

## **Le recours à l'altérité dans la pratique infirmière en milieux psychiatriques médico-légaux et correctionnels : une exploration**

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En milieux médico-légaux et correctionnels, il n'est pas rare de voir les infirmières, les infirmiers et autres professionnels de la santé dépersonnaliser leurs patients et leurs clients en faisant usage de certains termes. Par exemple, non seulement l'utilisation de mots comme « détenus », « prisonniers », « psychopathes », « schizophrènes » ou « monstres » pour parler des patients évoque-t-elle des images stéréotypées mais elle projette surtout l'individu dans le rôle de l'autre. L'utilisation de l'altérité est généralement vue comme une forme négative d'engagement et contraire à une pratique infirmière respectueuse de la déontologie. Par le biais d'une exploration de facteurs relationnels et contextuels contribuant à ce phénomène, l'auteure argue que le recours à l'altérité est une question morale contemporaine qui nécessite un dialogue continu au sein des communautés infirmières des milieux médico-légaux et correctionnels.

Mots clés : recours à l'altérité, pratique infirmière en milieux psychiatriques médico-légaux et correctionnels, question morale

# **An Exploration of Othering in Forensic Psychiatric and Correctional Nursing**

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In forensic and correctional environments, it is not uncommon for nurses and other health-care practitioners to depersonalize their patients and clients through their use of language. For example, referring to patients as “inmates,” “cons,” “psychopaths,” “schizophrenics,” or “monsters” not only evokes stereotypical images, but, more importantly, casts the individual in the role of the other. Othering is generally viewed as a negative form of engagement, one that is contrary to ethical nursing practice. Through the exploration of relational and contextual factors contributing to this phenomenon, the author argues that othering is a contemporary ethical issue that requires ongoing dialogue within the forensic and correctional nursing communities.

Keywords: othering, forensic psychiatric and correctional nursing, ethical issues in practice

I became interested in “othering” a long time ago. I didn’t know what othering was, but I certainly lived with its consequences in my day-to-day practice as a forensic psychiatric nurse. I could feel the hatred in the words of those who engaged in othering. I was mocked and laughed at when I referred to the individuals I was working with as patients. I was new, I wanted to fit in, but I could not adopt the derogatory language of my peers — many of them nurses. How could I form therapeutic relationships with my patients if I thought so little of them as individuals, as fellow human beings? And I remember the correctional supervisor who, with a raised, clenched fist, walked off the unit declaring he was going to go and do some “therapy.”

Forensic and correctional institutions are among the most extreme and stressful environments known to contemporary society. Sadly, for a variety of reasons and life circumstances, such environments have become health-care “havens” for a large portion of vulnerable and at-risk populations. Accepting the challenge to provide nursing care in environments where health-care delivery is not the primary goal is fraught with moral dilemmas not often encountered in more traditional health-care settings. The profession’s obligations to caring, often touted as the essence of nursing, should not be affected by the fact that those seeking care have been charged with, or convicted of, criminal acts. As Drake (1998) asserts,

“whatever the setting, the provision of optimum holistic health care is the *raison d’être* for professional nurses” (p. 52).

However simple this edict, the development of therapeutic relationships, the foundation of health-care provision, is tenuous at best, and can be particularly difficult if the patient has committed a grievous or heinous crime (Chaloner, 2000). In practice, it is not uncommon for forensic psychiatric and correctional nurses to use language that depersonalizes their patients and clients. For example, referring to those in their care as “inmates,” “cons,” “psychopaths,” “schizophrenics,” or “monsters” not only evokes stereotypical images but, more importantly, casts the individual in the role of other. The process of engaging others — those who are perceived as different from self — is referred to as othering in the contemporary health-care literature (Canales, 2000; MacCallum, 2002; Myhrvold, 2003). Considering the hierarchical power structure in forensic and correctional environments, othering is perhaps inevitable: those who are hospitalized and/or incarcerated are at risk for eliciting this response from those who work with them (Corley & Goren, 1998).

Although othering is usually seen as a negative or exclusionary form of engagement, one that leads to stereotyping, labelling, and marginalization (Canales, 2000; Corley & Goren, 1998; MacCallum, 2002), connecting with the other can be an empowering and transformative experience, one that promotes inclusion over exclusion (Bunkers, 2003; Canales; Zerwekh, 2000). By exploring the relational and contextual factors that contribute to the enactment of this phenomenon, it is argued that othering reflects a contemporary practice issue of moral significance — one that addresses the provision of competent and ethical nursing care and one that requires ongoing dialogue within the forensic and correctional nursing community.

### **Defining Other and Othering**

*The New Oxford Dictionary of English* defines other as a noun, “used to refer to a person or thing that is different or distinct from one already mentioned or known about,” and as a pronoun, “that which is distinct from, different from, or opposite to oneself” (Pearsall, 1998, p. 1314). Canales (2000) defines othering as engaging “with those perceived to be different from self — the Other” (p. 16). In philosophical writings, reports Myhrvold (2003), the other is someone who falls outside of the “established support system” (p. 41). The apparent clarity of these definitions conceals the fact that designating the other and engaging in othering are complex, multifaceted phenomena revealed only within a relationship of power (Canales; Carabine, 1996).

In its broadest sense, othering has its roots in feminist discourse, post-colonialism, critical theory, and symbolic interactionist theory (Canales, 2000; Kirkham, 2003; Kitzynger & Wilkinson, 1996; Varcoe, 2004). Accordingly, individuals may be designated other on the basis of their skin colour, gender, sexual identity, and social class; whether they are homeless, illegal immigrants, refugees, addicted to drugs or alcohol, experience a disability, are HIV-positive, have a diagnosis of tuberculosis or mental illness, or are a prisoner (Bunkers, 2003; Canales; Doyle, 1998; Kirkham; MacCallum, 2002; Reaume, 2002; Stevens, 1998; Strickland, 2001). The same individuals generally considered vulnerable by society and the health-care community (Flaskerud & Winslow, 1998; Myhrvold, 2003) are those at risk of being labelled other and subjected to othering by those charged with meeting their health-care needs. And, as with vulnerability, those who might be labelled other at any given point in time is not a constant factor but is continually evolving (Kirkham; Myhrvold). Canales outlines several questions that are critical to any discussion of othering: "Who is designated as Other? By whom? How? Under what conditions? And with what consequences?" (p. 18).

The prevailing sentiment regarding othering is typically negative or exclusionary. Othering occurs in relationships between the powerful and the powerless, where vulnerabilities are exploited and where domination and subordination prevail (Canales, 2000; Carabine, 1996; Kitzynger & Wilkinson, 1996). Therefore, othering as a form of engagement is not restricted to individuals but is manifested on multiple levels: personal, professional, institutional/organizational, and societal (Canales; Corley & Goren, 1998; Zerwekh, 2000). The consequences of othering include alienation, marginalization, stigmatization, oppression, internalized oppression, and decreased social and political opportunities (Bunkers, 2003; Canales; MacCallum, 2002). From a health-care perspective, these consequences impede the development and maintenance of therapeutic relationships and ultimately affect every aspect of health care, including health promotion, health maintenance, and health restoration (Canales; Evans, 2000).

Kitzynger and Wilkinson (1996) provide a concise summary of othering that is relevant to this exploration:

A key aspect of the various theoretical approaches to Othering (albeit differently treated by each), is the observation that the notion of who and what Others are (what they are like, the attributes assigned to them, the sorts of lives they are supposed to lead) is intimately related to "our" notion of who and what "we" are. That is, "we" use the Other to define ourselves: "we" understand ourselves in relation to what "we" are not. (p. 8)

## **Factors Impacting on Othering in the Forensic and Correctional Milieu**

This exploration of othering centres on the nature of forensic psychiatric and correctional nursing. Forensic psychiatric and correctional facilities are controversial; they elicit strong reactions from various sectors who debate their proper place in society. As public-sector institutions, they provide the community with both social necessities and social goods. Social necessities are, by definition, essential to a community's existence. Social goods, on the other hand, are perceived as a kindness; although not essential, they do benefit the community. However, the distinction between a forensic psychiatric facility and a correctional facility is not a clear one. Both fulfil their social-necessity mandate through the social control of their populations; the protection of the community is perceived to be a direct consequence of the confinement and control they provide. Forensic psychiatric hospitals and correctional facilities also fulfil a social-goods mandate, in that they provide health care to those who are confined. In essence, nurses are faced with the dilemma of providing a social good (health care) but within institutions dedicated to the provision of a social necessity (confinement) (Osborne, 1995; Peternelj-Taylor, 1999; Peternelj-Taylor & Johnson, 1995). The moral climate of forensic psychiatric and correctional settings is shaped as the competing demands of custody (social necessity) and caring (social good) are embraced by health-care professionals (Austin, 2001).

The impact of the environment on nursing practice cannot be ignored, as nurses are clearly influenced by the organizational context in which they work. There exists a continuum of controlled or secure environments, operated as part of the health-care system, the criminal-justice system, or, in some jurisdictions, jointly operated. Although the ideological priorities of the correctional system centre on confinement and security, while forensic psychiatric facilities function as hospitals within the ethos of the health-care system, power, control, and authority are manifested in the physical and interpersonal environments of both settings and can run counter to the achievement of health-care goals (Blair, 2000; Drees, 1994; Holmes & Federman, 2003; Maeve, 1997; Weinberger & Screenivasan, 1994). It is no wonder that Osborne (1995) declares, "There is a blurring of the mission of corrections and mental health facilities" (p. 5).

### ***The Power of Language***

Adshead (2000) observes that the ethical dilemmas encountered in forensic settings often reflect the nature of the patient population. As a highly stigmatized and stereotyped group, this population is frequently "deemed

as *valueless* by the rest of society” (p. 304). Questions such as “Why would you want to work *there*?” “How can you stand working with those *mentally ill criminals*?” “Aren’t you afraid of getting hurt?” are all too familiar to nurses practising in forensic psychiatric and correctional settings. Scheela (1999), a nurse therapist who works with sex offenders, adds her own list of questions, such as “Why would anyone want to work with *them*?” and “What’s the matter with *you*?” (p. 25). Such questions indicate that individuals receiving care in forensic and correctional settings are also cast in the role of other by outsiders, whose fear and ignorance also breed contempt for health-care professionals, as they too are stigmatized and rendered suspect (Chaloner, 2000; Doyle, 2001; Martin, 2001; Peternelj-Taylor & Johnson, 1995; Scheela).

Kitzinger and Wilkinson (1996) observe that “Others are *constructed* — by those who do Othering, by those who reflect upon that Othering, and by the Others’ own representations of themselves” (p. 15). Individuals who seek health care within forensic and correctional settings are frequently portrayed by correctional staff (and sometimes by health-care staff) as inherently manipulative, conniving con artists even when their health concerns are legitimate (Doyle, 1999; Maeve, 1997; Martin, 2001). Regardless of what othering labels are applied in these settings, they all have a similar, distressing tone. Not only do they elicit strong emotions, stigmatize, and stereotype, but they all construct the person as something other than a person, in many cases as a “monster” (Evans, 2000; Holmes & Federman, 2003; Scheela, 1999).

Even use of the term “inmate”<sup>1</sup> is not without problems, although it is officially sanctioned in correctional facilities. In some institutions, policy dictates that nurses refer to their patients as inmates — for example, “Inmate Smith” — while in other institutions individuals are referred to by their institutional number — for example, “Inmate 47329.” So even though inmate is a legitimate term, it can have derogatory implications. It places the nurse in the role of professional keeper; nurses work with patients and clients, correctional staff work with inmates. In the nurse-inmate scenario the helping, therapeutic role of the nurse is lost, replaced by a custodial role.

Drake (1998) reports that when conducting research with incarcerated women she would ask them directly if they found it insulting to be referred to as inmates. To her surprise, the women said that it depended on who was using the term and how it was being used. Clearly, the term can be used in a way that maintains the power differential between those who are institutionalized and those who are free, between those who

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<sup>1</sup> Defined in *The New Oxford Dictionary of English* simply as “a person living in an institution such as a prison or a hospital” (Pearsall, 1998, p. 941).

exert power and those who are oppressed. When nurses refer to individuals as inmates instead of as patients or clients, a punitive atmosphere prevails, with the nurse being cast in the role of custodian rather than that of caregiver.

Even terms that have a quasi-legitimate place in health care — for example, “psychopath,” “schizophrenic,” or “borderline” — are problematic, even though they can generally be found in the professional literature. The significance lies in the meaning of the label and how it is used (Corley & Goren, 1998). Does “borderline,” for example, imply that one is unworthy or has brought one’s problems upon oneself? (Nehls, 1999). Does “psychopath” suggest that one is incurable and therefore unworthy of treatment? (Horsfall, 1999). Individuals who are mentally ill are subjected to a number of derogatory, stigmatizing labels — for example, “spinner,” “psycho,” “schizo,” “loon” (Doyle, 1999; Reaume, 2002); those who have been diagnosed with schizophrenia are not individuals but “schizophrenics,” or, to use Reaume’s words, “the dreaded other” (p. 424). Othering practices find their principal focus not in person-as-a-person (MacMurray, 1961) but in person-as-an-illness (Swinton & Boyd, 2000).

Any label associated with mental illness can be problematic in correctional settings. Some individuals incarcerated for violent crimes even resist the label “patient,” as it may imply that they are mentally ill and thus subject to abuse by their peers. Being identified as a “bug,” a “goof,” or a “spinner” invites ostracism and victimization by one’s peers and, to a lesser degree, by correctional staff (Doyle, 2001; Peternelj-Taylor & Johnson, 1995). Holmes and Federman (2003) conclude that all such derogatory labels “are superimposed on the nurse’s common theoretical representation that a patient is a person for whom care is provided” (p. 945.) When a patient’s behaviour is interpreted solely as manipulative, caregivers will respond negatively to that patient’s needs. Labelling someone as manipulative only serves to perpetuate othering, such that strategies for exploring and effectively dealing with the “manipulative behaviours” are lost to the psychotherapeutic relationship (Weinberger & Screenivasan, 1994).

Language is exceedingly powerful and “shapes how nurses define their presence with clients” (Mitchell, Ferguson-Paré, & Richards, 2003, p. 49). Negative labelling conveys an attitude of disrespect and contributes to powerlessness. Language can be accusatory and dismissive, and can be non-conducive to the establishment of a trusting relationship (Horsfall, 1999). Particularly derogatory labelling prevails in forensic and correctional settings. It includes terms that on the surface appear innocuous (e.g., patient, inmate) as well as terms that are used to describe individuals who are criminals or those who are mentally ill, some of which are too crude to include in this discussion. The negative labelling that occurs

in verbal discourse is further perpetuated and reinforced in the written word. For instance, Mohr (1999) observes that othering is revealed in nurses' charting and documentation in patients' medical records, through implicit preconceptions, assumptions, and stereotypes as the self of the nurse is exposed through his or her relationship with the othered. For example, the lack of documentation on the therapeutic relationship, mutual definition of problems, or inability to explore solutions (Martin & Street, 2003) may reflect the nurse's fears or inadequacies, or the nurse's unwillingness to engage forensic patients therapeutically. In essence, othering may be reflected in what is not documented.

One thing is clear. When the person who is othered is a forensic psychiatric patient or an individual who has been charged with or convicted of a criminal act, the consequences of othering are significant. The enacting of othering through language often reflects the informal culture of the organization, by separating "them" from "us" — those who are "kept" from those who are the "keepers" (Corley & Goren, 1998).

### ***The Power of the Interpersonal Climate***

Othering, whether on the part of health-care professionals or correctional staff, does not occur in a vacuum (Corley & Goren, 1998; Myrhold, 2003). Understanding the referent groups within institutions, and the power they wield, is critical. Even though there may be a clash of cultural and professional values, the power exercised within correctional institutions often influences how othering is enacted, tolerated, and sanctioned by peers. In many settings a nurse's peer group is made up not of nurses, or even health-care professionals, but custodial or correctional staff. Clearly, the ideological priorities of the correctional system are contrary to nursing's caring mandate (Blair, 2000; Corley & Goren; Mitchell, 2001). Nurses employed by correctional systems are often at odds with policies and personnel as they struggle to fulfil their professional obligations within the confines of the correctional mandate. Blair reports that when nurses are faced with dilemmas in their practice they often choose not to intervene or not to advocate on their patients' behalf for fear of disturbing the status quo, resulting in conflict among health-care staff or between nurses and correctional staff. Stohr, Hemmens, Kifer, and Sholer (2000) acknowledge that "doing the right thing" is not always easy and in many situations impossible. Weinberger and Screenivasan (1994) conclude that as correctional psychologists they often feel that their role is simply one of "window dressing." It is not uncommon for correctional staff to undermine the power of health-care professionals by ignoring their clinical decisions, often under the guise of serving the greater good of the institution (Blair; Drees, 1994; Peternelj-Taylor & Johnson, 1995).



Holmes and Federman (2003) found that nurses working in a correctional psychiatric unit reported changes in the way they provided care for their patients over the course of their employment, learning to conform to the facility's norms and correctional mandate. Doyle (1999), Maeve (1997), and Maeve and Vaughn (2001) caution nurses to be wary of being co-opted by the correctional mandate and abandoning their nursing ideals. In addition, although doing the right thing may be possible (Stohr et al., 2000), it is not always an easy choice, especially if it means not getting along with others. Fisher (1995) reports that when one's clients have a known history of violence getting along with colleagues takes precedence over speaking up and doing what might be perceived as the right thing, as staff may depend on one another for their personal safety. Thus, nurses quickly learn the "right way" of behaving, even if such behaviour is not illustrative of the right thing to do (Corley & Goren, 1998; Fisher; Stohr et al.).

Doyle (1998) affirms that forensic and correctional nurses face unique clinical challenges as they strive to meet the idiosyncratic needs of their patients and clients while balancing the issues that arise from their professional coexistence with custodial staff "who function as powerful others over nurses" (Maeve, 1997, p. 506). In the final analysis, forensic psychiatric and correctional nurses must articulate their professional authority and responsibility in order to maintain their professional integrity (Lindeke & Block, 1998).

### **Implications for Ethical Nursing Practice**

Othring as it is articulated in forensic and correctional nursing clearly demands further ethical reflection. A nurse who adopts othering behaviours as embodied in both the written and the spoken word fails to see the "person-as-a-person" (MacMurray, 1961). Othering represents an attempt to separate "them," those who are othered, from "us," those who do the othering. In essence, when nurses engage in othering they are forced to look at themselves, as they come to know themselves through their relationships with others (Bunkers, 2003; Canales, 2000; Kitzinger & Wilkinson, 1996).

Forensic psychiatric and correctional nurses care for a client population that is frequently stigmatized, stereotyped, and subjected to othering, often at the hands of those charged with their care. The personal experiences of nurses may well colour their worldview, and ultimately their therapeutic response to their patients and clients. It may well be that not all nurses will be able to embrace non-judgemental behaviours with all patients and clients in all situations, but they should be encouraged to "build a bridge" (Liaschenko, 1994) and approach their work in a non-

condemnatory manner. Martin (2001) concludes that “it would be naïve for nurses to ignore the impact of patients’ offending on the personal beliefs of the nurse, and subsequently on the nurse–patient relationship” (p. 28). Clearly, some patients and clients possess characteristics that could easily provoke negative responses in their caregivers. Not all patients are likeable, easy to care for, and appreciative of nurses’ efforts to provide care (Maeve, 1997; Maeve, & Vaughn, 2001). The potential for manipulation is very real in forensic and correctional nursing. Some individuals in correctional facilities may attempt to manipulate health-care services for some secondary gain (e.g., medication, escape from the facility, social diversion), and issues pertaining to safety cannot be ignored (Brewer & Nelms, 2000; Flanagan & Flanagan, 2002).

Patients and clients may also be disrespectful towards nurses and engage in their own othering activities. For instance, they may view nurses as part of a much-hated system and refer to them using derogatory terms that are usually reserved for correctional officers, such as “screw” or “bull.” Worse yet, serial offenders may other the nurse as their next victim, in which case the nurse may engage in intentional othering for self-protective purposes. And, similar to the use of aberrant humour in stressful clinical situations, othering might be used as a means of coping with the accumulation of fear, pain, or horror resulting from exposure to difficult clinical situations. Finally, othering may be a call for help, particularly if enacted by a nurse who is usually seen as a patient advocate (Sayre, 2001).

### ***Impact of Othering on the Therapeutic Relationship***

Othering can have an enormous impact on the therapeutic relationship and ultimately on the quality of care received by patients and clients. It has a direct impact on the creation and maintenance of the therapeutic relationship (Evans, 2000; Peternelj-Taylor & Johnson, 1995). It may result in care that is not individualized, that is less than optimally supportive, or that does not take the patient or client’s psychosocial needs into account (Corley & Goren, 1998). It may also result in care providers being “under-involved” (Peternelj-Taylor, 2002) or may lead to misrepresentation of individuals through oppression (MacCallum, 2002). When the forces of othering are at play, nurses are less likely to explore concerns that have been raised or to take the time to conduct the thorough assessments that are necessary before appropriate interventions can be administered (Blair, 2000).

### ***Engaging the Other***

In Holmes and Federman’s (2003) study with nurses working in a correctional psychiatric unit, the nurses began to question whether they

were still practising nursing, as they believed they had surrendered their professional ideals to those of the institution. As a way of coping with this realization, some nurses “reconstructed” their care, treating their clients as individuals in need of care rather than as “monsters.” The authors found, however, that this care was, in general, provided without the tacit knowledge or sanction of nursing peers or correctional staff. In exercising their professional identity and relating to patients as fellow human beings, nurses may excite the wrath of other nurses or, more likely, the correctional staff, who might see such attempts at engaging the other empathically as their downfall (Maeve, 1997). Even though such practices as treating people like human beings may be adopted for the noblest of reasons, if carried out in isolation they can cause great consternation among team members and contribute to division within the team, as well as invite excessive scrutiny of one’s nursing practice. Moreover, practising in isolation from the team is dangerous and can lead to boundary transgressions. The creation and maintenance of treatment boundaries is critical to safe and effective clinical interventions. Communication among nurses and other team members (including security staff in the case of correctional settings) is vital to safe and professional practice. Clinical work can be particularly demanding and challenging, and nurses need to be able to rely on the support and strength of the team (Peternelj-Taylor, 2002; Peternelj-Taylor & Yonge, 2003).

In her work with incarcerated women, Maeve (1997) concluded that ethical care was achieved through a process of identifying with the women relationally. To gain such an appreciation for the other, nurses must “learn to think about difference in relation to self and Other” (Canales, 2000, p. 29). Similarly, Gadow (1999) states that “the valuing of persons requires special perception of each one’s uniqueness, and perception involves engagement” (p. 63).

Othering is grounded in relationship. In nursing we can no longer ignore othering, believing we are immune to its consequences simply because we are nurses. Canales (2000) states that in order to avoid the negative consequences of othering nurses must be able to assume the role of the other and view the world from the other’s perspective. Bunkers (2003) suggests that by “acting with a spirit of hospitality” (p. 308) nurses can come to comprehend the other’s experiences without judging or labelling. This notion of role-taking, or engaging the other in a spirit of hospitality, is a tall order for forensic and correctional nurses, especially considering that many of their patients have committed horrid, grievous crimes. Can a nurse empathize with a person who has committed a violent sexual offence, or a person who has invaded the home of an innocent family and robbed them of their sense of security, let alone their

worldly possessions? Maeve (1997) reports that nurses often try to make sense of their role by acknowledging their own vulnerabilities, as reflected in their personal disclosures: “At another time in my life this could have been me, or someone I love” (p. 505). Through role-taking, “persons can come to know and understand the Other and interact based on these understandings” (Canales, p. 26).

To understand the other is to understand the failure of multiple systems to address issues of poverty, interpersonal violence, substance abuse, criminalization of the mentally ill, and lack of access to adequate health care (Peternelj-Taylor, 2003). To understand the other, nurses must be politically astute, capable of influencing social policies and effecting social change (Canales, 2000).

### ***Emerging Recommendations***

How nurses relate to those in their care is fundamental to their ability to establish therapeutic relationships and to resist the temptation to engage in othering behaviours. Nurses should advocate for the consistent use of professional language in their interactions with individuals seeking health care, and, when working with persons with mental illness, refer to them as individuals and avoid the use of pejorative labels. The advocacy role in forensic and correctional environments is tenuous at best. It should be endorsed not only by individual nurses but also by the administrative structure of the facility. Lützen and Schreiber (1998) conclude that when nurses lack the support they need to function as patient advocates, the very nature of patient care is compromised. Nurses need to adopt a philosophical stance that views health-care recipients not as problems, or as criminals in the case of forensic or incarcerated patients, but as persons, and they need to seek ways of discovering who they are as individuals (Evans, 2000).

The work of forensic psychiatric and correctional nurses requires careful attention to clinical supervision, education, and training. Their clientele can test even the seasoned veteran; clearly, knowledge and clinical judgement are necessary ingredients for working through clients’ challenging behaviours in the context of the therapeutic relationship. Kitzinger and Wilkinson (1996) emphasize the need to listen to others and to create the conditions “under which it is possible to hear the voices of Others ‘talking back’: to ‘us,’ over ‘us,’ regardless of ‘us,’ to each other, or to other Others” (p. 17). Bunkers (2003) reiterates this point of listening, as manifested in what she calls “true presence” — “how we language our care, our concern, and our honoring of others by the way we move and are still, by the way we speak and are silent” (p. 308).

## **Concluding Remarks**

Otherring in forensic and correctional nursing is an ethical concern that faces all nurses working in such settings. Despite the concern that forensic and psychiatric environments are rife with moral and ethical dilemmas, nurses have been more or less silent on matters pertaining to exclusionary othering in their professional roles. Conversely, engaging in inclusionary othering provides opportunities for nurses to understand the other's story (Bunkers, 2003) and to learn about themselves. It is through such engagement that othering can lead to empowering and transformative experiences.

Although this analysis of othering represents only a glimpse of how nurses work and care for individuals in forensic and correctional environments, it may challenge nurses to situate themselves within this dialogue as they reflect upon, relate to, and refute othering, and in so doing be better positioned to work in a competent and ethical manner with individuals who have come into conflict with the law.

Because this exploration of othering is still in its infancy, fundamental questions remain unanswered. Does othering, as described herein, unequivocally have a negative impact on the quality of care provided to patients and clients? Does language in essence construct reality? Do nurses and other health-care professionals blame correctional staff for their othering behaviours, thereby negating the need to look at themselves and their professional and ethical responsibilities? Can the suggested strategies for engaging the other be applied in forensic and correctional settings, given the nature of the clientele and given the interpersonal climate? Does othering lead to moral distress for nurses? What impact does the nurse's philosophy regarding crime and punishment have on nursing care within forensic and correctional settings? Will nurses' attempts at inclusionary othering be thwarted by administrators and correctional staff and be perceived as over-involvements and boundary violations?

Nurses represent the largest group of health-care professionals working in forensic psychiatric and correctional settings. Clearly, they have a significant role to play in influencing the health and well-being of those in their care, by providing health care in a competent and ethical manner. In the final analysis, nurses who practise from a position of ethical integrity "see human possibilities where others see no hope. Thus power is born when caring others value another and believe in human potential" (Zerwekh, 2000, p. 60).

I have long contemplated issues that affect the development of therapeutic relationships in nursing practice, regardless of the practice setting or the presenting problems of those seeking care. Forensic psychiatric and

correctional settings may be considered hotbeds of othering, and it may well be that othering needs to be explored as a form of countertransference. Nonetheless, when I am being completely honest with myself I know that I too am guilty of othering in aspects of my personal and professional life. It is through such personal revelations that I humbly engage in personal character building. Moreover, it is in such moments that my personal vulnerabilities and frailties prevail — for I too am the other.

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