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Chapter 2

Organizations As Evil Structures

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Background

Nursing practice in forensic psychiatry opens new horizons in nursing. This complex, professional, nursing practice involves the coupling of two contradictory socioprofessional mandates: to punish and to provide care. The purpose of this chapter is to present nursing practice in a disciplinary setting as a problem of governance. A Foucauldian perspective allows us to understand the way forensic psychiatric nursing is involved in the governance of mentally ill criminals through a vast array of power techniques (sovereign, disciplinary, and pastoral), which posit nurses as "subjects of power." These nurses are also "objects of power" in that nursing practice is constrained by formal and informal regulations of the forensic psychiatry context. As an object of "governmental technologies," the nursing staff becomes the body onto which a process of conforming to the customs of the forensic psychiatric milieu is dictated and inscribed.

> *Estrangement is the core function of spatial separation. Estrangement reduces, thins down and compresses the view of the other: individual qualities and circumstances which tend to be vividly brought within sight thanks to the accumulated experience of daily intercourse seldom come into view when the intercourse is emaciated or prohibited altogether: typification takes then the place of personal familiarity, and legal categories meant to reduce the variance and to allow to disregard it render the uniqueness of persons and cases irrelevant.* (1)

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Introduction

In order for modern society to be a success, those who prey on others must be separated out. The early idea of modern incarceration was premised on the creation of a community of captives who willingly accepted their terms of confinement because society made it clear that certain types of persons needed to be excluded from the general population for security reasons. The founders of the carceral regime of prisons and hospitals were convinced that the "removal of deviants and dependents from the community was a prerequisite" of any moral civilization *(2)*. The Quakers thought the purpose of the prison was to foster each individual's "inner light," a substance that all persons carry within them. The prison, then, had at its origin a somewhat benign purpose, a desire to uplift those who have fallen away. True, the prison confined; but, among American republican theorists, it was also educational and restorative. Could the prison be one thing without being another? What kind of institutional setting was constructed?

Gilles Deleuze speaks of "centres of enclosure" *(3)* that mark the advent of modern society. The individual "moves from a closed circle to another. …It is a never ending beginning" *(3)*. The creation of the modern hospital and prison around the idea of a panopticon reinforces the idea of an institution of capture as circularity; and further marks these institutions as disciplinary, whether in a Quaker sense or not is irrelevant. The point is that incapacitation was the result of an individual failure that needed to be restored (or simply confined) for the purposes of the general good. The hospital and prison, then, are in constant dialogue between the agents of care and the imprisoned. These agents exist as a duality: they are in the prison but free from it. What role, then, does the setting play in the idea of confinement?

The panopticon is, of course, the modern-day sign not just of prison, but also of society itself. Surveillance is a product of modernity *(4)*. Deleuze, however, sees the panopticon as a failed myth *(5)*. The failure of the panopticon lies not just in an inability to achieve its original aims and the exploitation of uncertainty, but also in the visibility of power and the rationality of control. The panopticon belongs to the "social physics" of the Enlightenment philosophers *(6)*, an 18th-century understanding of power relations based on institutional balancing and social harmony. The panopticon allows for a stark duality that expresses a form of governance that we relate to: not only are the prisoners under constant surveillance, but so too are the guards. We are all prisoners; we are all being watched. The gaze is everywhere. But this begs the question, whose gaze? The panopticon image (as a 19th-century image) fails to note the creation of "zones of indistinction" *(7)*, the breaking down of walls and structures and the merging of concepts that previously existed as binary

structures. Zones of indistinction mean the creation of spatial ambiguities that allow for rethinking concepts and power relations, in which meaning can be found in between spaces, as in the modern creation of persons as both subjects and objects, or in the twofold meaning of "discipline" that refers both to an academic enterprise and a manner of control. The "dissolution of bounded social sites" that accompanies the presence of "zones of indistinction" experienced by late modernity doesn't exclude the reintroduction of new and different power relations. The overall tenor of such assessments, according to Yar *(8)*, "is that corrective panopticism was the correlate of a socio-historically specific regime of power (that of discipline), and that with its decline the normalizing panoptic principle is also passing into abeyance, replaced by mechanisms which correlate with the logic of power-as control."

What we would like to show in this chapter is that the idea of capture does not just have a passing resemblance to Jeremy Bentham's panopticon. Surveillance, control, and the need for disciplinary tactics are all part of the fabric of carceral institutions that have merged nicely with the idea of surveillance in postmodern society. Giddens *(4)*, for example, sees surveillance operating on two levels in modernity: the use of surveillance for "internal pacification" purposes, crucial for the inner workings of the nation-state, and the monitoring of the workplace *(4)*. In either case, the point to note here is that the setting of surveillance is an important factor in the control of captive populations housed in forensic psychiatric settings.

Architectural settings do more than structure organizations; they influence behavior at multiple levels within the organization *(9)*. Surveillance techniques operating in the workplace track and monitor behavior at every stage of production (as seen in chain stores throughout the United States and Canada), as well as in many aspects of our public lives, for example, as on the streets of London. As Gary Marx writes *(10)*, "New technologies for collecting personal information which transcend the physical, liberty enhancing limitations of the old means are constantly appearing." However, the control over captive populations within some forensic psychiatric settings still rely on old-fashioned techniques of control, the manipulation of caring professionals, the use of pacification techniques to obtain docility, and the outright use of power and fear to tame potentially recalcitrant populations. Pointing out some differences with the "new surveillance" in no way suggests that power is one directional. On the contrary, inquiry into the role of nurses reveals just how "capillary" power is. It comes from all sides of the prison hospital complex. It resides not in one institution or within one regulatory scheme, but attaches itself to bodies throughout the organization. Power infects everyone in forensic psychiatric settings.

Dispositifs, Capture, and Forensic Psychiatric Nursing

It is necessary to understand that so-called forensic psychiatric nurses evolve in a state "*dispositif*" (apparatus) that comprises two (if not more) multifaceted administrative systems (e.g., the justice system and the health care system), each of which conceive the security and health of a captive population as the official goal of their mandate *(11–13)*. An apparatus in this context should be understood as: "A thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions…the apparatus itself is the system of relations that can be established between these elements" *(14)*.

Some are "apparatuses of capture" (e.g., prisons, psychiatric institutions), whereas others seem to be neutral or benevolent in their objectives and practices. But all are carefully designed to achieve specific purposes and all of them are permeated by a vast array of power relations *(13,15–19)*. No doubt that forensic psychiatric units (and programs) whether in jails, hospitals, or community settings are apparatuses of capture. As Mason and Mercer *(13)* point out, despite their architectural features and designs, the true nature of these apparatuses are to be found at their micro-level. Following up on this assertion, we are interested in showing the importance that human agents have when deployed (as objects/subjects of power) within these apparatuses, because they constitute the agency that produces and reproduces the culture of such institutions. Such institutions are known to house the dangerous selves.

Mentally disordered offenders have often been portrayed (and continue to be seen) as monsters or maniacs. Monsters show themselves in many different and culturally specific forms *(20)*. However, their bodies no longer betray their danger; modern-day monsters do not appear in the guise of monsters *(21–23)*. They emerge as products of civil society, produced by institutions and subject to the mores of modernity. Seltzer *(24)*, for example, locates the rise of the serial killer (a modern-day monster) around 1900 along with the advent of the modern corporation and the rise of the United States as a military power. A modern monster is both a physical and a mental phenomena. The signs of the inner monster are buried within the respectable self *(25)*.

Foucault *(26)* points out that modern monstrosity really began with Louis XVI: "all human monsters are the descendants of Louis XVI," because the fight over deviance and liberty during the Revolution was a fight over the space to define those terms. Saint Just categorized Louis XVI an enemy of the social body, a producer of filth. But if Louis XVI was easily seen as a monster in revolutionary France, modern monstrosity takes on different characteristics. Modern monsters are much more dangerous than the monsters of the Renais-

sance, who looked dangerous because of physical deformities. It is now necessary to find the "key" that will enable the health care professional to "detect" the "disease" that lies buried deep within the subject's personality *(27)*. As Judith Halberstam *(28)* wrote: "Monstrosity no longer coagulates into a specific body, a single face, a unique feature, it is replaced with a banality that fractures resistance because the enemy becomes harder and harder to locate, and looks more and more like a hero."

In forensic settings, monstrosity takes on the multiple masks of murderer, rapist, thief, and so on. Modern monstrosity, however, implicates the role of institutions in the formation of monsters. Images of monstrosity permeate traditional understandings of institutions. Prisons, for example, are not only places of punishment (if they ever were), but also of physical and mental torture *(29)*. For the pupose of this chapter, however, we would like to partially distance ourselves from this perspective, and look at institutional monstrosity and explore how forensic psychiatric settings are evil structures permeated by power relations.

Power is most pervasive and visible in "total" institutions such as forensic psychiatric organizations, where groups of mentally disordered offenders eat, sleep, and interact. Nearly all elements of the captives are minutely regulated—practices must be tightly scheduled and regimented in time and space for the institution to function "efficiently" *(19)*. Such institutions are also characterized by barriers to social intercourse with the outside world *(17)*, in which the imperatives of therapeutic care and security collide. But in the creative tension between them, a subtle collusion emerges around the broader agenda of social control in which nurses are enjoined in the regulation of deviance, and the extension of surveillance (as a primary mechanism of control) into all spheres of inmates' activities *(30)*. The disciplinary technologies deployed in forensic psychiatric settings represent a continuation and intensification of what happens in "ordinary places," such as schools and homes *(19)*. The anatomopolitical (management of the body through disciplinary power) investment of everyday life is pervasive and rendered visible through the deployment of specific intervention tools, such as hierarchical observation, normalizing judgment, and finally, the examination. The corollary of the exam (client assessment of all forms) is the confession, which serves as a prerequisite to rehabilitation and normalization *(31)*. These microtechniques are common to all forensic psychiatric settings, fitting functionally within a larger system. Few health care settings escape the gaze (read tyranny) of the "expert" as an instrument of a normalizing power and arbiter of deviance. Renewed forms of governance replace forms of centralized, authoritarian state power, focusing on the cultivation of new subjectivities of personal empow-

erment and risk management *(32,33)*. In forensic settings, inmates and nurses are subjected to various forms of power (sovereign, disciplinary, and pastoral) *(12)*. Both are emotionally invested in acquiring and displaying social or professional competence in their understanding and uptake of institutional dominant discourses as fundamental to their own personal growth and identity, and in so doing both become bound to new "softer" (but no less strong) tentacles of power *(19)*.

Organizational Evil at Play

Prisons and hospitals are the signs of modernity. The old joke that when a sailor washed ashore on a deserted island and said, "Ah, civilization" at the sight of a guillotine, tells us more about modernity (and ourselves) than we acknowledge. The origin of modern, liberal government is inseparable from the problematic duality of the invention of the subject. Modern liberalism first introduced the idea of society as a near-impermeable space, virtually cut off from the state and its operations. The central image was of a blind market force operating alongside the sovereign individual. The production of this view of man, working with a minimal degree of friction within the open space of civil society, meant that the subject of society was both a free subject and subjected to society's limitations. This is not as paradoxical as it sounds. To act freely, "the subject must first be shaped, guided and moulded into one capable of responsibly exercising that freedom through systems of domination" *(34)*. The abstraction society, then, is not as beneficent as it first appeared. The individual can only operate within a structured space of a juridically created liberalism. Institutions become the only source through which individuals can mediate between state and society. Institutions perform a managerial technique, designed (in principle) for the benefit of those being managed. In this view, institutions can be perceived as liberating, in the sense that the agents who carry out the institutional schemes are doing so without bias.

Forensic psychiatric settings, of course, are not only institutions operating within society; they are perceived as caring institutions, where health care professionals are not agents of the state or of power, but of care. But the duality of subjectivity is not lost in a forensic psychiatric setting. Nurses as subjects of power constitute a cluster of state agents, who link the goals of forensic settings and programs to the very objects of these goals, i.e., mentally disordered offenders. As subjects of power, nursing personnel are vested with the mission of providing psychiatric nursing care that is coupled on a daily basis with the mission of discipline, which includes surveillance and punishments. These two missions merge toward the official goal: a so-called "successful social rehabilitation of mentally disordered offenders." Empiri-

cally speaking, such a duality—to care for and exert control over a population of psychiatric inmates—proves to be complex in the socioprofessional sphere. As pointed out by Burnard *(35)*, the forensic psychiatric role must take on various "opposing" functions and as such to "consider illness, crime, morality, treatment, containment and possibly punishment." Such affirmations are corroborated by several other authors in the field *(13,36–42)*.

Furthermore, in order to carry out this paradoxical task, institutional rules support that nurses must show initiative and authority *(12,18)*. Hence, it is not surprising to see nurses utilize various forms of power in order to care (and control) for inmates while ensuring safety and order. Thus, power exerted by nursing staff over a secluded population is continuous and takes on many faces: sometimes straightforward and visible, sometimes rather subtle and insidious. These forms of power, as they pertain to this peculiar nursing practice, take on various forms according to circumstances and desired results, such as coercion, discipline, and therapy, all of which are directly and respectively concerned with finalities, such as repression, transformation, and assistance.

In their daily practice, nurses fulfill functions related to control, discipline, and psychiatric care. Although hired as nurses, they also play an active role in the penal/psychiatric apparatus. Indeed, nurses are officially permitted in forensic psychiatric settings (e.g., the jail) to apply the necessary measures needed to ensure the respect of institutional regulations. According to Castel *(15)* and Goffman *(17)*, staff working in total institutions find themselves in the paradoxical pitfall of caring while enforcing strict regulations that threaten this very caring process. Forensic psychiatric nurses can thus deal directly with delinquents or indirectly by bringing the punishable incidents to the attention of another competent authority *(43)*.

While on duty the nurse carefully assesses this option and acts as a subject of power by making the strategic decision to call for the authority figure most likely to cause the patient's submission *(17)*. We can thus see how essential correctional guards are to the nursing practice in a forensic psychiatric setting. Its crude and even brutal manifestation characterizes this first form of power. Without physically restraining inmates, nurses use a coercive power, in which correctional guards are the executants in order to reach disciplinary or therapeutic goals.

Moreover, forensic nurses resort systematically to a disciplinary type of power in their daily practice with mentally disordered offenders. Nursing duties are not limited to the psychiatric treatment *per se*, but rather are assorted with additional tasks aimed at ensuring that penitentiary operations run smoothly and inmates are controlled. Indeed, nurses are directly involved in discipline in forensic psychiatric settings, to the extent that they undertake functions

related to surveillance and reprimand, control over activities, and punishment of deviant acts with regard to norms ruling the premises.

Discipline touches all aspects of the inmates' everyday life. It is understood that the nursing staff must reinforce conformity with regard to the distribution of inmates within the environment and as it pertains to exerting control over their activities or the sequencing of these activities. Conformity plays an active part in structuring inmates in space and time *(44)*. Each prisoner occupies his own space and shares common areas where he may socialize with peers. This regulation is enforced with regular rounds carried out by nurses and correctional agents alike *(43)*. The spatial distribution of inmates is thus enforced by internal regulations particularly for safety reasons. Such spatial ordering is reminiscent of Foucault's historical work on prisons as the paramount of all disciplinary spaces.

Despite the importance of the nurse–patient relationship, the discipline imposed on prisoners relies on continuous surveillance in addition to possible sanctions, in order to increase its efficiency. Nurses are commissioned to this task. During their daily rounds, nurses collect data of both a clinical and a correctional nature with regard to the prisoners they are in charge of. Moreover, these rounds serve the purpose of cell inspections, for hygiene purposes, or to identify signs of illegal activities, such as substance abuse or the manufacturing of contraband alcohol *(43,45)*. Rounds provide the perfect opportunity for nurses and correctional guards to search cells and personal effects. Suspicious objects that may serve as weapons, tools for drug use, or fruits to be used for brewing alcohol, and so on, may be confiscated by staff. However, because the use of coercion and discipline does not prove to be sufficient in reaching the very grain of mentally disordered offenders, forensic psychiatric settings reinforce these two forms of power exploited by nursing personnel by a third one: therapy.

Along with coercion and discipline, psychiatric nursing care provided to inmates constitutes an important dimension of nursing practice and power. Thus, investing time in observing the inmate is a key to the "therapeutic" process *(43)*. The delinquent must become accountable with regard to his mental condition, personality disorder, or any other "criminogenic factors," which could lead to a punishable offense.

From the moment that a prisoner is accountable for his mental health and the transformations needed for his behavioral re-education, he must devote himself to his treatment. He must feel the obligation to constantly behave responsibly and respect the penal apparatus *(43)*.

Treatment aims to eradicate criminal conduct, so that an individual no longer poses a threat to fellow citizens. In order to reach this goal, nurses are

directly involved in therapeutic actions that encourage global awareness with regard to one's difficulties. This awareness supposes a dialogue, which involves a "caring" power, traditionally associated with nursing practice in a psychiatric setting. Thus, nursing interventions aim to consolidate behavioral self-regulation by a prisoner who faces many challenges. In this respect, nurses convey the official discourse of the forensic psychiatric setting.

Indeed, nurses favor introspection and awareness by the prisoner in the face of his personal problems. Ultimately, resocialization of a prisoner rests on the acquisition of intellectual and emotional abilities, such as self-control, accountability for one's actions, and behavioral self-regulation. Clinton and Nelson *(46)* suggest that discipline and surveillance can also be achieved through noncoercive approaches. "For by engaging in self-care, people with a mental illness not only seek to recover themselves, but also to regulate themselves and their behaviors in more deeply penetrating ways than was possible when psychiatric practice was at its most coercive" *(46)*.

However, this "therapeutic" encounter is subdued by a strict code of conduct enforced by the institutional culture. The prisoner is invited to talk about his family or grief following the loss of a loved one. Nurses explained that their reaction to the suffering expressed by an inmate differed from their response to the expression of suffering by a patient in a civic hospital. An informant added that if an inmate cried, she would not touch him in an attempt to offer comfort as she would in a hospital setting *(12,45)*.

Within a forensic psychiatric setting, nurses use coercion, discipline, and therapy because of their hybrid socioprofessional status (care and custody) and the mandate with which they are vested. In a forensic psychiatric setting, surveillance, control, coercion, and discipline rely on nursing practice, which in turn relies on them, thus creating a paradox not devoid of socioprofessional friction for nurses. Such a "therapeutic process" through "pastoral" acts does not exclude concomitant use of coercion and discipline in order to govern mentally disordered offenders.

However, a deeper look at the functioning of forensic psychiatric settings suggests that the nursing staff, like the group of inmates, is a target of a phenomenon that aims at objectifying them, thus forcing them to conform to the forensic psychiatric setting's norms. The results corroborate the panopticon metaphor used by Foucault *(44)* in his book *Discipline and Punish* to describe the "carceral" environment. Foucault states that although prisoners are under continuous surveillance, the same applies to the staff in corrections. The director of the institution may spy on his employees: nurses, doctors, foremen, educators, and guards; he will be able to judge them continuously, modify their behaviors and force his own ways on them as he sees fit *(44)*. In fact, every time there are numerous individuals to enforce a task or a behavior, the

panopticon pattern may be reproduced *(47)*. Although subject to change, it may be used in every institution in which a number of people must be kept under surveillance in a restricted space. This surveillance applies to inmates and nurses alike, because both are trapped in this "infernal machine," those who watch over are watched over in turn. Surveillance leaves nothing to chance and spares none. Thus, visibility is a trap. Whoever is watched, whether they are inmates or nurses, are inexorably exposed to the judgment of others *(45)*.

In light of previous research results *(45)*, we can establish parallels between inmates' living conditions and nurses' working conditions. The point here is to derive an overall picture of the institution in order to express a judgment about how all actors on the prison scene are subjects, whether they be inmates or nurses to various technologies of power. In an ethnographic study concerning the insane individual's social condition in psychiatric environments, Goffman *(17)* briefly discussed the working conditions of personnel in total institutions, placing the latter in opposition with the patients they look after. However, our data suggests that some of the inmates' existential aspects can also be found in the nursing staff. Indeed, a "conformation process to prison norms" that tries to force onto nurses a new nature and behavior adapted to a jail setting, was clearly identified throughout this research. Bodies of nurses are sites of inscription that are distributed in an "apparatus of capture."

According to Goffman *(17)*, the newly arrived individual enters a total institution with a representation of himself, which is the product of permanent dispositions from his domestic environment. However, as soon as he is admitted, the mental patient or the inmate sees himself stripped of this representation as the result of stages leading to a new identity. For Goffman *(17)*, isolation from the outside world accelerates this hazing process of identity "deconstruction" and "reconstruction." Safety devices and isolation consolidate, in a symbolic and practical manner, the barrier between the total institution and the outside world. Inmates are exposed to the institutional "objectification" described by Goffman *(17)* as a "civil death." Indeed, a range of psychiatric or forensic techniques is used on the mentally ill or on inmates to accomplish exclusion from society. However, the first step (exclusion) of the "mortification process" *(17)* is akin to the feeling of marginalization expressed by nurses who work in forensic psychiatric settings *(12,45)*. Hence, just as Goffman's inmate *(45)* witnesses the remodeling of his identity, nurses working in a forensic psychiatric jail setting come to realize that the prison regime modifies the roles, attributes, and representations of the person they care for and, as a result, forces them to adapt to the forensic psychiatric milieu by distancing themselves from their previous roles. This distance is necessary in order to force the staff to reproduce the organizational (penal) order.

For inmates, this distance between their "roles" also passes through a series of phases, in which his original personality is "mortified," even "violated" *(17,48)*. The processes used to mortify a personality are similar in every total institution *(17)*, whether they are prisons, asylums, or hospitals. Self-image degradation and moral contamination are two "personality mortification techniques" (as stated by Goffman) that are rather enlightening in light of this research. Inmates who live in a total institution lose those attributes that normally distinguish them from others in society. The inmates' self-representation is altered. Goffman made this observation, but it also applies to nurses. The "masculinization" of care and behaviors typically linked to feminine attributes, in order to follow the penitentiary order, is comparable to and well integrated in what Goffman calls "self-image degradation" *(17)*. Bourdieu *(49)* insists on the fact that institutional "rituals" render the domination of one group over another official. Institutional rituals refer to all activities taking place in an institution, which ensue from its particular "culture" *(17)*. Bourdieu *(49)* underlines the fact that institutional rituals confirm one group's hegemony (namely masculinity) because just as it dictates the order of things, the masculine order also dictates bodies through tacit injunctions, which are involved in work or a division of labor. It is through the training of these bodies that the most fundamental dispositions of virilization and defeminization will take place *(49)*. Indeed, some social milieus promote virilization and defeminization more strongly, meaning that such rituals facilitate the rupture with the "maternal" and "feminine" world. The virilization and defeminization processes occur on admission in a man's world *(49)*.

Empathy and attentiveness toward inmates are perceived as feminine characteristics that are strictly forbidden, leading to the need to suppress them, for instance, through scoffing in a typically machismo and chauvinistic manner by correctional guards (and some nurses as well). Regardless of whether male or female nurses express these caring attitudes, they are openly proscribed in the strict penitentiary order. This "adapted form" of caring is thus a constraint, which weighs heavily on nursing staff in general and female nurses in particular.

Moreover, nurses have to show continuous deference to correctional guards in order to obtain their collaboration when dispensing routine psychiatric nursing care. The moral constraint caused by this deference is a contributing factor to self-image degradation discussed previously by Goffman *(17)*, in his work on psychiatric patients' social conditions. Any contact with a prisoner must occur in the presence of a correctional guard for obvious safety reasons. However, the research data *(45)* also suggest that nursing staff must constantly "nurture" the relationship with correctional officers in order to

avoid possible personal or ideological conflicts that may interfere with their professional practice in a forensic psychiatric setting. Delays and excuses are frequent, and a correctional guard's refusal to do a "round" with one particular female nurse or male nurse (much rarer) will serve as a potent negative reinforcement on the nursing team as a whole.

Goffman *(17)* observed the deference expressed by inmates in a total institution and linked this behavior to the deprivation of their identity described earlier. Having to ask for permission to carry out an action that normally does not require another individual's consent emphasizes self-image degradation. Holmes *(45)* was able to witness interactions of the same nature among nurses (in Canadian forensic psychiatric settings), whose "reconstructed" identities bear striking resemblances to Goffman's description of the mortification phenomenon that shapes the inmate's personality. Goffman's conclusions describing the relationship between mentally ill patients and staff also illustrates the relationship between nurses and correctional guards in which words exchanged between inmates and staff members must often be accompanied with verbal manifestations of deference, feeling the need to implore, begging insistently or humbly for services *(17)*.

Conclusion

We are forced to acknowledge that nurses, as objects of power, share with inmates the sphere of the "governed." Nursing staff are also an object of governmental technologies. The parallel between the inmate's mortification process and the nurse's conformation process shows once again the complexity of social and professional relationships in a forensic psychiatric setting. Nurses, as agents of governmentality, practice at the core of the forensic psychiatry apparatus, at the crossroads of psychiatric and penal apparatuses, where they exert three types of power over inmates: sovereign (coercion), disciplinary (discipline), and pastoral (care). However, in such a perverse setting, nurses bear similarities with inmates, because they are both objects and subjects of technologies of "government," which attempts to mold their behaviors. Nurses and inmates are caught in a powerful web of power relations. They are both subjugated to the vicious effects of forensic settings.

We believe that forensic settings constitute an unrestrained variable of nursing practice. These settings deeply affect the quality of nursing care and make possible three forms of nursing care that can be expressed in the language of *governmentality*. These three capacities sometimes take brutal forms, sometimes subtle; they are sovereign, disciplinary, and pastoral. These forms of power constitute powerful instruments to control the conducts of a doubly stigmatized population. This double stigmatization of being both a prisoner

and mentally ill corresponds to the hybrid institutional medium of the forensic settings in which care takes place. The assumption of responsibility of a deviant and at risk population, by a group of experts, is registered in the heart of governmentality, in which the nurse acts like an agent of transformation, standardization, and conformation. Additionally, the representation that is made of the nurse and of the clientele he or she looks after results from the combination of many social variables (preconceived ideas, stereotypes, judgments, official institutional speeches, socialization with the tested personnel, offenses of the mentally disordered offenders, and so on). The summation of these variables leads to the construction of a symbolic identity system that exacerbates the negative characteristics of these delinquent patients described as dangerous, manipulative, and violent, constituting an important risk for the entire nursing staff. This representation of the patient as essentially at risk justifies that one remains wary of them, which burdens the bonds of confidence and makes the therapeutic intervention of the nurse more difficult.

It is now well established that forensic psychiatric settings do not constitute a neutral institutional setting in which care takes place free from the larger influences that operate within society. Forensic psychiatric settings are not caring institutions that have unfortunately evolved into carceral centers. Rather, they are part of the matrix of disciplinary institutions within civil society. They occupy an important space that is constantly expanding, ever-molding bodies to conform to ideas and practices that are found within the spaces occupied by the bourgeoisie. The forensic psychiatric unit is both an architectural and a disciplinary space. But it is also an exclusive space, "used to prolong and perpetuate that mutual estrangement between the governed and the governors" *(1)*. It more than just creates the image of care, it establishes the means by which care constructs its identity. Because of the spatial elements of forensic psychiatric settings, there is a carpentry to the institution of care that creates bodies and boundaries, and nurses and patients, that shapes the meaning of care in disciplinary directions. Monsters can only be created out of disciplinary institutions. If we only understand monstrosity as an individual phenomenon, and not as caught up with the matrices of institutional settings, then we will fail to grasp the importance of the workings of power in forensic psychiatric settings.

References

1. Baumann, Z. (2000) Social uses of law and order. In: Criminology and Social Theory (Garland, D. and Sparks, R., eds.), Oxford University Press, Oxford, UK.
2. Rothman, D. (1971). The Discovery of the Asylum: Social Order and Disorder in the New Republic. Little Brown, Boston, MA.

3. Domenech, M. and Francisco, T. (1997) Rethinking institutions in societies of control. Int J f Transdiscipl St 1: Available from Web site: http:www.geocites.com/Paris/Rue/8759/extituciones.html. Accessed July 27, 2004.
4. Giddens, A. (1985) The Nation-State and Violence. Polity Press, Cambridge, UK.
5. Deleuze, G. (1995) Postscript on the Societies of Control: Negotiations. Columbia University Press, New York, NY.
6. Lyon, D. (1994) The Electronic Eye: The Rise of Surveillance Society. University of Minnesota Press, Minneapolis, MN.
7. Agamben, G. (1998) Homo Sacer: Sovereign Power and Bare Life. Stanford University Press, Stanford, CA.
8. Yar, M. (2003) Panoptic power and the pathologisation of vision: critical reflections on the Foucauldian thesis. Surveill and Society 1:254–271.
9. Jacobs, J. (1977) Stateville: The Penitentiary in Mass Society. University of Chicago Press, Chicago, IL.
10. Marx, G. (2002) What's new about the "New Surveillance"? Classifying for change and continuity. Surveill and Society 1:9–29.
11. Ewald, F. (1998) Un pouvoir sans dehors. In: Michel Foucault, philosophe: rencontre internationale, Paris 9, 10, 11 janvier. Seuil, Paris, France.
12. Holmes, D. (2002) Police and pastoral power: governmentality and correctional forensic psychiatric nursing. Nurs Inq 9:84–92.
13. Mason, T. and Mercer, D. (1999) Forensic psychiatric nursing. In: Advanced Practice in Mental Health Nursing (Clinton, M. and Nelson, S., eds.), Blackwell Science, Oxford, UK, pp. 236–159.
14. Foucault, M. (1980) The eye of power. In: Power/Knowledge and Selected Interviews and Other Writings 1972–1977 by Michel Foucault (Gordon, C., ed), Pantheon Books, New York, NY, pp. 146–165.
15. Castel, R. (1998) Présentation. In: Asiles : Étude sur la Condition Sociale des Maladies Mentaux (Goffman, E., ed., pp. 7–35) Les Éditions de Minuit, Paris, France.
16. Foucault, M. (1991) Governmentality. In: The Foucault Effect (Burchell, G., Gordon, C., and Miller, P., eds.), The University of Chicago Press, Chicago, IL, pp. 87–104.
17. Goffman, E. (1998) Asiles : Étude sur la Condition Sociale des Maladies Mentaux. Les Éditions de Minuit, Paris, France.
18. Holmes, D. and Gastaldo, D. (2002) Nursing as a means of governmentality. J Adv Nurs 38:1–9.
19. Poland, B., Lehoux, P., Holmes, D., and Andrews, G. (in press) How place matters: unpacking technology and power in health and social care. Health Soc Care Community 13(2):170–180.
20. Shildrick, M. (2002) Embodying the Monster: Encounters with the Vulnerable Self. Sage, Thousand Oaks, CA.
21. Curran, A. and Graille, P. (1997) The face of eighteenth-century monstrosity. Eighteenth-Century Life 21:1–15.
22. Dahmer, L. (1994). A Father's Story. William Morrow, New York, NY.
23. Wilson, P. (2002) Eighteenth-century "monsters" and nineteenth-century "freaks": reading the maternally marked child. Lit Med 21:1–25.

24. Seltzer, M. (1998) Serial Killers: Death and Life in America's Wound Culture. Routledge, New York, NY.
25. Riot, P. (1982) The parallel lives of Pierre Rivière. In: I, Pierre Rivière, Having Slaughtered My Mother, My Sister, and My Brother (Foucault, M., ed.), University of Nebraska Press, Lincoln, NE.
26. Foucault, M. (1997) Il Faut Défendre la Société. Seuil/Gallimard, Paris, France.
27. Norris, J. (1988) Serial Killers. Anchor Books, New York, NY.
28. Halberstam, J. (1991) Skinflick: posthuman gender in Jonathan Demme's The Silence of the Lambs. Camera Obscura 27:7–52.
29. Midgley, J. (2003) Prison litigation 1950–2000. In: Prison Nation: The Warehousing of the Nation's Poor (Herivel, T. and Wright, P., eds), Routledge, New York, NY.
30. Federman, C. and Holmes, D. (2000) Caring to death: health care professionals and capital punishment. Punishment & Society 2:441–451.
31. Knox, S. (2001) The productive power of confessions and cruelty. Postmod Cult 11:3.
32. Fischer, B. and Poland, B. (1998) Exclusion, "risk," and social control: reflections on community policing and public health. GeoForum 29:187–197.
33. Rose, N. (1999) Powers of Freedom: Reframing Political Thought. Cambridge University Press, Cambridge, UK.
34. Dean, M. (1999) Governmentality. Sage, Thousand Oaks, CA.
35. Burnard, P. (1992) The expanded role of the forensic psychiatric nurse. In: Aspects of Forensic Psychiatric Nursing (Morrison, P. and Burnard, P., eds.), Ashgate Publishing Group, Aldershot, NH, pp. 45–60.
36. Burrow, S. (1993) The role conflict of the forensic nurse. Sr Nurse 13:20–25.
37. Burrow, S. (1998) Therapy versus security: reconciling healing and damnation. In: Critical Perspectives in Forensic Care: Inside Out (Mason, T. and Mercer, D. eds.), Macmillan, Hampshire, UK, pp. 171–187.
38. Dale, C., Tarbuck, P., and Rae, M. (1995) Changing the culture in a special hospital. Nurs Times 91:33–35.
39. Fisher, A. (1995) The ethical problems encountered in psychiatric nursing practice with dangerous mentally ill persons. Sch Inq Nurs Pract 9:193–208.
40. Mason, T. and Chandley, M. (1998) Seclusion: a catacomb of control. In: Critical Perspectives in Forensic Care: Inside Out (Mason, T. and Mercer, D., eds.), Macmillan, Hampshire, UK, pp. 85–101.
41. Peternelj-Taylor, C. and Johnson, R.L. (1995) Serving time: psychiatric mental health nursing in corrections. J of Psychiatric and Ment Health Nurs 33:12–19.
42. Wilmott, Y. (1997) Prison nursing: the tension between custody and care. Br J Nurs 6:333–336.
43. Holmes, D. (in press) Governing the captives: forensic psychiatric nursing in corrections. Perspect Psychiatr Care 41(1):3–13.
44. Foucault, M. (1995) Discipline and Punish. Vintage Books, New York, NY.
45. Holmes, D. (2001) Articulation du contrôle social et des soins infirmiers dans un contexte de psychiatrie pénitentiaire. Thèse de doctorat.: Université de Montréal, Montréal, Canada.

46. Clinton, M. and Nelson, S. (1999) Recovery and mental illness. In: Advanced Practice in Mental Health Nursing (Clinton, M. and Nelson, S. eds.), Blackwell Science, Oxford, UK, pp. 260–278.
47. Bentham, J. (1843) Jeremy Bentham: Collected Works. J. Bowring, London, UK.
48. Castel, R. (1976) L'ordre Psychiatrique: L'âge d'or de L'aliénisme. Les Éditions de Minuit, Paris, France.
49. Bourdieu, P. (1998) La Domination Masculine. Seuil, Paris, France.