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Received: 18 April 2020 | Revised: 24 July 2020 | Accepted: 2 August 2020

DOI: 10.1111/jocn.15456

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ORIGINAL ARTICLE

Journal of Clinical Nursing WILEY

Subordinated masculinities: A critical inquiry into reproduction of gender norms in handovers and rounds in a forensic psychiatric care

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Abstract

Aims and objectives: To examine how gendered discursive norms and notions of masculinity are (re)produced in professional conversations about men cared for as patients in forensic psychiatric care, with a particular focus on the centrality of language and gender.

Background: During verbal handovers and ward rounds, care staff converse to share information about patients and make decisions about their mental status. Spoken language is thus a pivotal tool in verbal handovers and ward rounds, one able to reproduce discourses and gender norms.

Design: Qualitative. Data collected from audio recordings of verbal handovers and ward rounds in a forensic psychiatric clinic were subjected to discourse analysis. The COREQ checklist was used.

Results: While discussing patients, staff subordinated them by reproducing a discourse typical of heteronormative, family-oriented care. The overarching discourse, which we labelled *subordinated masculinities*, was supported by three other discourses: *being unable to take responsibility*, *being drug-addicted* and *performing masculinity*. Such discourse was identified as a disciplining practice that subordinate's patients as a means to maintain order, rules and gender norms.

Conclusion: The study reveals a caring practice that position male patients as children or disabled individuals and, in that way, as subordinated other men within a context were staff reproduces a heteronormative family structured care. The process also reveals a practice were downplaying aggressive and deviant behaviour could disempower and reduce patients´ responsibility for personal actions and their possibilities to participate in their care. That finding especially seems to contradict previous findings that patients want to be able to act responsibly and, to that end, want care staff to help them.

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Relevance to clinical practice: Nurses need to deepen their understanding of how language (re)produces discursive norms of gender and masculinity in forensic care and that process's consequences for such care.

KEYWORDS
discourse, forensic care, masculinity, power, verbal handovers

1 | INTRODUCTION

In Sweden, approximately 500 individuals convicted of violent crimes, sex crimes or arson suffer from severe mental disorders and, as such, can be referred to forensic psychiatric care under The Forensic Mental Care Act (SFS 1991:1129). At forensic psychiatric clinics, most patients are men, most are diagnosed with psychosis, and approximately 90% of all patients require a high level of security (National Board of Health and Welfare, 2018). During the often long periods of care at such clinics, patients are discussed in verbal handovers and shift reports, which usually occur three times daily, and in ward rounds, which typically occur on a weekly basis. On those occasions, nurses, assistant nurses and physicians convey information to each other about daily routines of care and the mental status of patients and their behaviour. In this article, we use the term *verbal handovers* instead of shift report. Verbal handovers are defined by Buus, Hoeck, and Hamilton (2017) as interdisciplinary reports occurring when one work shift ends and another begins.

What does the paper contribute to the wider global clinical community?

- The language used in verbal handovers and ward rounds in forensic psychiatric care (re)produces gender stereotypes that subordinate some masculinities in favour of others.
- Such language seems to (re)produce family-oriented care that positions patients in ways that they do not recognise and therefore cannot influence.
- Subordinating masculinities prompts social exclusion that seems to free men from taking responsibility for their behaviour and limit their options to participate in their care.

1.1 | Background

In all types of nursing care, verbal handovers and ward rounds are important events (Buus et al., 2017; Matic, Davidson, & Salamonson, 2011). In psychiatric practice in particular, such handovers and rounds are central in producing knowledge about patients, whose mental states are assessed during observations of their behaviour, activities and speech, all of which depend upon context (Buus, 2006; Eivergård, Enmarker, Livholts, Aléx, & Hellzén, 2018; Scovell, 2010). In verbal handovers and ward rounds, language plays an important role as a tool for conveying information (Hedegaard, 2019; Salzmann-Eriksson, 2018). However, in those contexts, language should not be conceived as a simple way of objectively transferring information but as a convention of social groups. By extension, knowledge should be understood as the effect of power constituted in language (Crowe, 1998; Foucault, 1994). In language as such, gender operates as an overall categorising principle (Hedegaard, 2019; Kumpula, Gustavsson, & Ekstrand, 2018; Mercer & Perkins, 2014; Perron & Holmes, 2011). For that reason, the perceptions of patients in general are constructed from normative, context-bound perspectives about how women and men should behave, act and talk (Eivergård et al., 2018; Hamilton & Manias, 2006)—that is, how they should or do perform gender (Butler, 2007).

There has been limited research on men and masculinity in forensic settings (Kumpula & Ekstrand, 2014). For example, Kumpula and Ekstrand (2012) found that the care offered by male staff was built on social and cultural ideas of masculinity. By doing things together the relationship would become deepened which could be a benefit for the care but, if staff are unaware of how they construct gender in daily care they are at risk to reproduce generalised knowledge about the men they care for (Kumpula, Ekstrand, & Gustavsson, 2019). Mercer and Perkins (2014) examined how staff and patients talked about pornography and found that there was a collective talk and shared discourses that made it possible for male staff and patients to relate to each other as men but also marginalise female nurses. In the same time, there was a distance because construction of otherness.

In research on the topic, particularly on how healthcare professionals discussed patients in a somatic context, Hedegaard (2019) found that the staff did not convey sufficient awareness of patients who exhibited gender-normative behaviour and, when discussing such patients, communicated primarily about their medical conditions. However, the opposite was true when patients somehow deviated from socially accepted gender norms. In those cases, the staff tended to use more informal language in which patients became judged according to those norms. In other recent work, Eivergård et al. (2018) revealed that when discussing women in forensic care, healthcare staff would refer to feminine norms about how the women should behave in order to become acceptable. For instance, if the women acted aggressively or were inadequately dressed,

then the staff would deliberate disciplinary strategies that might normalise their behaviour. Along similar lines, Kumpula et al. (2018) found healthcare staff's language in forensic settings to problematically assign patients certain characteristics that could be problematic for the care.

Despite those and other studies on verbal handovers in different healthcare contexts, research examining how gender is (re)produced in those contexts has been sparse, especially in relation to masculinity. In response, we designed our study to contribute to knowledge about masculinity in forensic psychiatric care, particularly about the power inherent in the language used by the care staff. With reference to the literature, we targeted our study to examine how gendered discursive norms and notions of masculinity are (re)produced in professional conversations about men cared for as patients in forensic psychiatric wards.

1.1.1 | Theoretical points of departure

In adopting the perspective of social constructionism in our study, gender is understood as a social construction within socially, discursively constructed reality (Crowe, 2006; Yazdannik, Yousefy, & Mohammadi, 2017). From that perspective, we also assumed that discursive formations define not only conceptions of what is possible to think and say about men in forensic psychiatric care, especially forensic psychiatric wards, at certain times but also ways of categorising patients, understanding their subjecthood and perceiving their identities in relation to context-dominant norms (Dowd, 2010; Hedegaard, 2019; Perron & Holmes, 2011).

Gender has typically been analysed as an organisational principle that sorts individuals into two categories—women and men—and acknowledges a power dynamic between and within those categories. Although common in all societies, such categorisation can differ according to historical and social contexts (Connell, 2009). According to Connell, within gender regimes, which occur in all institutions and societies albeit in different ways, individuals can construct a range of diverse gender arrangements from one context to the next. At the same time, individuals are expected to take responsibility for their behaviour insofar as it pertains to gender.

Connell (2008) has additionally identified hegemonic masculinity as being the normative construction, one representing a predominant view of what it is to be a so-called "real man" in relation to context, more often in terms of authority than violence. In contrast to hegemonic masculinity, she has also defined other masculinities as subordinated, often by being described in relation to heterosexuality versus homosexuality, and in that regime, gay men are subordinated by cultural exclusion and even violence (Connell, 2008). Although hegemonic masculinity can be difficult to uphold, most men nevertheless benefit from the hegemonic patriarchal order, which allows them to participate in that order by way of so-called "inner relations" (Connell, 2008, p. 118). However, within that order, marginalisation occurs in relation to the dominating group's legitimated authority (Connell, 2008).

From other perspectives, Dowd (2010) has argued that *masculinity* can be defined as not feminine and not homosexual. Beyond that, Coston and Kimmel (2012) have argued that hegemonic masculinity, based on the construction of the American man as someone who is irreplaceable, brave, strong, emotionally stable, critical, logical, rational and in good health, is a common ideal norm in Western society, one that some men cannot reach due to illness and/or disability. In line with Coston and Kimmel (2012), Dowd (2010) has therefore stipulated that men, both as individuals and in groups, can become disadvantaged by the hegemonic gender system. In turn, such disadvantage could affect men's health, for different masculinities are at more or less at risk of engaging in unhealthy behaviours (Hearn, 2010).

2 | METHODS

2.1 | Design

This study was part of a larger project designed to generate audio recordings as empirical material to investigate the importance of language in psychiatric contexts. In particular, our qualitative study involved identifying those audio recordings that address ongoing situations in forensic psychiatric wards, including verbal handovers and rounds, and subjecting them to discourse analysis. The material derived from audio recordings, with the purpose of producing content unadulterated by the authors aside from verbatim transcription. All verbal handovers and ward rounds were conducted on a daily basis, irrespective of the researcher's presence. The method that we followed to produce material has been described by Silverman (2005, pp. 25–32) and Potter (2012).

This study conforms to the COREQ check list (Tong, Sinsbury, & Craig, 2007).

2.2 | Setting and participants

We collected data from six forensic psychiatric wards purposively selected as ones where patients have received long-term, involuntary treatment subsequent to committing a crime under the impact of a psychiatric disorder (Forensic Mental Care Act, 1991). All wards were located in one regional forensic psychiatric clinic in mid-Sweden, and at the time of the study, each ward was caring for approximately 14 patients daily.

Participants included both ward staff and patients receiving treatment in the ward. Participating staff—nurses, assistant nurses and a physician—included 39 professional healthcare workers. Whereas the gender distribution among the nurses was nearly equal, most assistant nurses were men. The physician, a woman, reported having extensive experience in psychiatry; the nurses reported having from 2–20 years of experience in psychiatry, and the assistant nurses' reported experience varied from a few months to several years. To be included in the sample, staff had to be healthcare professionals working in the forensic psychiatric wards when the audio recordings were being made. By contrast, staff in acute care wards, emergency departments and

clinics that made an ethical request to abstain from participating were excluded from the sample.

Meanwhile, the sample of patients included 43 individuals—all men—ranging in age from 20–60 years. To be included in the sample, patients had to consent to having their conversations be recorded. Staff collected patients' written informed consent to participate targeted patients who could speak for themselves and respected any patient's refusal to give consent.

2.3 | Procedure

The first author (KE), a well-trained psychiatric specialist nurse and researcher, contacted several forensic clinics by email. The ones who answered were contacted again with the purpose of gaining access to their wards. One clinic replied in the affirmative and access to its wards was obtained first from the hospital management and later from the ward staff.

Next, the first author held two briefings to clarify the study's purpose to the staff and that staff who wanted to participate need to provide their written informed consent. Staff also received information about the procedure for collecting consent from patients. The procedure involved informing patients about the audio recordings; explaining that participation was entirely voluntary, that they could refrain from participating by not providing their consent and that they could withdraw their consent at any time during the study; and requesting their consent to participate. Patients and staff who did not provide their consent were not addressed and did not engage in the recorded verbal handovers or ward rounds. Ultimately, none of the staff or patients who provided their consent withdrew from the study.

During the recordings, a recording device was centrally placed in front of the staff, and the first author remained passive by not participating in the discussion or asking questions during the verbal handovers, which lasted half an hour each, or ward rounds, which lasted about an hour and a half each. After completing each recording, the device was sealed in an envelope and coded. According to the ethical procedure, a secretary anonymised all materials and transcribed them verbatim. In the field notes, the first author noted the place(s), how many patients were talking and how many staff participated. Transcripts of the audio recordings were not returned to participants, following the ethical review board's decision that the secretary who performed transcription should erase all data in the transcripts that could be used to identify any participants or contexts. Therefore, it was impossible to identify which text belonged to which ward. Participants were provided with the findings once the study was completed.

2.4 | Ethical considerations

An application for ethical review was made in accordance with Sweden's Ethical Review Act, because consent to participate from both patients and staff was required. To maintain the confidentiality of both staff and patients, the ethical review board required the audiotaped material to be submitted to a medical secretary who would erase all content that could be used to identify hospitals, departments or participating staff or patients.

2.5 | Data analysis

To analyse the material, we conducted Foucauldian discourse analysis (FDA). According to Foucault (2008, p. 181), different discourses strive to preserve their own borders, with the consequence of prohibiting other discourses and explanations. Drawing from that understanding, Winther Jörgensen and Phillips (2000) have described FDA as an analytical framework that integrates both theory and method, that prioritises identifying nodal points, signifiers, discursive field and signs in a given text. Added to that, they have argued that FDA is an interpretive process of accounting for both speech and text, all in relation to context. From another angle, Beedholm, Lomborg, and Frederiksen (2014) have claimed that discourse analysis can be applied to analyse language in use, in which language can be deployed as a tool for (re) producing norms embedded in a certain context. Considering all of the above, we recognised the importance of understanding FDA not as a step-by-step process but as an undertaking that is whole within itself (Stevenson, 2004). Thus, we applied social constructionism and gender theory during our analysis. Our particular approach to FDA has been described by Jansen (2008) and Springer and Clinton (2015).

To establish the best credibility and validity possible, all five authors (KE, IE, ML, AL and OH) read the data individually and provided individual input during analysis. Transcripts of the staff's conversations and statements were read through, and with inspiration from Winther Jörgensen and Philips (2000), we identified a nodal point or privileged sign—namely, "he". Because "he" can have different meanings in different discourses, it is a floating signifier. With "he" as our guide, we analysed how the signifier had been articulated. Of course, other signifiers and signs imbued the statements with their content, and some positioned the patients as either children or people who shirked responsibility: "not comfortable with him," "a child," "playing on the border," "disabled," "incapable," "meagre" and "brain-damaged". By contrast, other central signs—"nice," "calm," "social," "satisfied" and "compliant"—emerged as well. All signs were grouped and formulated as questions: why were adult men discussed as children, and why did the staff discuss themselves as parents? why were discussions about drug smuggling and women not questioned but accepted as normal topics in the wards? why did men on the staff discuss patients and their bodies in disrespectful ways? last, what are the potential consequences of discussing patients' care in those ways?

3 | RESULTS

3.1 | Subordinated masculinities

In answering the questions articulated above, all authors identified an overarching discourse in the empirical material: *subordinated masculinities*. That discourse was undergirded by three other discourses,

also found in the material: *being unable to take responsibility, being drug-addicted* and *performing masculinity*.

The overarching discourse—that is, subordinated masculinities—encompassed how the staff's discussions about the men in their care actively produced and reproduced discursive power strategies that authorised the staff to act in ways that beside subordination, marginalise the patients as a group. At the same time, such discourse subordinated the patients within a heteronormative gender order. According to Foucault (2017), that disciplinary practice of fostering men inside a heteronormative family sphere generally aims to maintain rules and norms as means to handle outbursts, aggression and defiant behaviour. Along those lines, a remarkable finding was that the staff seldom reported physical violence among the patients, although most of them had been committed to forensic care for perpetrating violent crimes. It is also interesting in relation to other studies were staff talk about patients as not trustworthy and violent (Kumpula et al., 2019).

In what follows, we present and elaborate upon examples of staff's statements about the men in their care. Therein, nurses are identified with names beginning with N, assistant nurses with names beginning with AN and the physician as P.

3.1.1 | Being unable to take responsibility

As the audio recordings revealed, the discourse about men as being unable to take responsibility was reinforced by speech about the patients as acting similar to children, functioning at a lower level and being unable to control their eating behaviour. Exemplifying the perception of the men as children, one of the nurses began describing a patient in light of his recent contradictory behaviour as problematic and behaving as a child might. Other staff explained his actions by assuming that he was at odds with himself and thus immature:

> N1: And we have a guy who's not completely comfortable with himself all the time, if I may say so. He has a sleep cycle that's totally out of synch.
>
> N1: There are daily conflicts and disagreements between him and mainly himself but also with other patients and staff. He looks for points of contact where he can create conflict.
>
> N1: When you [staff] don't show up as ordered—if there's no nurse here in the ward—he becomes very—
>
> N2: He's very defiant, despite his attitude….
>
> AN1: But then he plays on those boundaries every day….
>
> P: Yes. Well, one must consider that he does. Yes, sure. He's also like a child on the inside.
>
> (Recording 6)

When the staff cast themselves as parents and the patient as a child, they reproduced a power relation that subordinated the patient's masculine behaviour. Positioned as a child, the patient no longer seemed to pose any threat to masculine norms or the gender order. Moreover, the staff thereby did not seem to regard his behaviour as strange or as normal masculine behaviour but as what any child would do.

Shortly after, the staff also discussed the patient's verbal and physical outbursts, and one of the nurses explained that his behaviour could be managed by setting limits:

> P: Are there conflicts that get out of hand, or is it possible to…?
>
> N1: No, it almost never gets out of hand that way. We try to handle it… and try to be there and provide balance…. So, it almost never becomes so bad that it's totally unmanageable….
>
> P: Have you found some trick that kind of makes him…?
>
> N1: No, what makes him unwind a bit is… kind of when you make stricter reprimands.
>
> P: Then he understands that there's a boundary.
>
> N1: Yes, exactly: where he's reached his limit.
>
> P: If he can't get what he wants, he begins to kick and fight and threaten and things like that. So, it's important to be clear with him about those things, of course, so he sees where the limits are…. He shows contempt and provokes and checks to see whether the parents can manage being stood up to, and if we don't have the strength for a while, perhaps he can look for someone else who gives up more easily. I mean, [it's] just like the kids do at home. It's kind of what he does. Yes. So, what counts is that all of us are united about where the limits are.
>
> (Recording 6)

By talking about setting limits because the patient acts similar to a child, the physician uses a technology of power that doubles as mild discipline. An alternative approach would be using repressive strategies, which Foucault (2017) has described as a power strategy that mitigates resistance by being productive instead of punishing.

Similar strategies also manifested when staff discussed joking with a patient who had irritated them. Therein, the patient became subordinated when the assistant nurse remarked that the staff have to "stoop down" to the level of patients:

> AN1: And then he wanted to joke around a little. He said, "Are you going to get a slap in the face?" [And I

> replied] "No, we'll take it next week, when you're better in the back so you can have a better swing". He thought that was funny: beating me. You get two back. [*Laughed*.] Then he laughed and went and smoked….
>
> AN1: Sometimes we have to stoop down to the level of the patients.
>
> (Recording 2)

Stating that staff can and sometimes have to descend to the level of patients reveals a discourse describing the lower status of patients in the hierarchy of care in the ward that, in turn, imposes an imaginary limit that segregates patients from the staff (Foucault, 2010).

During a verbal handover one morning, a nurse discussed another patient with four assistant nurses, one of whom described the patient's tendency to follow the rules but not uphold adult masculine norms, namely by wanting only to play on the computer instead of being outdoors. In that conversation, the patient's behaviour was discussed as deviating from expected masculine behaviour, and, as a result, he was cast as being immature:

> N1: In the city, he's adaptable like that….
>
> AN3: Yes, nothing special. No, it's more that it's a little bit peculiar for a grown man. The only thing he wants to do is eat tasty food and then buy computer games and come back here.
>
> (Recording 2)

The discussion supported the discourse of normative masculinity by expressing that a grown man should not want to play on the computer so often. At the same time, because the staff portrayed the patient as being compliant, his behaviour did not seem to be a major problem. Nevertheless, because playing computer games for hours on end is neither strange among men outside the institution nor risks one's mental health, the staff's discussion of the patient's behaviour as non-normative should be understood as a strategy to maintain masculine norms that are desirable in the ward.

A similar strategy surfaced between two assistant nurses as they discussed why a particular patient should be active in a more social way:

> AN1: The reason was that he wouldn't… he just sits there… all day. He buries himself in his work and writing and all of that.
>
> AN2: He has to go out and do other things. He has to take care of his affairs and show himself a little.
>
> (Recording 3)

Albeit brief, that part of their discussion showcased the staff's presumed responsibility to foster and discipline, all as a part of a family discourse in which they cast themselves as parents and the patient as failing to behave as grown men should. Likewise, while describing the patients' relationship with food, other staff characterised the patients as being unable to take responsibility for their behaviour and therefore needing assistance from the staff. In turn, such assistance was discussed as setting limits and assuming responsibility because patients cannot:

> N1: Then you can talk him out of it [doing what]. Yes, exactly. Talking about a person or a… is enough for him…. It's just that someone is regulating him: someone assumes responsibility in the last quarter.
>
> AN1: Yes, he needs someone to tell him that.

The nurse ended the exchange by saying:

> N1: We present the food and then snacks, so none of the staff are there. They [the patients] live their own lives. Then you see them sitting and squeezing food.
>
> (Recording 6)

In that closing statement, the nurse described the patients as acting similar to beasts, not humans, once they, the "parents," were out of sight. Such talk not only subtly subordinates the patients but functions as discourse in which observation is derogatory, precisely because it occurs in the closed space where the family forms its truth (Foucault, 1994). Such strategies become ways of exercising power by attributing traits to patients and casting them in subject positions unbeknownst to them and that they cannot influence. In that way, new and old categorisations are produced and reproduced by virtue of how patients are named, described and assigned positions in the prevailing discourse. The individual or group that decides what is relevant, as well as what is possible to say and do, often occupies a position that allows a certain scope in the exercise of power.

3.1.2 | Being drug-addicted

The overarching discourse of subordinated and marginalised masculinities was also supported by a discourse of addiction, which itself was undergirded by speech that served to normalise behaviour involving the abuse and smuggling of drugs. In an initial statement, the staff discussed patients who have violated the clinic's rules by smuggling drugs into the ward, while at once suggesting that their behaviour did not require significant attention. In that way, their language anticipated and condoned such behaviour among the patients. Later, the staff's characterisation of a drug-abusing patient as being calm and pleasant reinforced and reproduced a masculinity that is acceptable in the context of care in the ward. Two examples from two wards illustrate those trends:

Ward 4

N4: And this time, he's been with us for just 2 weeks…. So, the doctor was here and talked to him seriously then, because he had to… stop with his business and keep at it. And it… has become a bit calmer around him now, at least during the last week, you could say. But I don't know…. He's very nice and polite in the ward… but then he's heavily addicted to drugs. He wants tablets from me all of the time…. Yes, and from other patients too, as has come to my knowledge. Yes, but it should've been better. I hope that he hasn't… taken or bought tablets from other fellow patients in other ways.

N5: There's nothing more to him. We're satisfied with that.

(Recording 4)

Ward 1

N1: [There's] a male patient who's been cared for here at X for 5 years. [He's taken] many drugs…. And he had that incident with Concerta [i.e. Ritalin].

AN1: Yes, exactly. He tried to sneak Concerta into the ward. But otherwise he's… kept a very low profile here in the ward. Nothing more to him? It's going rather well anyway, I have to say.

(Recording 1)

In those statements, staff discussed the abuse and smuggling of drugs among patients in ways that normalise such behaviour in the context of forensic psychiatric wards. According to those norms, if patients behave well, then their incidents involving drugs are overlooked, with the consequence that the staff appear to downplay the problem, while the patients can continue the behaviour without taking responsibility for it.

At times, the discourse of addiction was also infused with the discourse of disability, as occurred in a conversation between a physician and a nurse, who characterised the patient being discussed as a drug courier because he cannot act for himself, obeys others and is incapable of saying no:

P: Because he becomes very… both abuses himself with drugs and becomes a [drug] courier, I think… yes… for others… mmm…. He can't really manage to say no.

(Recording 6)

Because being unable to restrain patients seemed to disempower the staff, they tended to explain the patient's behaviour as emanating from within himself:

P: But that's what is: a "yes".

N1: It feels a bit like… he was a "pill popper" a few weeks ago….

N1: I looked at his addict self a little bit like that…. I felt that we need to keep an eye on that….

P: And make it clear that that's how it is. There's a boundary and… I think he stops short at that.

(Recording 6)

In that dialogue, the staff depicted drug addiction as both a behavioural problem and a problem from within, namely by describing the patient as possessing an "addict self". By discussing the patient in that way, the physician employed a medical discourse in which addiction is a sickness. Even so, having ensured that the patient understood the "boundary," the staff also propagated a discourse about people addicted to drugs as being morally weak individuals who need correction as a means to become normal (Prestjan, 2004).

Later, considering another patient's upcoming release from care, the physician advised the termination of medication. The patient's discharge was postponed, however, because, as one nurse stated, the patient had become a "little" courier for others and was "unable" to abstain from getting involved with drugs. By using the word "little," the nurse diminished the patient and subordinated him as a man, which paralleled the physician's subsequent portrayal of the entire situation in terms of a mental or physical shortcoming:

P: I don't really know him… [or] whether he has a learning disability in some way or something—some sort of cognitive impairment. He sometimes seems a bit parched; you might sense that when you're talking to him. I think… I haven't talked to him very much. He's been evaluated over the years as still being quite healthy… but he still hasn't been able to leave the clinic. Surely there must be something of that sort… if it's brain injury or something else… that interferes.

(Recording 6)

The physician's statement produced an understanding of the patient's failure as a learning disability, a cognitive impairment, a "deficiency" or else brain damage. In doing so, the physician seemed to invoke the power of medicine to reproduce a masculine norm that a man who does not act acceptably in a given context or society is necessarily disabled in some way. As such, the patients were positioned as men with individual identities marked by sickness. The examples thus underscore how talking can reproduce different masculinities that position men as being immature or disabled due to their failure to behave as expected in the given context.

3.1.3 | Performing masculinity

Also upholding the overarching discourse of subordinated and marginalised masculinities was the discourse of performing masculinity, which was reinforced by statements focused on the male body and heteronormative practice. In one recording, an assistant

nurse described how another assistant nurse and a patient, while walking in the city, met some young women whom the patient discussed in a way that the reporting assistant nurse thought was "weird":

> AN1: And in town he made all sorts of weird statements about women….
>
> AN1: He wanted a computer that was like a mannequin and the on–off button… was the breasts. That's what he said, and then he kind of… like nothing.
>
> N2: What is that? What does it mean?
>
> N1: Considering his body… I don't think he would've got anywhere…. He's not harmless… it's good to monitor [him].
>
> (Recording 2)

The assistant nurse's statement that the patient's body would not bring him success with the opposite sex positioned the patient as lacking external attributes that are acceptable for attracting women, which reproduces a masculinity opposed to the patients. In so doing, the assistant nurse positioned himself as being normal and having a normal man's body.

Later, one of the nurses discussed the patient's preference for sweets by referring to what the patient's brother had said about his body:

> N1: Because it was a bit shameful when his brother said… that he looked like… yeah… Barbapapa… yeah [*Laughed*].
>
> (Recording 2)

Such talk can be understood as a disciplinary technique in which the patient becomes subordinated when his statements are described as "weird" and his body as unattractive. In that process, the normative masculine body—an ideal body that is strong and rational—becomes subtly expressed by virtue of its opposite (Bengs & Wiklund, 2015). By adding that the patient is "not harmless," the staff's positioning of his body became even more complex: that it does not attract women and may even be harmful. In that way, the staff justified using their clinical gaze (Foucault, 1994) to keep an eye on him.

The statements also showcase a strategy by which caregivers assert their dominance, one that Connell (2008) and Dowd (2010) have characterised as a marginalising tactic always deriving from the dominant group's hegemonic understanding of masculinity. In that light, the statements can be interpreted as a normalising strategy to reproduce a masculinity that is expected in the given context and in which men on the staff position themselves as ordinary, normal men. Thus, men providing care generally need patients who are men to exist as others in order to maintain accepted masculine norms (Connell, 2008) and the border between "us" and "them," between rational and mad (Foucault, 1994).

Last, when men on the staff and patients became involved in discourses of heterosexuality, both powerless men and powerful ones discussed women in ways that allowed them to maintain heteronormativity and masculinity. Indeed, in one conversation, men on the staff discussed a patient's interest in women and reinforced it by referring to the patient's good mood and by laughing about it:

Ward 1

> AN1: Who wouldn't look at women…? [*Laughter*].
>
> (Recording 2)

Ward 2

> AN1: He was great yesterday. I would like to add that.
>
> AN2: Yes, he even played cards before the evening….
>
> AN1: There are many girls here now….
>
> AN2: Yes. He likes young girls… [*Laughed*].
>
> (Recording 3)

Those statements capture how men on the staff upheld a masculine norm that allows men to discuss women in sexualised ways. By doing so, they not only confirmed a heterosexual norm but also undermined any non-heterosexual norm. Likewise, by not discussing other sexual orientations, the staff did not threaten heteronormative discourse and even preserved and protected the social order based upon the heteronormative family.

4 | DISCUSSION

The purpose of our study was to analyse how gendered discursive norms and notions of masculinity are produced and reproduced in professional conversations about men cared for as patients in a forensic psychiatric context.

The overarching discourse that we identified—that is, subordinated masculinities—was supported by three other discourses: being unable to take responsibility, being drug-addicted and performing masculinity. The language used during verbal handovers and ward rounds reveals a caring process influenced by practices that subordinates patients under dominant masculinities expressed by the staff and other patients in the wards. By using language that subordinates and also marginalises patients, staff express a heteronormative practice of power that downplays aggressive behaviour, forgives drug abuse and smuggling and, at the same time, constructs borders between themselves and patients, primarily by casting themselves as parents who must set limits upon patients' behaviour. Kumpula et al. (2019) also observed that care staff talked about themselves as parents and that they mobilised correction, discipline and control as tools for use in caring for patients. However, such limits always concern more than the

behaviour of patients, because, as Butler (2007) has stressed, staff are also performing masculinity, especially a type of masculinity that prioritises acting with authority and purpose and, in that way, draws a line between rationality and madness, between "us" and "them" (Foucault, 2017).

Other authors have also reported that care staff may conceive patients, especially ones who are men, as children or as disabled individuals (e.g. Hörberg, 2008). Among them, Werbeke, Vanheule, Cauwe, Truijens, and Froyen (2019) found that patients sensed their de-subjectivation in relation to staff and believed that their power resided in their relationships with staff or lack thereof. Along similar lines, Hörberg and Dahlberg (2015) and, more recently, of course, those findings contradict how patients in other studies describe themselves. As Hinsby and Baker (2004) have shown, patients may indeed portray themselves as responsible, rational adults. Added to that, McKeown et al. (2016) found that patients in forensic care may desire to act responsibly and, to that end, even want the staff's help. Taken together, it seems that two discourses vie for precedence: one conceiving patients as responsible and rational—that is, respected as persons and upholding accepted masculine norms—and the other conceiving patients as children, disabled and at odds with normative masculinity.

When care staff discuss patients as though they are children, disabled or lacking masculine attributes, they reproduce a masculine norm (Coston & Kimmel, 2012) opposed to those identities that prioritises stability, indispensability and physical strength. Positioned as children, patients thus become subordinated to that masculine norm and assume the roles of interchangeable figures in the healthcare context. The staff's use of language creates such positions of power that seem to allow an effect of care—to borrow Foucault's (2017) term, *discipline*—instead of repressive punishment. In that way, by correcting behaviour or simply clarifying status, the staff can remain calm and maintain order in the ward. By extension, when the staff position themselves as parents, they construct a gender arrangement that reproduces a pattern in psychiatric practice active since the early 1900s, in which the physician acts as a father figure and caring women, often as nurses, represent the good mother. As part of that practice, family ideals are used to justify not taking punitive measures but instead using subtle, liberal ways of guiding patients to the so-called "correct" behaviour (Eivergård, 2003). Consequently, defiant behaviour remains nonthreatening. By the same token, patients who deviate from or resist adopting those norms are brought into line with paternal and maternal care. As studies by Kumpula and Ekstrand (2009) and Kumpula and Ekstrand (2012) have shown, the discourse of forensic psychiatry, as a practice, seems to organise gender in a traditional, heteronormative way. That institutional, family-like pattern of care supports the hierarchical positioning of both staff and patients, and heteronormativity seems to occupy a central, normative role.

In that gendered system, when staff discuss men's use and smuggling of drugs, they seem to downplay such behaviour, even though it violates the institution's rules, as aligning with a masculine way of acting. Although drug abuse and smuggling may also uphold behavioural expectations for immature men, if the patients show weakness or struggle to resist pressure from other patients to become involved with drugs, they seem to cross the border of what may be understood as masculine behaviour (Seidler, Rice, River, Oliffe, & Dhillon, 2018). Wilcox, Finlay, and Edmonds (2006) found that such explanations could have implications for accountability and an overall structure of coercion made by discipline (Foucault, 2017).

At the same time, the staff in our study also seemed to have adopted roles common in models of education, particularly the roles of caring women and caring men, the latter of whose exhibited masculinity becomes dominant or, in Connell's (2008) terminology, *hegemonic* and that which immature, disabled men are judged against. In turn, the caring men's position as role models for men in terms of security and bodily strength bears great significance on understandings of health care as the work of fostering others. Kumpula and Ekstrand (2009), who observed how men working in forensic psychiatric care relate to other men, both colleagues and patients, have argued that the work performed was mostly based on a social order in which men, through physical activity, achieve acceptance in the community as well as superiority over men in their care. In our audio recordings, staff indeed discussed some patients' bodies as not fulfilling masculine norms assumed to attract women. The male body inhabited by the staff thus received higher status than that inhabited by the patients. According to Kumpula et al. (2019), it can be understood as the patient's body then becomes an object for correction, and staff's bodies becomes tools for controlling disturbing behaviour.

In forensic psychiatry, a context in which most inmates and patients are men (National Board of Health and Welfare, 2018), the majority of individuals being treated have committed crimes before being admitted to care. In our material, however, we found no trend of discussing violence among the patients. If their crimes were a performance of masculinity, then it is interesting that studies have shown how men diagnosed with psychosis and committed to forensic care have not vied for power or dominance over others (Searle, Hare, Davies, & Morgan, 2018). In that light, threats and violence should be understood as acts of frustration on certain occasions and in certain contexts than as acts of preserving masculinity.

When staff upheld a masculine norm that allows men to discuss women in sexualised ways, they confirmed a heterosexual norm which could become a problem in a context as forensic care. This is what Mercer and Perkins' (2014) also discuss in a study where they found that staff in other forensic psychiatric wards participated in reproducing a masculinity that allowed, if not encourages, men to discuss women in sexualised ways as part of their maleness. They also found that both patients and men on the staff normalised the consumption of pornography within their homosocial relationships as a means of enhancing the legitimacy of heterosexual performance. This, they state could lead to a toxic culture and no benefit for the care.

The paternalistic, disciplining strategy used to manage the patients in forensic care could perhaps be a benefit for both patients

and staff. By contrast, it could disempower and reduce the patients' ability to participate in their own care. Barnao, Ward, and Casey (2015) found that although patients described care as occurring when staff were listening and helpful, they did not feel central in making decisions that would affect them, because consultation dominated over collaboration. However, as Seidler, Rice, Oliffe, Fogarty, and Dhillon (2017) have found, men with depression in particular need opportunities to collaborate in their own treatment, because collaboration strengthens the feeling of participation and having control over one's life. If patients become subordinated and do not receive opportunities to collaborate in their own care, then they may avoid responsibility for their actions, which can challenge their recovery towards becoming good citizens and men.

Above all, staff should understand the expression of their individual positions as a discursive practice (Foucault, 2008), in which orders of normality and gender are bound to context and expressed in language. In that practice, patients always become positioned in certain ways in their respective contexts, which, for psychiatric care staff, makes some discourses possible for discussing patients and others impossible (Beedholm et al., 2014; Foucault, 2008).

4.1 | Limitations of the study

Although one of the researchers, a woman, was present while recordings were being made, her presence never caused any disturbance, possibly owing to her experience as a psychiatric nurse. At the same time, what was stated during verbal handovers and ward rounds could be understood as diverging from what would have been stated if the researcher had not been present. Furthermore, the researcher's gender may have also affected what was stated in those conversations.

It is difficult to draw more far-reaching conclusions than those presented here, because only one audio recording was made in each psychiatric ward. As a consequence, conditions facing patients offered only a glimpse of their life in the institution, not the big picture. Although the fact that none of the wards appeared in multiple recordings can be understood as a limitation, it also offered a degree of reliability, because similar phenomena in language manifested in the distinct wards.

5 | CONCLUSION

The study confirms that the language used in verbal handovers and ward rounds is discursively and context constructed. This reveals a caring practice that position male patients as children or disabled individuals and, in that way, as subordinated other men within a context that reproduces a heteronormative family structured care. That process of subordination also reveals a practice of power in which a hierarchy of men, including both staff and patients, downplays aggressive and deviant behaviour which could disempower and reduce patients' responsibility for personal actions and their possibilities to participate in their care. That finding especially seems to contradict previous findings that patients want to be able to act responsibly and, to that end, want care staff to help them.

6 | RELEVANCE TO CLINICAL PRACTICE

Our findings underscore how staff working in forensic psychiatric care need to be aware of the power of language that they use and how it contributes to positioning patients in different, often subordinated ways. If such awareness is lacking, then staff run the risk of diminishing patients and smothering their sense of responsibility by not reflecting on the power of norms, especially norms of heteronormativity and masculinity. Additional studies on the topic continue to be necessary, especially ones addressing perspectives on gender, sexuality, class and ethnicity, to expand knowledge about and challenge the norms and values that affect staff's talk, actions and decisions about the health of patients in forensic psychiatry.

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How to cite this article: Eivergård K, Enmarker I, Livholts M, Aléx L, Hellzén O. Subordinated masculinities: A critical inquiry into reproduction of gender norms in handovers and rounds in a forensic psychiatric care. *J Clin Nurs*. 2020;29:4227–4238. https://doi.org/10.1111/jocn.15456