with her concept of abjection. Kristeva (1982) also rejects the notion of a pre-existing holistic self that enters into the world. However, in her psychoanalytic perspective, all of us, as subjects, are perpetually attempting to create boundaries around our physical and psychic selves in an attempt to maintain a holistic sense of self. Central to this process is abjection (McAfee, 2004). Abjection is the rejection and repulsion of the abject—that which is considered disgusting. This process begins in infancy; things like sour milk or faeces first constitute the abject as the infant begins to separate itself from the mother and become its own subject. This rejection of the abject is an attempt to establish boundaries between the self and others and is central to the infant's development. However, this process of abjection persists and remains throughout life. The subject is forever encountering the abject, that which threatens the porous boundaries drawn around the self. What Kristeva (1982) referred to as the 'clean and proper self' is the self-controlled body 'we imagine we are referring to when we use the word "I". It is the one social institution's demand of us when they check on our cleanliness, our truthfulness, our hard work and honest citizenship' (Mansfield, 2000, p. 82). That which constitutes the abject consists not only of bodily fluids like urine, vomit and feces but can also include transgressive persons, such as criminals or the mentally ill. When the abject is encountered, the subject recoils, working to maintain the physical and psychic boundaries of the clean and proper self.

The implications of abjection in forensic mental health nursing practice are profound. We have explored these implications in greater depth elsewhere (Johansson & Holmes, 2021, 2022) Nurses in conventional practice settings routinely encounter the abject in their day-to-day work with patient bodies and the fluids contained within (and without). In forensic mental health settings, nurses also routinely encounter persons they may perceive as abject: the murderer, the sex offender, the filicide and the aggressively psychotic. Knowledge of patient crimes and diagnoses can elicit this sense of abjection—a sense of disgust or repulsion towards the perpetrator (Holmes et al., 2006; Jacob et al., 2009), with subsequent negative impacts on patient care (Johansson & Holmes, 2021, 2022). Jacob et al. (2009) explored the potential for nurses to see these particularly reprehensible patients as monsters. Shildrick (2002) described the apprehension and distancing that occurs when these perceived monsters are encountered as an effort to secure our own boundaries from this abject other. Nurses in forensic mental health settings may create both emotional and physical distances from these abject patients as a means of protecting their own subjectivities. The perpetual porousness of our physical and psychic boundaries constantly threatens to be penetrated by the abject; the process of abjection protects these boundaries through distancing practices. This process of abjection simultaneously produces the subjectivities of both nurses and patients. The patient, whose symptoms of mental illness and history of crimes committed are well known by the nurse, becomes the monstrous other through this process of abjection. At the same time, by distancing themselves from these patients in an effort to establish boundaries, nurses distinguish themselves from these monstrous others. They become the opposite. Their own nondeviant subjectivities are reinforced in contrast with those of their patients. The patient, as abject other, serves to maintain the 'clean and proper' boundaries of the nurse subject. This distancing, this establishing of boundaries may affect the nature of the nursing care provided to patients in forensic mental health settings (Jacob et al., 2009), but also outside of these settings. For instance, Smith (2016) explored the provision of nursing care to incarcerated persons in community-based perioperative settings and noted similar potential for nursing care to be affected. The distancing and othering of

patients perceived to be abject on account of their crimes committed may lead nurses towards more custodial practices and away from therapeutic interventions.

4.1 | Nurse subjectivities

The subjectivities of nurses are not immune from the power relations and discourses of the forensic mental health setting. Like their patients, nurses do not enter the forensic setting with a pre-established, fully intact identity; their subjectivities, too, are produced by the power relations, discourses and abjection of the environment. Holmes and Federman (2006) described the 'parallels between inmates' living conditions and nurses' working conditions' (p. 24). As illustrated above, nurses face a paradox of custody and caring (Peternelj-Taylor, 1999) not encountered in most typical practice settings. The care and practices of nurses in these settings differ from those in civic environments. Holmes (2002) described a nurse who would not touch a crying patient like they would in a typical hospital setting. This 'masculinization' of care (Holmes & Federman, 2006) is typical of forensic settings; attributes such as empathy are characterized as feminine and are considered inappropriate for the carceral environment. Relations between nurses and corrections officers influence these behaviours; nurses are chided by officers and some nurses for being kind or empathetic towards patients. Nurses may be critical of their peers who fail to strictly adhere to the rules and expectations of the setting (Johansson, 2020). Fear of patients (Jacob & Holmes, 2011) and abjection (Jacob et al., 2009; Johansson & Holmes, 2021, 2022) affect the approach to care nurses take; patients are constructed as deviant, as monsters that necessitate a more custodial (and less caring) approach. The power relations of the setting, the discourses that exist and the knowledge of patient histories all perpetuate the custodial approach to patient care. As noted by Holmes and Federman (2006), 'power infects everyone in forensic psychiatric settings' (p. 17). Even when engaging in perceived therapeutic activities with patients, these are aimed at patient behavioural modifications aimed at the type of self-regulation deemed appropriate by institutional objectives. An imposition of the discourse of the forensic setting (Holmes & Federman, 2006). Any nursing care permitted within the setting must adhere to its carceral logic. The carceral logic that subsumes forensic nursing is not exclusive to this practice setting (Dillard-Wright, 2022; Jenkins et al., 2022), but here it is most transparent.

An analysis of subjectivity from the perspective of both Foucault (1978) and Kristeva (1982) is highly relevant in the forensic mental health setting. Patients enter into the forensic setting carrying a history of both criminal behaviour and mental illness, resulting in a dual stigma (Drennan & Alred, 2012b). The forensic setting purports a mandate of rehabilitation and care, but also carries exclusionary obligations: to separate the mentally ill criminal from society until they can be safely reintegrated. Patients enter a highly restrictive and disciplinary setting (Johansson, 2020), wherein anything but strict compliance with institutional rules and expectations results in disciplinary measures. Discourses within the setting are congruent with this disciplinary milieu; documentation on patients describes the appropriateness of behaviours and requests, how 'calm' the patients remain and adherence to expected routines (Perron & Holmes, 2011). Patients are constructed based on their adherence to the disciplinary and custodial order. A nurse's knowledge of patient histories, including crimes committed, results in abjection, further shaping both patient and nurse subjectivities. A physical and psychic distancing occurs; nurses eschew therapeutic interventions with patients in an effort to maintain the boundaries of their own subjectivities. The monstrous and deviant subjectivity of the patient reaffirms the clean and proper, nondeviant subjectivity of the nurse. In such an environment, it is folly to accept that a therapeutic mandate of nursing practice is achieved.

5 | RESISTANCE

While it remains appropriate to despair at the negative and monstrous patient subjectivities created by the power relations, discourses and abjection of the forensic setting, as well as the highly restricted and custodial nurse subjectivities also created, a recognition that subjectivities are not static and exist in an open system (McAfee, 2004) provides an opportunity for change. Adopting the perspective that subjectivities are not essential, not fixed to the individual allows for resistance to the pressures placed upon them by the power relations, discourses and abjection of the forensic setting. Here allows the opportunity to see patients not as monsters or deviants in need of correction, but as 'a nuanced identity from which to understand how to live differently' (Ben-Moshe, 2020, p. 1). And nurses, too, need not be restricted to custodial approaches to patient care. To illustrate this point, Foucault's (1978) concept of resistance and Deleuze and Guattari's (1987) concept of deterritorialization will be explored.

Foucault (1978) famously noted that 'where there is power there is resistance' (p. 95). Power is capillary and fluid and flows in all directions; it cannot be held or the sole property of those in positions of authority. And whoever is subject to techniques of power is capable of resistance. Whereas the forms and techniques of power extant in the forensic mental health setting have been well explored here and elsewhere (Berring et al., 2015; Holmes, 2002, 2005; Holmes & Federman, 2006; Jacob, 2012; Jacob & Holmes, 2011; Jacob et al., 2009; Perron & Holmes, 2011), less attention has been given to forms of resistance. What does resistance (from both patients and nurses) look like in these highly restrictive settings? The most well-explored forms of patient resistance are those of aggression—resistance to the disciplinary and coercive practices of institutional staff—through acts of violence, threats and verbal abuse (Aiyegbusi & Kelly, 2015; Berring et al., 2015; Bowers et al., 2011; Johansson & Holmes, 2021).

But resistance can take on more subtle forms. Holmes (2002) identified patient silence as a form of resistance. In a setting where self-examination and therapy constitute pastoral power as a form of

social control, nurses rely on patient engagement and confession. A simple refusal to engage in conversation with nurses entails an act of resistance by patients. Nurses, too, are capable of acts of resistance. In a setting where a masculine approach to care is expected, and demonstrations of kindness or empathy towards patients are criticized, simply being nice to patients constitutes an act of resistance (Johansson, 2020). In this highly secure and regulated setting, where surveillance of patients is expected, institutional rules strictly enforced and routines required, it may appear that nursing practice skews entirely towards custody and away from caring. Caring itself may be conceived as an act of resistance. Nurses may also enact resistance through the selective enforcement of rules and a willingness to not punish every rule violation observed (Johansson, 2020). Nurses described this approach as producing a more convivial and positive practice milieu with patients described as challenging to work with, despite criticism from peers for nonadherence to workplace expectations. McKenna et al. (2014) described this approach as taking 'calculated risks' (p. 68) when working with patients. Both patients and nurses possess the ability to resist the dominant power relations and discourses of the highly restrictive forensic mental health setting.

The expected endorsement of conventional patient and nurse subjectivities—rooted within the dominant power dynamics, discourses and abjection of the forensic mental health setting—also provides an opportunity for resistance. Where nurses are expected to survey and discipline their patients, to view and document them based on their level of risk and compliance to institutional rules and to practice in fear of the abject bodies they encounter on a daily basis all provide opportunities for resistance in the formation of patient subjectivities. And given that subjectivities, in the poststructuralist lens, are not fixed, inherent or static, these acts of resistance bear the potential to transform both patient and nurse subjectivities. Though the sheer force and breadth of the dominant culture of forensic mental health settings may seem insurmountable, illusions of indomitability should not dissuade nurses from attempts at transformation. Here the work of Deleuze and Guattari (1987), specifically their concept of deterritorialization proves helpful. What may appear to be stable and fixed should instead be viewed as 'temporary accretions of an immanent process that late in his career Deleuze simply referred to as "life"' (Adkins, 2015, p. 22).

Deleuze and Guattari (1987) proposed the concepts of the major and the minor. The major is that which bears significance and influence, whereas the minor is that which bears neither significance nor influence. The major constitutes the dominant ideas within a culture or an institution; it is what is considered normal and against which all else is measured (Braidotti, 2011). In contrast to the major, the minor is that which is considered the other, the lesser or unprivileged voices and perspectives. Within the forensic mental health setting, the major is commensurate with the dominant 'security culture' and modes of practice, those that are custodial in nature, that construct patients as deviant and abject, those that aim to normalize or 'fix' the perceived deficits of the inhabitants (both patients and nurses). The minor in these settings constitutes the patients who fail to adhere to the norms and expectations of the setting—the 'dings', as referred to by Cloyes (2007)—those marked as deviant or noncompliant. But the minor may also constitute the nurses who resist the dominant order of practice, who dare to be nice to patients or who choose to only selectively enforce the rules. Deleuze and Guattari described the apparatus of capture as the mechanism wherein the major seeks to subsume or phagocytize the minor. This apparatus of capture 'operates as a method of social control' (Barlott et al., 2020). Within the forensic mental health setting, this apparatus upholds and maintains the dominant power relations and discourses that construct the subjectivities of both patients and nurses, which presents patients as abject others to be feared and controlled. It territorializes the minor. The process of deterritorialization occurs when the minor breaks free from the rigid confines of the major, producing what Deleuze and Guattari (1987) refer to as a line of flight. Deterritorialization is a disruptive process that seeks to reject the major and transform its striated (rigid) spaces into smooth (flexible) ones. The result of this deterritorialization is a reterritorialization, wherein a new space is created. Deterritorialization is a radical and disruptive break from dominant modes of practice and presents a model for which resistance to the patient and nurse subjectivities is constructed within the forensic mental health setting.

6 | CONCLUSION

How, then, could nurses enact this process of deterritorialization to disrupt the dominant subjectivities extant in this setting? The first step is to activate the fluid and dynamic nature of patient subjectivities, to recognize that they may be transformed. Subjectivities are the effects of the power relations, discourses and abjection present within the forensic mental health setting. They constitute the major of this apparatus of capture. But nurses can resist these constructions. We may refuse to view patients in terms of their risk factors or their criminal records or the symptoms of their mental illness and instead take a more nuanced and compassionate view of their histories and the greater contexts of their lives. Shildrick (2002) proposed, when encountering abject and monstrous bodies, an approach of vulnerability, to 'embrace instead the ambiguity and unpredictability of an openness towards the monstrous other. It is a move that acknowledges both vulnerability to the other, and the vulnerability of the self' (p. 3). Instead of documenting patient deficiencies, failures to adhere to routines and expectations, and symptoms of mental illness, we can document their strengths, the content of our conversations and the wishes and goals they propose. Instead of strict enforcement of institutional rules and expectations based on custodial practices, nurses may choose to structure their practice and interactions with patients on more positive and therapeutic grounds. Even if chastised for doing so, nurses are autonomous professionals, capable of independent practice. Quite simply, practices of caring and kindness are acts of resistance in these highly punitive and masculine spaces. Nurses may resist the

subjectivities created for them as compliant accomplices in the punitive apparatus of capture, who adopt more 'masculine' practices and who take a subservient role to corrections officers. Just as nurses possess the capacity to resist the subjectivities constructed for patients, they can also resist the subjectivities constructed for themselves. These acts of resistance constitute a deterritorialization, a disruption of the dominant discourses and practices of the forensic mental health setting. These lines of flight allow for the construction of new subjectivities for patients, based not on deficiencies, risks and fear, but on strengths and opportunities. And they also allow for the construction of new nurse subjectivities, based not on compliance and control, but on autonomy, professional practice and therapeutic interactions. This would constitute a reterritorialization, the creation of new spaces that privilege the minor and reject the major. From within the apparatus of capture, in this highly punitive forensic mental health setting, nurses may dismantle and deterritorialize their practices, to undo the cognitive dissonance and emotional labour required to work in this setting, much to the benefit of both themselves and their patients.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no data sets were generated or analysed during the current study.

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