Doing Health, Undoing Prison:
A Study with Women who have Experienced Incarceration in a Provincial Prison

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Abstract

Studies on health and incarceration have extensively demonstrated that incarcerated women have poorer health statuses than non-incarcerated women and than incarcerated men, both as a result of confinement and of the intersection of abuse, poverty, homelessness and addiction that are simultaneously pathways to criminalisation and to poor health. Without denying the reality of disease, physical and mental suffering experienced by women in prison, this thesis conceptualizes the "problem of health in prison" by framing it as a vehicle of and effect of power relations. By studying neoliberal rationalities and technologies that constitute health, poststructuralist scholars have demonstrated how neoliberal subjects are enticed to continuously pursue health and to adhere to the imperative to be healthy. Demonstrating the intersection of neoliberal health governance and penal governance, criminologists have shown how prisons produce the subject of a healthy prisoner, who is a self-regulated woman, freely working towards her rehabilitation. Rather than studying programs, public policies and archives, this thesis innovates by examining the experiences and narratives of the subjects who are being governed and enticed to be "healthy." Specifically, my research provides a contextualized analysis of how women negotiate and manage their health during incarceration and upon their release from prison.

The first article focuses on tensions between this work's conceptual framework and its methodology, i.e. participatory action research. An emerging literature has been building bridges between poststructuralism and participatory action research, highlighting the latter's potential for transformative action. Using examples from participatory action research projects with incarcerated or previously incarcerated women, the article discusses how "participation" and "action" can be redefined by using a poststructuralist definition of subjectivity. The second article tackles the issue of how women "do" health in prison. Using three issues—access to health care services, smoking, and the management of body weight—the article explores how participants adopted different embodied subjectivities, which conflicted or aligned with neoliberal governmentality. It describes how, through failure to conform to neoliberal ideals of "health," mechanisms of self-surveillance and self-regulation are relayed by feelings of guilt, shame, and anxiety, even when incarcerated women attempt to conform to imperatives to be healthy. Finally, the last article focuses on how, upon prison release, participants attempted to "undo" the imprint of penal governance on their bodies and health. Through the exploration of corporal practices, such as taking care of one's appearance, the use of psychoactive medications, and defecating, the article shows how women attempt to "undo" prison in order to pursue health. Though these two articles focus on different periods of participants' lives and rely on different yet related concepts—embodied subjectivities and corporal practices—the common thread between the two is to show the attempts by participants to "undo" prison from their embodied selves, and to "do" health as incited by the ethical imperatives to be healthy. The thesis concludes with a

discussion about the pursuit of health, and its effects on the populations deemed as “at risk” and “unhealthy.”

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Chapter 1

Introduction

From my experience in doing research, my only conviction is that doing research is a rather messy endeavour, in which the researcher jugglesconstant streams of information—theoretical, empirical, experiential—and get lost, confused, and exhausted, but also find meaning and purpose, and often further questions and avenues of inquiry. This doctoral thesis is the result of five years of determined inquiries around three themes: prison, health, and power. As a dissertation by articles, it is structured in the form of three independent papers that each can be read as a stand-alone piece. I chose to write in this format for professional reasons, as well as to engage with three specific issues that became evident during my fieldwork. However, writing in this format was a frustrating process, as it left little room to account for the walls I hit, the dead ends I encountered, and the "eureka" moments I had along the way. In other words, it maintains what Cohen and Taylor (1972) defined as the chronological lie, namely, that research is a linear process, from the elaboration of a research question to the conclusion. This introduction aims to provide a glimpse of the reflexive, iterative, and cyclical processes that inescapably constitute the practice of research, as well as to build linkages among the three papers.

The starting point of my doctoral thesis was my practice as a case manager for street-involved youth with mental health and addiction issues. Although I worked with many youth who had been criminalized, one case particularly struck me. One of the youth with whom I had been working for two years got arrested and sentenced to a few months in prison. I tried to reach out to him for a few weeks, to no avail: I was later informed of his prison release because he walked into my office as a "free" man. I continued to support him, mostly around addiction and mental health issues, but as he failed to properly "reintegrate," and went back to prison a few times, he became increasingly alienated from his circle of friends,

as well as various community organizations. Eventually, I lost contact with him. Yet, after I started my PhD, I ran into him on the street. We chatted for a while, and he told me that his mental health symptoms and his addictions were out of control: as he walked away, he concluded: "Prison is just bad for you—it made me a freaking homeless man."

This young man's story is, sadly, nothing exceptional for anyone who has worked with street-involved people, but it prompted my interest in developing a research project about the effects of incarceration upon health, focusing on women's experiences of incarceration. Studies and reports show that women in prison are not "healthy," as they report higher prevalences of chronic illnesses (Covington, 2007; Fisher & Hatton, 2009; Lewis, 2006), infectious illnesses (Giroux & Frigon, 2011; Martin et al., 2013; Poulin et al., 2007) and higher rates of mental health and substance abuse problems than non-incarcerated female populations or incarcerated males (Covington, 2007; Fisher & Hatton, 2009; Giroux and Frigon, 2011; Irwin & Owen, 2005; Lewis, 2006; Martin et al., 2013). I identified a knowledge gap with respect to the realities of women who are incarcerated within provincial prisons, and I thus focused on that specific population in Quebec. Mindful of the constraints I faced as a student, I adopted a methodology inspired by participatory action research (PAR), a choice that was motivated by my desire to do research *with and for* incarcerated women rather than *on* and *about* them, as well as by the low number of studies that used participatory or community-based methodologies with incarcerated populations. Thus, I developed a multi-tiered research design inspired by PAR in which I first conducted interviews and a focus group, and then developed a collective project with participants.

After I started interviewing participants and engaged in my analysis, I was propelled into the proverbial rabbit hole. Participants' accounts of the effects of prison on their physical

and mental health was rich material, often troubling and appalling, and reflected issues that were abundantly discussed within prison studies: the pains of incarceration (Crewe, 2011; Sykes, 1958), carceral shock (Lhuillier & Lemiszewska, 2001), the medicalization of mental health (Archambault, Joubert & Brown, 2013; Kilty, 2012; Pollack, 2005). Ironically, as my fieldwork went flawlessly and I easily recruited participants, I was left with a feeling of going round and round in circles, with little material that was innovative enough for a doctoral thesis, since it reflected issues that had been discussed and dissected from different angles in the literature. In an attempt to pull myself out of the rabbit hole, I went back to the theoretical drawing board. Two authors were particularly meaningful in reframing my research project: Michel Foucault and Mary Bosworth.

Evidently, Michel Foucault is one of the greats in prison studies, as he developed an analysis of prison that situated its inner functioning within larger power relations, rather than treating it as an exceptional institution (Combessie, 2004). However, it is not his work on disciplinary power that got me out of the rabbit hole, but, rather, his inquisitive posture. Talking about his own work, he explained that one of his objectives was to interrogate what appeared to be self-evident, natural or truthful (Foucault, 1980): subjectivity, penalties, sexuality, and mental illnesses were explored by Foucault as mechanisms, vehicles, and effects of power, rather than as fixed social constructs. He summarized his approach in one single statement:

> Aider d'une certaine manière à ce que s'écaillent quelques "évidences", ou "lieux communs", à propos de la folie, de la normalité, de la maladie, de la délinquance et de la punition, faire en sorte, avec bien d'autres, que certaines phrases ne puissant plus

> être dites aussi facilement ou que certains gestes ne soient plus faits au moins sans quelque hésitation, contribuer à ce que certaines choses changent dans les façons de percevoir et les manières de faire, prendre part à ce difficile déplacement des formes de sensibilité et des seuils de tolérance, etc. – et je ne me sens guère en mesure de faire bien davantage[1]. (Foucault, 2001, p. 849)

Considering my own research project, I started to raise the question of the "evidence" of the problem of health in prison: why was health a "concern" for incarcerated women—in fact, why was health a concern at all? It is not "evident" that incarcerated women would necessarily articulate health as a problem in prison and experience it as a problem. In questioning the "evidence" of health as a problem for women in prison, I stepped away from the biomedical discourses on health, and explored how participants' subjectivities and experiences of "health" were the site of the deployment of various technologies and apparatuses[2] of power during incarceration and upon prison release.

As I reviewed my theoretical framework, I also found myself further isolated from my participants, up and away in the ivory tower. The dissonance between the theoretically informed notion of "subjectivities" and the narratives of research participants was striking: the constitution of "subjectivities" by neoliberal governmentality and gendered penal governance clashed with participants' descriptions of prison's smells, the wounds and illnesses with which they were dealing, or their fears of rejection by their children. Mary

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[1] Translated by the author: « Helping to debunk certain "evidence" or "common knowledge" about madness, normality, sickness, delinquency and punishment, so that some sentences won't be said as easily or certain actions won't be taken without some sort of hesitation, so as to contribute to changes in how we perceive and how we act, to take part in this difficult transformation of sensitivities, of tolerance limits, etc. – I feel I can't do more than that."

[2] In line with many of Foucault's commentators (see Burchell, Gordon & Miller, 1991), I used "apparatus" as a translation for "dispositif".

Bosworth (1999) enabled me to find my way back to my fieldwork. As she herself worked on the issue of agency and resistance among incarcerated women, she discussed the risk of alienating those whose lives we seek to understand. A strong advocate for theoretically informed qualitative empirical enquiry, she made the case for the articulation of a reflexive dialogue between theory and practice: her objective was not to have empirical data "fitting" into preset theoretical categories, but, rather, to "weave a web of interpretation between women's testimonials and contemporary theories" (Bosworth, 1999, p. 91). Adopting her metaphor of a "web," I approached my thesis as a dialogue between theory and practice in which one could illuminate the other in succession, rather than by following a linear empirical logic, in which analysis follows theorization. In doing so, I was able to ground and materialize the notion of subjectivity by integrating the notion of embodiment, as conceptualized by feminist poststructuralist scholars such as Frigon (2012, 2003), Grosz (1994), and McNay (2000, 2012).

By continuously engaging with theory while conducting fieldwork and data analysis, three issues emerged and became the anchor for the three papers that constitute this thesis. The first paper focuses on the alignment between my theoretical framework and my methodology. Building on an emerging literature that advocates for a theorization of PAR using a poststructuralist theoretical framework (Dillon, 2004; Golob & Giles, 2013; Kothari, 2004, Lennie, Hatcher & Morgan, 2003), it describes how a poststructuralist conceptualisation of subjectivity sheds new light on two key concepts of PAR: participation and action. The second article delves into the heart of the topic: prison and health. Informed by governmentality studies, I approached health as an apparatus of power that takes the form of an ethical imperative to take care of one's health (see Aïach, 2009; Lupton, 2012, 1995;

Petersen & Bunton,1997; Yaya, 2009). As penal governance and the imperatives to be healthy are conflated in the carceral space (Robert & Frigon, 2006; Robert, Frigon & Belzile, 2007; Smith, 2000), paradoxically constituting incarcerated women as subjects who should take actions to improve their health in a "unhealthy" environment, I explore how participants have deployed different embodied subjectivities during their incarceration in order to "do health" in prison. The last article tackles the issue of "doing health" upon prison release, focusing on the corporal practices participants adopted to take care of their "health." The topic for this last article was dictated by my fieldwork: as participants talked about the challenges of prison release, they focused on their actions and their corporeality, the habits and lifestyles changes they underwent once out of prison, rather than how they felt or experienced health. Though these two articles focus on different periods of participants' lives and rely on different yet related concepts (embodied subjectivities and corporal practices), the common thread between the two is the attempt by participants to "undo" prison's grip on their embodied selves.

This thesis contributes to the field of population health by interrogating "health" as a site for the unfolding of power relations. The literature on the social determinants of health demonstrates how poverty, exclusion, and racism—factors commonly bundled into the concept of the "social determinants of health" —play a key role in shaping the health status of individuals and populations (Commission on Social Determinants of Health, 2008; Evans, Barer & Marmor, 1994; Marmot, 2004; Wilkinson & Pickett, 2009). Considering that women's criminalization is shaped by the increasingly punitive governing of poverty, homelessness, mental illnesses and drug abuse, as well as the systematic exclusion of Aboriginal women (Brassard & Jaccoud, 2002) and racialized women (Maidment, 2006),

the issue of women's health in prison is undeniably constituted by social determinants of health. However, despite an increasing emphasis on the social determinants of health, key concepts in the field of population health (such as power, marginalization, and exclusion) are in need of theorizing and critical interrogation. As the public health agenda is increasingly embedded within neoliberal technologies of responsibilization (Aïach , 2009; Lupton, 1995, 2012; Petersen & Bunton,1997, Schrecker, 2013), studies are needed to explore how responsibilization is deployed on "vulnerable" and "at risk" populations, and critically interrogate its effects. It is to this area of study that this thesis contributes.

I explained from the start that this introduction aims to provide a common thread linking the three articles. At this point, the reader has enough background information to delve into each paper, in the order that best fits her or his interest. I have, however, chosen to provide some additional background information on my object of study, my theoretical framework, my methodology, the ethical considerations that were raised during my fieldwork, and on my research question and objectives, as follows.

Defining the Research "Object:" Women, Prison, and Health

Before delving into the topic, it is important to underline that the Canadian correctional system is divided into two jurisdictional levels. Federal correctional services have jurisdiction over adult offenders who are serving a custody sentence of two years or more, as well as offenders who are on conditional release in the community (parole or statutory release). Provincial and territorial correctional services have jurisdiction over adult offenders who are serving a custody sentence that is less than two years, on offenders who are being held awaiting trial or sentencing, on offenders serving community sentences, and,

in the cases of Quebec and Ontario, on provincial offenders on conditional release in the community. There are more women in provincial/territorial facilities than in federal correctional facilities, and their stays in prison are, on average, shorter than for federally-sentenced women (Correctional Services Program, 2015).

Each correctional level operates different correctional facilities, and each offers different services for its incarcerated population. Federal imprisonment for women underwent major organizational changes in the 1990s. Based on rehabilitative ideals outlined in *Creating Choices* (Task Force on Federally Sentenced Women, 1990), five regional facilities were created, with an innovative architecture that aimed to support women in living in community, rather than in a traditional carceral setting. A new "approach" to women's corrections was developed, with an emphasis on "empowering" women and promoting "shared responsibility" between the community and the women themselves in regard to reintegration. Many scholars (see Frigon, 2002; Hannah-Moffat, 2001; Maidment, 2006) have demonstrated that feminist and Aboriginal notions of "empowerment" have been incorporated into correctional discourses and practices, and recast as a neoliberal strategy of government, as it will be discussed in chapter 3 and chapter 4. For now, suffice it to say that the reform of the federal system of women's incarceration has included the assumption that incarcerated women are different from their male counterparts, and that specific forms of correctional interventions should be used to address their needs. Consequently, the reform at the federal level had trickle-down effects, especially in the development of programs targeting women's specific needs (Giroux & Frigon, 2011).

In the province of Quebec, there is one prison for women in Montreal and one section of a prison that is reserved for women in Quebec City. In the rest of the province,

sectors of prisons for males are reserved for women to stay in temporarily, until they can be transferred to the Montreal or Quebec City facilities. The unsanitary living conditions and overpopulation issues of the only prison for women and the only dedicated prison sector for women in Quebec City, as well as the challenges posed by the provisory detention of women in prisons for men outside of urban areas, have been repeatedly denounced by the Quebec Ombudsman (2013). In contrast to federal facilities, provincial facilities usually have traditional carceral architecture: prisoners are sharing cells, and are grouped into sectors with shared common areas. Meals are provided through catering services, and consumed in the common area of the sector. Many critics have underlined how provincial facilities offer few rehabilitative services or, if they do, access is limited due to waiting lists, as well as the uneven provision of health services (Bertrand, 2002; Kilty, 2012, Maidment, 2006), leading Kilty (2012) to argue that provincial facilities are "little more than holding cells for women who cycle in and out [of prison]" (p. 164). As this study focuses on the experiences of women who have been incarcerated in provincial prisons in Quebec, the following section will provide a brief portrait of this population.

Provincially Incarcerated Women in Quebec: a brief Portrait

In the United Kingdom and in the United States, women have been the fastest-growing carceral population (Covington, 2007; Fisher & Hatton, 2009; Irwin & Owen, 2005), but conflicting claims have been made with respect to Canada. In an extensive study of the imprisonment trends of women in Canada, Gartner, Webster and Doob (2009) concluded that there has been an increase since the 1980s, but that increase is far from being substantial. Gartner et al. (2009) stressed the limits of their results, since data at both the national and provincial level are fragmented and measured using different tools. Considering

the population of incarcerated women in Quebec, recent reports from Quebec's correctional services seem to indicate that the number has been rising and will continue to rise (Chéné, 2014). According to the 2014 statistical report from Chéné (2014), women constitute 6% of the incarcerated population in custody in Quebec (as measured by the number of people in prison on any given day), an increase of 45.6% since 2003. For women who have been sentenced to custody, the average length of time spent in prison is 35 days; the majority of women (70%) actually stay less than a month in prison (Giroux & Frigon, 2011). Finally, it is important to emphasize the phenomenon of cycling in and out of prison: over a one-year period, 74% of incarcerated women have been incarcerated once, 16% were incarcerated twice, and 10% were incarcerated three times or more (Giroux & Frigon, 2011). It is also important to underline how the proportions of women who are in pre-trial custody has been rising over the last ten years (Correctional Services Program, 2014). Additionally, the amount of time spent in prison before trial also increased over a nine-year period, from 9.1 days to 12.2 days between 2007–2008 (Giroux & Frigon, 2011).

There are few studies detailing socio-demographic data about provincially incarcerated women in Quebec: the most recent and extensive study on the subject was conducted by Giroux & Frigon (2011), who looked at all women under the care of Quebec's correctional services in 2007–2008. This population included women who were incarcerated, those who were serving community sentences, and those on probation. According to Giroux and Frigon (2011), the average age of women under the care of Quebec's correctional services had been rising, from 31.7 years old in 1992 to 35.8 years old in 2002. As in the rest of Canada, Aboriginal women are overrepresented within the carceral population, especially women from Inuit and Cree nations (Brassard, Giroux & Lamothe-

Gagnon, 2011). According to a report by the Office of the Correctional Investigator (2013), racialized women and men are overrepresented within the Federal correctional population and, according to community organizations working with incarcerated women, the same trend can be observed within provincial carceral populations (Canadian Association of Elizabeth Fry Societies, 2003). However, although the overrepresentation of Aboriginal men and women has been well-documented in official statistics, there is very little information for racialized men and women, although reports have documented racial profiling in Quebec (Eid, Turenne & Magloire, 2010) and community organizations have reported that racialized women are overrepresented in prison (Pollack, 2008). In terms of language, 81.4% speak French; 9.6 English; 7.1% speak both, and 1.9% speak other languages (Grioux & Frigon, 2011). Although they had limited data on the subject, Giroux and Frigon (2011) underlined how 78% of women had gone to and/or finished high school, and highlighted the needs of women in terms of employability, as only a minority of women worked prior to their incarceration (Strimelle & Frigon , 2007). Finally, Giroux and Frigon (2011) stressed that almost a third of the population under study declared at least one dependant person, raising important concerns in respect to parental responsibilities. Focusing on that specific issue, Blanchard (2002) showed that, despite incarceration, 67% of the children of women in his study were their mothers' legal responsibility, and under the care of third parties following out-of-court agreements. Thus, despite incarceration, an important proportion of incarcerated mothers are the sole providers for their children. In brief, women who are incarcerated are likely to have limited education, be racialized, be unemployed or employed precariously, be single mothers, and, as will later be discussed, struggle with addiction or mental health issues.

In the wake of a decreasing social security, de-institutionalization of mental health services (Laberge & Landreville, 1994), and increasing poverty and inequalities (Raphael, 2008), Canadian women in low income groups are overrepresented within vulnerable populations, especially Aboriginal women, visible minority women, women with disabilities, and single parent mothers (Statistics Canada, 2011). Strimelle and Frigon (2007) showed how criminalized women in Quebec struggled to find and maintain stable and adequate employment both before and after their incarceration, and Boutet, Lafond and Guay (2007) highlighted the precarious socioeconomic conditions that women faced prior to incarceration. Maidment (2006) argued that, in fact, the common denominator among criminalized and incarcerated women is "a chronic cycle of poverty and dependence on welfare" (p. 59). As situations that were formerly defined as social problems, such as homelessness (Hermer & Mosher, 2002), are now recast as "law and order issues" and managed through penal policies and the carceral apparatus (see Wacquant, 2009a, 2009b), the incarceration of women can be traced back to the intersection of poverty, racism, sexism, and social exclusion (see Maidment, 2006; Pollack, 2015).

An examination of the infractions for which women have been convicted further demonstrates how the incarceration of women is embedded within their material and social conditions. According to Giroux and Frigon (2011), the most common infraction is failure to conform to a probation order. Studies have shown that, not only are the conditions of parole or release difficult to follow for women (Maidment, 2006), but they also "reflect whiteness, heterosexuality, ablebodiedness and middle-class norms" (Turnbull & Hannah-Moffat, 2009, p. 548). For instance, paroled women are subjected to non-association with people with criminal records, and their relationships are under scrutiny, in order to assess if they are

"prosocial" and to further their (re)integration. However, this condition isolates women from relationships they have built in prison, as well as potentially isolates them from their community of origin. Thus, women are potentially (re)incarcerated for their failure to uphold social norms associated with a privileged social position, irrespective of the actual social and material conditions they face upon prison release. Other common infractions—such as property crime violations, drug and alcohol violations, violations relating to the use of a vehicle—are related to property crimes, sex work, or addictions, and are thus connected to women's disadvantaged social and economic status (Maidment, 2006; Pollack, 2015). In brief, the criminalization and incarceration of women cannot be appraised without a careful examination of the nexus constituted by poverty, racism, mental health, homelessness, and social exclusion. The health issues faced by incarcerated women are also a demonstration of this nexus.

Women's Health and Prison

Many studies have documented how incarcerated women bear a substantial burden in terms of infectious diseases and mental and chronic illnesses (Poulin et al., 2005; Boutet, Lafond & Guay, 2007 ; Covington, 2007; Fisher & Hatton, 2009; Koyoumdjan et al., 2015; Robert et al., 2007). Poulin et al. (2007) reported that the prevalence of HIV and hepatitis C in their sample of provincially incarcerated women was 8.8% and 29.2% respectively. For each infection, the most important risk factor was injection drug use. The prevalence of mental illnesses is higher in the incarcerated population than in the general population, and higher in incarcerated women than incarcerated men, as demonstrated by epidemiological studies and the high numbers of prescription of psychoactive drugs in prison (Archambault et al., 2013; Frigon & Duhamel, 2007; Giroux & Frigon, 2011; Lafortune & Vacheret,

2009). Within the population of incarcerated women, the most prevalent mental illnesses reported are: alcohol and drug addictions (Plourde et al., 2007), post-traumatic stress disorder (PTSD) (Covington, 2007; Giroux & Frigon, 2011), anxiety and depression (Frigon & Duhamel, 2006), as well as borderline personality disorder (Giroux & Frigon, 2011). Many studies have highlighted the high rates of victimization of incarcerated women, and its impact on their mental health: data from Quebec suggests that half of the women who were incarcerated had been victims of sexual abuse, and 7 out of 10 had experienced violence in intimate relationships (Boutet et al., 2007; Frigon & Duhamel, 2006). With respect to chronic illnesses, Koyoumdjan et al. (2015)'s scoping review demonstrated that there is an important gap in the knowledge about chronic illnesses, injuries, and the sexual and reproductive health of prisoners, especially for females and provincially-sentenced prisoners. Consequently, though many studies have argued that incarcerated women show higher prevalences of diabetes, asthma, hypertension, and heart disease than non-incarcerated women, the data on which they rely is based on American or British studies. Although focusing on federally-sentenced women, a recent study on self-reported health from Stewart, Sapers, Nolan and Power (2014) can provide some indications about the extent of chronic illnesses and injury upon arrival in prison: female prisoners reported back pain (26%), head injuries (23%), hepatitis C (19%), and asthma (16%) as their most common health conditions, as well as obesity (30%) and injection drug use (27%) as risk factors related to lifestyle.

Although health care plays a limited role in the health status of individuals and populations (Commission on Social Determinants of Health, 2008; Evans, Barer & Marmor, 1994; Marmot, 2004; Wilkinson & Pickett, 2009), discussions of the health of incarcerated

women is often accompanied by an analysis of health care services in prison. These analyses mostly focus on health care services' challenges and shortcomings (Robert, 2008), which are explained by organizational factors, the challenges associated with the "difficult" prison population, and tensions that inhibit health care professionals in their duty to care for prisoners and their duty to enforce discipline (Holmes, 2005). Robert (2008) underlined that health care services are heavily utilized in both provincial and federal prisons, which is usually interpreted either as an indication that prisoners abuse health care services, or an indication of prisoners' poor health status. The issue of prisoners' health is thus articulated with recommendations for better and more efficient health care services (for instance, Ammar & Weaver, 2005; Plourde et al., 2007; Plugge, Douglas & Fitzpatrick, 2008). However, Smith (2000) and Robert et al. (2007) and Robert (2008) argued that the disparity between requests for women to be autonomous in respect to their health and the lack of options available to them need to be factored in to understand the (over)utilization of health care services in prison**.** In other words, incarcerated women (over)use health care services partly because they lack alternatives to engage in alternative and autonomous strategies of care.

In the field of prison studies, the question that is often raised about health and incarceration is the role that incarceration plays in worsening or improving women's health status, especially with respect to women's mental health. By its nature, confinement heightens the risk of infectious diseases (tuberculosis, flu, etc.), as well as constrains women to live sedentary lifestyles (Martin et al., 2013). Separation from loved ones, the loss of freedom of movement and social status can lead to psychic suffering, in the form of feelings of anxiety, depression, and boredom (see Giroux & Frigon, 2011; Lhuillier & Lemiszewska,

2001; Sykes, 1958). Considering that incarcerated women have overwhelmingly experienced sexual and physical abuse, disciplinary measures such as solitary confinement or strip searches can trigger memories of trauma and can cause significant emotional and physical distress (Giroux & Frigon, 2011; Kilty, 2012; Pollack, 2005). In fact, some authors argue that prison can re-traumatize women because it subjects them to a lack of intimacy, isolation from their social networks, and forces them to conform and obey orders (Maidment, 2006; Pollack, 2005). Taking into consideration the gendered construction of mental illness, critical feminist authors argue that prison authorities in fact pathologize women and label them as "mad" when they show signs of struggling in their adaptations to prison life, thus categorizing them as mentally unhealthy (Kilty, 2012; Maidment, 2006; Pollack, 2005). However, some incarcerated women have reported that prison is "the safest place I've ever been" (Bradley & Davino, 2002, p. 351), a place in which they could get better and get away from drug use or violence (Bradley & Davino, 2002), some studies promote prison as a place of "healing," arguing that incarceration is a key time for health promotion (for instance, Martin et al., 2013). The claim that prison is a safe place needs to be critically examined: prison's positive effects must be contextualized in women's life trajectories overwhelmingly marked by poverty, exclusion, homelessness, and drug use (Fields, Gonzàlez, Hentz, Rhee & White, 2008; Robert et al., 2007; Robert & Frigon, 2006; Smith, 2000). As Field et al. (2008) argued, in these cases, "(j)ail thus becomes a place to get care that is otherwise not available. The bitter injustice is that these women must be in jail and stripped of many rights in order to gain that access" (p. 79).

Studies show how women's experiences of release are shaped by the intersection of the criminal justice system with economic and social marginalization and exclusion. Studies

have highlighted the structural inequities that women face, including a lack of safe and adequate housing and access to adequate and sustainable employment (Maidment, 2006; Pollack, 2015; Shantz, Kilty & Frigon, 2009), as well as poor access to appropriate health care and social services (Giroux & Frigon, 2011). The aftermath of a prison sentence is also a time of (re)negotiating familial and intimate relationships that have been tried by separation (Giroux & Frigon, 2011; Maidment, 2006; Shantz et al., 2009). It is also a time during which women have to reach out for appropriate health care, cope with health issues that they developed during their time in prison, and strive to get rid of the marks of incarceration on their bodies, e.g. scars, premature aging, tattoos, etc. (Shantz et al., 2009). In other words, women continue to carry the burden of their time spend in prison with them while simultaneously struggling to (re)integrate into their communities (Maidment, 2006; Pollack, 2009; Shantz et al., 2009; Turnbull & Hannah-Moffat, 2009).

In brief, incarcerated women can be described as an unhealthy population, as they struggle with a multiplicity of health issues, before, during, and after incarceration. However, such an appraisal of health and prison assumes as "truthful" biomedical discourses on health, and takes for granted the problematization of women's health in prison. In other words, there is a knowledge gap in the literature on women's health and incarceration, not so much in terms of what the health issues faced by incarcerated women are, but in the interrogation of biomedical discourses and discourses on which this literature relies (with the exception of Smith, 2000; Robert et al., 2007; Robert & Frigon, 2006). Joan Scott's metaphor about visibility may help make that point; she highlighted how historians have attempted to uncover and make "visible" the "lives of those omitted or overlooked in accounts of the past" (1992, p. 23). In doing so, their "experiences" are made visible but

they are inevitably decontextualized, "making visible the experience of a different group exposes the existence of repressive mechanisms, but not their inner workings or logic; we know that difference exists, but we don't understand it as constituted relationally" (1992, p. 24). Thus, the literature on prison and women's health has attempted to make "visible" women's experiences of health, but few authors have explored how the "problem" of health and incarceration is constituted [with the exception of Smith (2000), Robert et al. (2007), Robert & Frigon (2006) regarding theorization; and Pollack (2005), Kilty (2012), in terms of mental health]. By focusing on women's narratives of taking care of their health during and after incarceration, this thesis attempts to highlight how the health of incarcerated women is constituted as a problem (problematized). In order to do so, I will engage with poststructuralist literature.

Theorizing "Health" in Prison: Power, Governmentality, and Embodiment

The following section maps out the theoretical framework that I have developed throughout the research project. As explained earlier, it is heavily based on the work of Michel Foucault and his commentators, as well as feminist poststructuralist scholarship. In the following section, I will first situate my work within the literature by and about Foucault, and then outline my own theoretical framework, based on Foucault's work on neoliberal governmentally and subjectification, in order to explore the processes through which women are produced as "subjects" with respect to their health. The purpose of this theoretical framework is to provide the tools to interrogate and unpack participants' experiences, subjectivities, and bodies as constituted by neoliberal discourses and practices, rather than starting from the biomedical "evidence" of health and disease. However, unlike most of the literature on governmentality, my empirical data are the experiences and narratives of living

subjects, rather than material from archives, governmental programs or policies. I also relied on poststructuralist feminist scholarship to develop some analytical tools that allowed me to not only map out how women are subjectified, but also to explore and assess how individuals engage with and negotiate power relations.

Foucault's Triangle of Power

Traditionally, power has been conceptualized as a resource that can be owned, taken away, or given back. In Structuralist and Marxist approaches to power, power involves obedience to an authority, may it be the State or a Queen. It is repressive, it forbids and punishes: the subject's action is constrained and limited by the authority, which dictates what is legal, acceptable, or even possible. But Foucault radically departed from such definitions, conceptualizing power as productive[3], constituting "docile bodies" (Foucault, 1975), knowledge and its objects (Gordon, 1980), populations (Foucault, 2004) as well as subjects—ethical and self-governing subjects (Foucault, 1976). He outlined his "analytics of power" (analytique du pouvoir) in *La volonté de savoir,* in five statements: 1. power cannot be owned; 2. power relations are immanent in all human relations; 3. power relations are played out in the most intimate and "micro" spaces (sexuality, family relations, etc.); 4. power relations are intentional and rational but they are not necessarily the effects of actors (such as the state or a ruling class); and, 5. resistance is intrinsic to power relations. Thus, Foucault's analytics of power does not focus on entities, such as actors or ideologies, but, rather, on the emergence sites or spaces in which objects, subjects, knowledges and "truths" are produced and constituted, and in which power relations are constantly destabilized and

[3] It is important to note that for Foucault, power could also take a punitive and constraining form, which he characterised as "sovereign power." However, sovereign power, as with other forms of power, cannot be "owned" by one ruling class or by the "king;" the five statements of his analytics of power are still applicable to that form of power.

unbalanced, always being reconfigured, and made possible because of the space that defines them (Dreyfus & Rabinow, 1983).

According to Foucault (2004), power takes the form of a triangle made up of sovereignty, discipline, and government. Each component deploys different strategies and rationalities, with different effects. As the triangle takes effect simultaneously on populations and individuals, the proportional contribution of each component depends upon the individuals and the populations targeted (Wilson, 2010). The issue of the different forms of power is of particular relevance for a study of prison, since prison is densely infused with relations of power. Evidently, sovereign power is deployed in prison, as it is an institution that is inherently coercive, since it constrains prisoners' liberty and confines them to a specific space, and coerce them into specific institutional routines. However, as demonstrated by Foucault (1975), prison is also a site in which disciplinary power is deployed, regulating every aspect of prison life through the strict regulation of time and space, surveillance, and normative sanctions.

Recent scholarship in prison studies has argued that the government component of the triangle of power has become increasingly present within contemporary prison, especially in its neoliberal form (Crewe, 2011; Hannah-Moffat, 2001). Foucault (1997) defined governmentality as the art of government, "in the broad sense of techniques and procedures for directing human behavior. Government of children, government of souls and consciences, government of a household, of a state, or of oneself" (p. 82). Neoliberal governmentality will be further discussed in the following section but, for now, suffice it to say that neoliberal penal governance deploys technologies of the self such as self-examination, self-care, and self-improvement, and prisoners are constituted as responsible

and empowerable subjects, "entrepreneurs of their own life" (Gordon, 1991, p. 44). As prisoners are enticed to examine, care for and improve themselves, they are addressed as though they *want* to improve themselves in specific ways, to take responsibility for their lives through specific forms of action (Crewe, 2011; Hannah-Moffat, 2011; Quirion, 2012; Rose, 1999).

In this doctoral dissertation, the component of the triangle that will be specifically studied is the government side, especially in its neoliberal form. Although each of the facets of the triangle is actively present within the carceral space and each form of power interacts with every other one (Hannah-Moffat, 2001), it is in the government contribution that a strategic alliance can be observed between the fields of "health" and "prison," constituting prisoners as subjects preoccupied with and mobilized around the issue of health (Smith, 2000, Robert et al., 2007, Robert & Frigon, 2006). In other words, neoliberal rationalities of power that are deployed within the carceral and transcarceral space intersect, constituting prisoners as subjects who *should* and *will* take care of their health (Smith, 2000; Robert et al., 2007; Robert & Frigon, 2006). Building on the literature on governmentality that tackles the issue of subjectification, the following section will explain neoliberal governmentality and the forms it takes on the issue of health. As I discuss neoliberal penal governance during incarceration and upon prison release, as well as the intersection of health with penal governance in chapters 2 and 3, I only will provide a brief overview of the issue here.

A few Words on Governmentality

Initiated by Michel Foucault and developed by the collaborators to the *Foucault Effect* (Burchell, Gordon, & Miller, 1991), as well as Cruikshank (1993) and Rose (2007), the governmentality approach tackles the question of political power by recognizing

multiple sites and multiple authorities in the action of governing, rather than by focusing on one entity, such as the state, and by focusing on the issue of neoliberal governmentality (Rose, O'Malley & Valverde, 2006). Building on Foucault's analytic of power, the governmentality approach explores *how* subjects are governed by articulating a connection between how people feel, think, and behave, with larger governmental rationalities. In other words, governmentality locates and embeds the subject in a specific battlefield of rationalities and technologies, while simultaneously exploring how the subject is an effect of its locatedness.

This dissertation specifically draws on the literature on neoliberal governmentality that addresses the process of subject formation, i.e. subjectification. The unified subject is one of the most constant legacies of humanist theories, and has been redefined by Foucault, among others (Burchell, Gordon & Miller, 1991; Dreyfus & Rabinow, 1991; Weedon, 1997). Within the humanist tradition, the self, as one's true and permanent core, has been theorized as the "seat" of feelings, thoughts, and autonomy, the source of individual differences and a universal humane essence. The subject has been made more complex by integrating the concept of identities, which surround the inner self, as well as psychoanalytic dynamics; yet, it remained that the subject, like an onion, could be peeled back layer-by-layer to its core. Foucault not only un-layered the self, but also argued that there is no centre to be discovered. Rather than being a onion, the subject is a multiplicity; there is no self to be discovered, but multiples selves, simultaneously co-existing and interacting. The subject is not one site, but, rather, multiple sites, an intelligible grid constituted by discourses and practices, embedded within specific social and historical contexts. Departing from the humanist tradition, subjectivity is thus defined as a process resulting from the interaction of

the "private" and the "public:" "Subjectivity is created both through the techniques of governmental self-formation produced by external authorities and agencies and through the practices of ethical self-formation by which individuals come to know themselves and give meaning to their experiences" (Dean, 1994, pp 156–7). In other words, subjectivity—namely the sense of self, emotions, perception, cognition—is an effect and a vehicle of power relations.

In their study of subjectification, governmentality scholars have paid close attention to how technologies of the self and technologies of domination intersect, thus privileging a certain "subjectivity" and "body." Neoliberal subjectivity has been theorized by many authors and has been empirically documented: in particular, Rose (1999) and Cruikshank (1993) have explored strategies related to how technologies of the self shape and constitute the neoliberal subject. Focusing on the knowledge and practices used in the social sciences, Rose (1999, 2000) demonstrated that freedom itself is a governmental strategy, rather than being a space for contestation and critique. Subjects are "obliged to be free" because "the self is not merely enabled to choose, but obliged to construe a life in terms of its choices, its powers, and its values" (Rose, 1999, p. 231). In doing so, government is exercised "at a distance:" lifestyles, leisure, work, and partnerships, are all assumed to be domains of life in which the subject exercises "free will" and "choice," regardless of the constraints she or he faces; each of these choices mould the subject's identity and sense of self, and become "a mark of our individuality, each is a message to ourselves and others to the sort of person we are" (Rose, 1999, p. 231). Cruikshank (1993) empirically illustrated the responsibilization processes of the excluded by considering Californian programs promoting self-esteem to solve social problems, from gender inequity to poverty. She outlined how the self-esteem

movement produced a subject that is governable through its desire to attain self-esteem, and how counsellors, social workers, and life coaches, namely, self-esteem experts, accompany the subject in its quest towards achieving happiness. In doing so, the subject engages in a process in which self-governance, a technology necessary in neo-liberalism, becomes the vehicle to her happiness. Cruikshank (1993) showed how "self-esteem is a social movement that links subjectivity and power in a way that confounds any neat separation of the 'empowered' from the powerful" (p. 341).

Neoliberal penal governance also deploys strategies of responsibilization, constituting prisoners as "empowerable" subjects who should work towards their self-improvement. It is important to note that, since chapters two and three discuss the deployment of neoliberal penal governance in prison and upon prison release, the issue of the empowerment of prisoners will be briefly addressed, before delving into the question of health. Within the Canadian literature, Hannah-Moffat (2001) painted an extensive portrait of women's penal governance in federal penitentiaries. Rather than focusing on one side of Foucault's triangle, she used the whole triangle to identify different historical phases, during which certain forms of power—pastoral, maternal, disciplinary, and empowering/responsibilizing—were deployed. The strength of her analysis is that, first, she demonstrated how penal governance is gendered and, second, she emphasized how different sides of the triangle of power interact. Addressing recent reforms, she showed that women in federal prisons are constituted as responsible and rational choice-makers, and that self-governance is conceptualized as the willingness to engage with institutional directives and objectives. The prisoner becomes responsible for the success of therapeutic intervention, which is measured in the deployment of a scripted subjectivity in which the prisoner takes

responsibility for his or her actions and becomes autonomous by, paradoxically, listening to and following professionals' advice (Pollack, 2005; Quirion, 2012; Hannah-Moffat, 2001). Conflating the notions of risk and needs, risk assessment tools reframe the psychosocial needs of women—dealing with past abuse, trauma, and (re)building relationships with children—as crimonogenic needs; "high risk" women who oppose institutional rules or exhibit behaviours that are not aligned with institutional rules—such as self-harm—are consequently managed through risk practices and punitive strategies (Hannah-Moffat & Shaw, 2001) In brief, women who fail to exhibit the behaviour of "rational agents" are problematized as " high risk," "disorderly" and "disordered" (Pollack, 2005).

As will be discussed further in articles two and three, neoliberal penal governance intersects with the New Public Health to produce incarcerated women as vectors of health that must be made responsible for their health and their families' health. In other words, "health" is another tool in the battlefield of power relations that constitutes incarcerated women as subjects who *want* to improve their health, to engage in a form of self-improvement for the purpose of improving their health or facilitating their "reintegration." Correctional practices further intermingle the two, as the stabilization of prisoners' mental health and the adoption of "healthy lifestyles" are unofficially associated with (re)integration (Maidment, 2015; Robert & Frigon, 2006). In order to lay the groundwork for the theorization of the strategic alliances between neoliberal penal governance and the pursuit of health, the following section will focus on the neoliberal governmentality of health.

Governmentality and Health

The proliferation of discourses about how to maximize health and avoid illnesses illustrates how health has become a guiding mantra for individuals, communities and

governments (Aïach, 2009, Petersen & Bunton, 1997; Cheek, 2008; Lupton, 1995; Rose, 2007; Yaya, 2009). According to Aïach (2009), concerns about health have "flooded society," not only because an increasing number of issues are considered to be health-related (such as working conditions, etc.), but also because health has become the highest ethical calling, the legitimation for all sorts of programs, policies, intersectoral interventions, community mobilizations, etc. The non-smoking movements (Snowdon, 2009) and the war on obesity (LeBesco, 2011) both promote the adoption of specific "healthy habits" and "healthy lifestyles" as the only ways to manage and to live one's life, constituting each of these behaviours as a "badge of honour by which we can claim to be responsible and worthy both as citizens and individuals" (Cheek, 2008: 974). This "badge of honour" relies on a categorization of subjects and bodies, in which some are constituted as "healthy," and other as "at risk" or "unhealthy," through the interaction of knowledges, practices, and discourses (Cheek, 2008; Lupton, 1995; Petersen & Bunton, 1997).

As this dissertation addresses the imperatives to pursue and maximize health, it will focus on the apparatus of power that drives that imperative, namely, New Public Health. In the midst of the AIDS crisis and in light of curative medicine's failure to "contain" it, the public health project was reactivated, but with a neoliberal twist; whereas public health has been traditionally concerned with "controlling filth, odour and contagion" (Petersen & Lupton, 1997, p.2), the New Public Health is concerned with the health of individuals and populations in order to improve health for all through evidence-based and preventative actions (Petersen & Lupton, 1997; Lupton, 1995). No institution or organization is out of the bounds for the gluttonous New Public Health; its reach is justified by the intrinsic value of "health for all." As Petersen and Lupton (1997) underlined, the New Public Health

movement relies on a discourse that draws on the language of other social movements (feminist, LGBTQ, etc.), such as "self-help," "empowerment," "participation," and "community based," language that had broad appeal and support. Yet, as Cruikshank (1993) and Moore and Hirai (2014) have argued, language of inclusion and empowerment is not necessarily revolutionary, and can reinforce existing power relations. Indeed, the language of New Public Health masks its closeness to the neoliberal project: as communities are invited to take charge of health issues, as individuals are invited to participate in support groups and to assess and evaluate their heaths risks, the state's duties and responsibilities towards its citizens shrink (Petersen & Lupton, 1997; Schrecker, 2013). Through a variety of agencies and the imperatives to be healthy, New Public Health acts at a distance by providing norms according to which citizens are assessed, monitored, and classified, norms that are presented as desirable, "natural," or moral personal objectives and goals to aspire to in order to attain personal health, balance and wellbeing (Lupton, 1995; Petersen & Lupton, 1997).

The New Public Health constitutes an "ideal" subject and an "ideal" body. This ideal subject "is autonomous, directed at self-improvement, self-regulated, desirous of self-knowledge, a subject who is seeking happiness and healthiness" (Lupton, 1995, p. 11). As self-regulation is a key constituent of "health," actions constructed as choices—smoking, abusing drugs, eating junk food—become the reflection, the "identity," of the subject. Thus, the "good" subjects pursues health and maximizes her health, which is expressed in her fit and slender body; the "bad" subject jeopardizes her health through poor health habits, and is seen as irresponsible and lacking self-control, diagnosable through her "fat" and "unfit" body (Bordo, 1993; Lupton, 1995; Petersen & Lupton, 1997; Rose, 1999). More than a

material that is "read," the "body" is also produced by technologies and rationalities of New Public health in the form of a "civilized" body that is constrained under the will, and which takes a gendered and racialized form, namely the white, middle-class, and young man (Petersen & Lupton, 1997).

Petersen and Lupton (1997) have identified three areas in which women are constituted differently from the ideal neoliberal subject and body, as implicitly "unhealthy" or more "at risk." First, women's physical and mental health are pathologized and medicalized: they are represented as more prone to illness than men, and as more dependent on medical care through various life stages (childbearing, menopause, etc.) (Bordo, 1993; Lorentzen, 2009; Ussher, 2010). Second, as women are cast as the main caretakers in the nuclear family, and as children's behavioural issues, foetal development, and poor nutrition are still attributed to poor and deficient mothering skills or to mothers' exposure to stress, women are thus considered to be a resource to build on to ensure the reproduction and the maintenance of health throughout society, or "vectors' of health in public health language. This constitution of women as vectors of health is salient for incarcerated women, as various studies make the case that investing in women's health improves community health (see WHO, 2007; Martin et al., 2013). Finally, not only can a woman herself have "poor health," but such a woman can also contaminate others through her deficiencies or her sexuality, which reinforces the imperative to educate these potential vectors of health. This idea of "contamination" is strengthened by the historical conceptualization of women's bodies as dangerous, emitting undignified and potentially dangerous fluids, closer to animality than civilization (Bordo, 1993; Grosz, 1994). As Grosz (1994) noted, women's ontological status and corporality is marked by a lack of self- containment, "as a leaking, uncontrollable,

seeping liquid; as formless flow; as viscosity, entrapping, secreting…not a cracked or porous vessel, but a formlessness that engulfs all form, as disorder that threatens all order" (p. 203). Thus, women's bodies need to be contained, disciplined and controlled through, among other things, their health (Grosz, 1994; Lupton, 2012).

The literature on governmentality provides an interesting map of the "battlefield" of power relations with respect to health and penal governance, thus providing a portrait of the subject that is constituted within that space: an empowerable and health-seeking subject. However, this discussion provides us with only limited tools to tackle *how* subjects navigate and negotiate that battlefield. Foucault's statement on resistance has been the foundation on which many authors have built a possible "agency" for individuals, since they have the option of "resisting" power relations; this resistance is assumed to have a destabilizing effect. In her excellent discussion of gendered norms of slenderness, however, Bordo (1993) warned against the assumption that resistance necessarily has destabilizing effects: it can also confirm, support, and strengthen configurations of power. Thus, the mechanical opposition to power that is manifested through resistance cannot account for the creativity of subjects in negotiating power relations when they adopt behaviours that coopt, bargain with, and/or question existing power relations, actions that may or may not have transformative or destabilizing effects.

In order to conceptualize *how* those who are "made up" subjects negotiate the battlefield of power relations, I turned to feminist poststructuralist scholarship, which interrogated the notion of agency of the subject, as well as embodiment. According to McNay (2000), Foucault's analytics of power seems to preclude any generative notion of agency by individuals, who appeared to be determined solely by relations of power. In other

words, the above portrait of the battlefield of power relations does not account for the "creative" potential of subjects (McNay, 2000). In her theorization of agency from a poststructuralist perspective, McNay (2000) makes the case for a definition of subjectifiation as a generative notion, emphasizing how subjects are constituted and enabled by the interactions between discourses, practices, materiality, identities, psyche, and the social. Briefly, she argued that, although power relations shape how individuals can self-reflect and exercise their autonomy, they do not pre-determine that reflection, precisely because the subject is not united and unified. However, it is important to underline that this does not presuppose a pre-social self: reflexivity itself is an effect and a vehicle of power relations and frames the subject's capacities, but it does not mean that it dictates the subject's courses of action. Constantly faced with a multiplicity of potential positions, the subject engages with positions that are determined by her locatedness but, simultaneously, she can be creative in deploying strategies that deviate from scripted forms of the self—in this case, deviating from the neoliberal script of "empowerable" and "health-seeking" prisoner. It is precisely these different subject positions that I explore in chapter two, in which I observe how prisoners engage with various subject locations, which are aligned with or contradict scripted subjectivities.

Feminist poststructuralist scholars have also worked on theorizing the self as a material, symbolic, historical, and discursive entity, that is embodied and embedded (e.g. Bordo, 1993; Frigon, 2012, 2003; Grosz, 1994). In order to do so, they have theorized the notion of the "body," aiming to dismantle the Cartesian divide between the mind and the body. It is important to underline that, in contrast to Foucault's conceptualization of the body as "passive," in feminist poststructuralist scholars' approach to the body, it is "not seen

as simply a blank slate awaiting social inscription, but recognized as that by which the self is constituted in ways which are not exhausted by discursive articulation, although it is mediated by it" (Gonzalez-Arnal, Jagger & Lennon, 2012, p. 3). In both articles two and three, I analysed how neoliberal penal governance and the imperatives to be healthy are embodied by participants, and article 3 specifically explores how the body is mobilized to "undo prison" upon prison release. Of course, the point here is not to reduce women to their reproductive capacities or their "biological criminality" or to argue that the body is where we feel at home, the vessel of our true self. As many feminist authors (Bordo, 1993; Frigon, 2003, 2012; Grosz, 1994; McNay, 2000) have argued and demonstrated, the inclusion of the body—or, more, correctly bodies—aims to understand it as a "series of processes of becoming, rather than a fixed state of being" (Grosz, 1994, p. 87). In other words, the body, as subjectivity, is multiple and fragmented: by integrating the concept of the body, the objective is to explore how materiality "talks back" (Frigon, 2003, p. 131) to subjectivity, as well as enacts it, in both cases, mediated by language and constructed through discourses and practices.

By conceptualizing subjectivity and embodiment as vehicles and effects of power relations, the health of incarcerated women can be interrogated as embedded in historical and social processes, thus enabling the questioning of biomedical accounts of health and prison that are enacted and embodied within participants' narratives of doing health in and out of prison. To reprise Scott's (1992) metaphor of visibility, such a theorization contextualizes and historicizes participants' accounts, thus making them "visible" within a specific battlefield of power relations. I will now turn to the methodology that structures and guides this research.

Methodology

In this study, the methodology used was inspired by participatory action research (PAR). I want to emphasize that I did not conduct a full-fledges PAR study, since, as will be described later, the first stages of the study were designed and conducted without the contribution of participants. The first stage— interviews—was designed as a preparatory step to explore the issue of health and prison; the second stage, the focus group, was when participants decided which actions they wanted to undertake, and the last stage was the planning and the implementation of a collective action related to the issue of health, namely, a collection of testimonials by formerly incarcerated women written for women currently in provincial prisons. Such a design does not correspond exactly to PAR methodology, which requires that the researcher and participants jointly develop the complete research project, from establishing the research topic to analyzing and disseminating its results (Gaventa & Cornwall, 2008; Reason & Bradbury, 2008; Reid, Tom & Frisby, 2006). The development of different stages of research was partly dictated by the fact that, as a doctoral student, I was required to have a research project prior to starting my fieldwork, and because the community organization I partnered with requested that I had approval from the University of Ottawa's Research Ethics Board before I started my study, which I could not obtain without having a detailed research project outline. Thus, I developed a three-tiered project, inspired by PAR. The outline of each stage of the study will be described later. I will first define PAR and its location within the field of health studies, and then delve into the specificities of my project.

PAR arose from a critique of conventional research. Its proponents have argued that this methodology challenges power inequities by co-building knowledge with and for

excluded and marginalized groups (Gaventa & Cornwall, 2008; Reason & Bradbury, 2008; Stoecker, 2009; Wallerstein & Duran, 2006). PAR is not simply actions taken for the sake of taking action or knowledge gathered for the sake of accumulating knowledge: rather, research is undertaken "as a process of reflection, learning, and development of critical consciousness" (Gaventa & Cornwall, 2008, p. 181). In other words, through participation, PAR aims to include in the production of knowledge those who are traditionally excluded; through action, PAR aims to change power relations and to improve the lives of the research participants (Stoecker, 2009). Although PAR began on the fringes of academic research due to its critique of objective-deductive research techniques commonly used in the Western world (Reason & Bradbury, 2008), health researchers have increasingly adopted PAR methodology (Israel et al. 2005; Wallerstein & Duran, 2006). As individuals and their communities are perceived as allied in health (Israel et al. 2005), PAR has been presented as an avenue to tap into local knowledges, as well as to engage communities in long-lasting changes to address health inequities.

According to Wallerstein and Duran (2006), the potential of PAR to address health inequities is based on two assumptions. First, the participation of communities and vulnerable populations is assumed to be associated with more effective interventions and programs engaging with pressing health issues (see Israel et al. 2005; Wallerstein & Duran, 2006). Since studies are framed and defined with and for participants, and local knowledges and practices are mobilized in the research process, it is assumed that the health interventions that emerge from PAR will necessarily be a better "fit" for the participating communities or groups, especially vulnerable and marginalized ones (Israel et al., 2005) than would be interventions and research designed and imposed using a "top –down" model.

Second, participation in and of itself supposedly has an intrinsic value for participants: as an empowering process, it has benefits for individual participants – such as confidence, skill building - that can trickle down to their families and communities (Ozanne & Anderson, 2010; Wallerstein & Duran, 2006). This assumption is closely associated with the claim that empowerment has positive effects on individuals' health statuses, since empowerment allegedly can counteract the adverse effects of the unequal distribution of social determinants of health (WHO, 2009). In other words, by including participants as researchers in the research process and by planning and implementing health interventions with them rather than imposing expectations on them, PAR reportedly upsets and resettles power relations, bringing about greater health equity.

As PAR has gained credibility in various disciplines, including health studies, the epistemologies and methods associated with PAR have become increasingly diverse (Anadon & Savoie-Zajc, 2007). Reason and Bradbury (2008) argued that PAR can be described as a rich and diverse family of approaches, "a family which sometimes argues and falls out, yet a family which sees itself as different from other researchers" (p.7). Recently, an increasing body of work has examined how PAR could be combined with poststructuralist epistemologies and theoretical work. Building on Foucault's conceptualization of power, many poststructuralist scholars have critiqued PAR's claims of transforming power relations and "empowering" its participants (Golob & Giles, 2013; Kothari, 2004). For instance, Kothari (2004) demonstrated how participatory development projects may have the paradoxical effect of concealing the inner dynamics among participants and non-participants, hiding the ways that inequalities are constituted and produced within the so-called "community." Dillon (2014) demonstrated how his position as

a doctoral student and academic power relations shaped and constrained the knowledge-making process of his study.

Rather than focusing on how a poststructuralist account of power can shed light on the repressive effects PAR can have, an increasing number of critiques have focused on the enabling effects of PAR (Cameron & Gibson, 2005; Golob & Giles, 2013; Lennie, Hatcher & Morgan, 2003). Specifically, moving away from an internal critique of how PAR can serve to maintain power relations, these authors have focused on how PAR can destabilize them. In particular, Golob and Giles (2013) have used Foucault's analytics of power to redefine PAR from a poststructuralist perspective. Using Foucault's definition of power, Golob and Giles (2013) highlighted how participation within a PAR study could provide marginalized participants with access to the nexus of power and knowledge, and how power in PAR has not only repressive effects but also enabling ones, as well as how the exercise of power is a corollary to any destabilizing effects to power relations. Arguing that PAR is a technology of domination and of the self, they also discussed how PAR practitioners could minimize the potentially dominating effects of PAR with respect to research participants. In line with Golob and Giles's (2013) work, the first article of this dissertation discusses the implications of a poststructuralist definition of subjectivity on two key concepts in PAR, namely participation and action. Using studies that used PAR with incarcerated or formerly incarcerated women, I make the case that PAR can provide a space for participants to critically reflect on their life experiences and trajectories by recasting them as the results of social processes, rather than as the results of their own personal failures. Of course, the purpose of PAR is not to uncover "true" experiences and the "true" self, but to reflect on the processes that produce incarcerated women as empowerable and health-seeking subjects. In

other words, PAR methodology can provide the possibility for participants to experience alternative subjectivities.

Research Question and Research Objective

My main research objective was to develop a project investigating the question of health in prison with women who have experienced incarceration. I chose to focus on women who have been incarcerated in Quebec's provincial prisons because few studies have addressed the issue of women's health in these institutions (Bertrand, 2002; Giroux & Frigon, 2011). Specifically, I explored how neoliberal penal governance and the imperative to pursue health shaped and constituted women's experiences of health and prison during their time in prison and upon prison release, while undertaking transformative action with previously incarcerated women on that question. My objective was thus twofold: to document the experience of health in prison with previously incarcerated women, as well as to collectively act on this issue. My research question is framed as, how do women "do" their health in prison and upon prison release, and what action can be undertaken collectively by women to address the issue of health?

Methods

As mentioned earlier, this study had three stages, each with its own method. The first stage of the study was considered to be exploratory, as I gathered information on the issues of heath and prison by conducting interviews. The second stage aimed to engage and mobilize participants around a common theme as the launching pad for a collective project. The last stage was the realization of the collective action, which took the form of a

collection of testimonials by formerly incarcerated women for incarcerated women. The following section will highlight the data collection and analysis methods I used.

Phase 1: Interviews. In order to explore how participants did health in prison, I conducted semi-structured interviews, using open-ended questions (see interview guide in Appendix A and consent form in Appendix B). These open-ended questions were devised as prompts to stimulate the discussion, rather than as a list of issues that had to be tackled during the interview (Quivy & Van Campenhoudt, 1995). All interviews were audio-recorded, and each participant chose the alias used in this study. The objective of these interviews was to document how women have been "doing" health in prison and upon prison release, namely, what being healthy in prison meant to them, what obstacles and challenges they faced in doing health, what coping strategies they used, etc. In line with my theoretical framework, I framed "health" as a concept to be explored, rather than as an observable and scientific fact.

For that first stage of the study, I also gathered sociodemographic data on all participants (Appendix C). Not knowing where the study would lead, I chose to gather data that would not necessarily be discussed in the interviews, but which could be eventually useful. It turned out to be an interesting device to engage with participants on issues of their identities, including as transgender, ethnic minority, and Aboriginal people.

Phase 2: Focus group. The second method I used was a focus group with participants I had interviewed (see Appendix D for the focus group guidelines). Just as in the interviews, the focus group was audio recorded. The objective of the focus group was to collectively examine the data collected during the interviews and attempt to "make collective sense of them" (Wilkinson, 2003, p. 277). According to feminist scholars, the

main advantages of focus groups in PAR are that they recast the balance between the researcher and the participants, as well as provide an opportunity to collectivize women's experiences, thus favouring the development of a collective action (Wilkinson, 2003). Moreover, compared to one-on-one interviews, the social context of the group itself "provides an opportunity to examine how people engage in generating meaning" (Wilkinson, 2003, p. 227). Thus, not only can focus groups foster participatory action, but they also give access to how knowledge is co-built in a specific social context.

Phase 3: Interviews for the collection of testimonials. As will be discussed in the section about fieldwork, the collective project that was designed and developed by participants is a collection of testimonials. In order to gather testimonials, participants from the first and second stages of the study and I conducted semi-structured interviews with new participants who were recruited at the same halfway house. Participants to the first and second stages of the study explicitly committed to respecting everyone's experiences and perspectives on health and prison. Thus, these interviews were not about getting the "facts" right, but rather providing a safe and understanding space for testimonials. These interviews started with one open-ended question (see interview guide Appendix E and consent form, Appendix F).

The participants' answers were not recorded; rather, they were immediately transcribed, so participants providing the testimonial could read the text immediately and provide their feedback on the transcription. Finally, at this stage, we did not collect sociodemographic data, as participants to the first and second stages of the study believed that this type of data was not required for the project. In fact, they expressed concerns that any form of standardised tool could discourage women from engaging in the project.

Methods of Data Analysis

Before addressing the methods of analysis I employed, I want to briefly discuss the issue of transcription. I transcribed each of the interviews, as well as the focus group. Transcription in itself is not a neutral process, as accents, tones, and other forms of non-verbal communication are generally absent from written transcriptions; it remains an interpretative practice (Riessman, 2008). In line with constructionist epistemologies, I approached each of the interviews as the constitution of a narrative by the interviewer and interviewee, embedded within a specific historical and social context (Paillé & Mucchelli, 2010; Riessman, 2008). Whenever possible, I referred to the emotions and tone of voice of participants (e.g., laughter), during the interviews and the focus group. As for the testimonials, the transcription was done with the interviewed participants. The rationale was guided by the fact that we wanted to be as close as possible to what the woman was saying, and make sure we had the maximum input.

In terms of methods of analysis, I conducted a discourse analysis of all the material collected and transcribed during the interviews, the focus group, and the testimonials. I chose to use discourse analysis because it focuses not only on what is said and how it is said, but also on the context underlying speech acts, aiming to uncover the interplay of power relations (Wilkinson, 2003). The early stages of my research was focused on health and incarceration, and discourse analysis allowed me to examine and interrogate concepts such as "health," "embodiment" and "prison," rather than attaching fixed meanings to these concepts in advance. Specifically, I used Carabine's (2001) approach of discourse analysis and her seven step analysis; please refer to Appendix G for the analytical grid I used.

Finally, I want to highlight that only two interviews were conducted in English: the rest were conducted in French. I conducted my analysis in French, but I chose to write my thesis in English, and I thus inevitably translated all interview extracts included in this dissertation from French to English. Where applicable, I attempted to stay as close as possible to prison slang, and tried to use words that are used in Quebec, rather than using words from, for instance, American contexts. Despite my best efforts in providing the most "accurate" translation, I want to stress that I am not a professional translator, and that I take full responsibility for translation errors that may be found. Additionally, I want to emphasize that translation is not a technical task: it is an interpretative act, in which meaning is constructed (Riessman, 2008). Consequently, the interview extracts discussed in this dissertation result from my interpretations of what has been said in the interviews, the focus group, and in the testimonials

Ethics

This study was approved by the University of Ottawa Research Ethics Board (REB)[4]. As the study was multi-tiered, I submitted two project proposals to the REB: the first one was for the interviewees and the focus group, and the second was for the collection of testimonials. The separate applications were required by the REB because the last phase of research could not be planned until after I had already completed the first phase. Since the study was conducted with women who had been incarcerated and who were at a halfway house, a special attention was paid to consent. The majority of the residents of the halfway house came from a prison setting in the context of parole, suspended sentences, or of

[4] Both the Ethics Approval Notices can be found in Appendix H.

probation. Thus, I was concerned that potential participants might feel pressured or coerced to participate in the study, since they might have feared that a refusal to participate could lead to their exclusion from the halfway house, which could, in turn, potentially lead to their re-incarceration. Two main steps were taken to ensure that participants did not feel coerced or forced to participate. First, community workers from the halfway house participated in recruitment by simply distributing a recruitment invitation to all residents. It was clearly established with both workers and residents that I would not follow up with community workers to account for who did or did not participate, thereby eliminating the risk of a woman being penalized for not participating. Before the interview, the focus group, and interviews for testimonials, all participants were informed that they could refuse or withdraw consent at anytime, and that the principal investigator would not report their withdrawal to community workers.

Another concern involved protecting the identities of the focus group's participants. Three participants were involved in the focus group, as well as in the planning and the development of the collection of testimonials. They provided testimonials themselves, and interviewed new participants to gather more testimonials. Although they were interested in taking an active role in the collection of testimonials, they were concerned about confidentiality issues, and feared that their testimonials, interviews, and focus groups could be linked together, threatening their confidentiality. All of these participants were under the jurisdiction of Correctional Services (provincial and federal), so confidentiality with respect to narratives that criticized Correctional Services was of most importance to them. Consequently, the participants and I agreed that a name of their choosing would be used when I quoted from their interviews and their participation in the focus group, and that a

different name of their choosing would be used for each of them in the collection of testimonials. The University of Ottawa Research Ethics Board approved that strategy.

Finally, I want to address an ethical concern that was raised during the first phase of my research. Two participants identified themselves as men who are transgender. Because their genders had been assigned as "female" at birth, they were incarcerated in a women's prison, regardless of their felt gender[5]. As I conducted a study on the health of women in prison, I could have chosen to exclude these two participants, but I chose to offer them the opportunity to participate, in order to resist their institutional invisibility. More importantly, both expressed considerable interest in the study, and strongly felt that something had to be done to change things in prison, especially in terms of the conditions under which people who are transgender are incarcerated. As reports from community organizations that defend transgender people's rights in prison (Egale, 2014; Transpulse, 2013), the experiences of being transgender in prison raises important and complex issues with respect to human rights, as well as mental and physical health. However, since there are very few incarcerated men in prisons for women, delving deeply into these issues inevitably raises the possibility that participants may be recognized. In accordance with participants' wishes, I included their input in my analysis whenever they discussed general prison issues, such as unsanitary conditions and the lack of exercise, etc., but I did not discuss the specificities of their experiences. The only exception is in the last article, when I discuss the issue of a man who is transgender and incarcerated in a prison for women being compelled to wear "women's clothes" and use "women's products." I therefore touch upon these important issues, which

[5] According to provincial and federal correctional policies, people who are transgender and considered "pre-operative" are placed in facilities according to their gender assigned at birth (Correctional Service Canada, 2015)

have also been raised in other studies (Transpulse, 2013), but I have been careful to exclude identifying information about the participants.

Doing Research: Description of Fieldwork

Although articles two and three provide brief descriptions of my fieldwork, this section describes it in greater detail. I conducted this research in a halfway house for women in the Province of Quebec. For the recruitment in the first stage of the study (i.e, the interviews), I used posters (Appendix I), business cards, and the recruitment invitation (Appendix J). Posters were installed in the common areas of the halfway house, and recruitment invitations were handed out to women in the halfway house by community workers. However, the most successful recruitment strategy was "hanging out" at the halfway house. I spent approximately 100 hours at the halfway house, chatting, cooking, helping residents with paperwork and looking for apartments online, etc. I hung out in a specific way: I did not want to interfere in residents' lives, but I wanted to be known by them. In order to do so, I used skills I had developed while I had been doing outreach with street-involved youth: I purposely located myself so that I would be accessible and visible, yet I would not invade residents' personal space. For instance, I would sit down at a table on my own, with an open newspaper, half reading it, so that residents would feel comfortable engaging or not engaging with me. I also consciously stayed away from staff areas of the office and staff toilets, so that I would not be considered to be a staff member. Certain evenings, I would help women prepare meals, clean the dishes, and sit down and eat with them, or watch movies with them. Using active listening, I let women direct conversations however they wanted, choosing the topics and the issues, and offering my perspectives,

point of view, or advice when requested to do so. In brief, I relied on my professional subjectivity to conduct that phase of the study, in order to connect with participants.

Interestingly, few participants "read" me as a social worker or a community worker—in fact, only one did, pointing out how I spoke like someone working in the field of addiction. When I was engaged in the first stage of the study, I was also visibly pregnant, and I was often referred to as the "pregnant researcher," both by staff and by residents. In other words, participants overwhelmingly read me as "pregnant." More than a merely identifiable feature, my pregnant body spontaneously constituted a space for intimacy. Participants, residents, and staff of the halfway house shared their birthing stories in details. They also questioned me on where I wanted to give birth and asked me about baby names, regularly commented on my weight, predicted my due date, and touched my belly. Noticeably, when women were smoking outside, they would walk away from me, or place themselves to avoid getting smoke in my face, and all expressed worries about smoke and the effect it might have on the foetus. Although some of them confided to me that they smoked during their pregnancies, they assumed that I was a non-smoker. Thus, my pregnant body was read as "in need of protection", and, simultaneously, created a space of "sameness," a "common experience" between participants and me (Longhurst, 1999). The sense of "connectedness" and "sacredness" associated with pregnancy in Western societies has been discussed at great length by multiple authors (Kannen, 2013; Longhurst, 1999). In particular, Kannen (2013) described how a pregnant body transforms and impacts academic research. Without delving too much into the topic, I want to underline that my experiences of pregnancy and the ones I heard about from participants were different. As a white doctoral candidate, married, and financially and emotionally supported, my experience of

pregnancy was marked by privilege. Participants in this study did not enjoy the same level of privilege during their pregnancies, and for some, they disclosed how pregnancy was time during which they experienced severe traumas. Thus, I want to stress how the connection between participants and me around my pregnant body was strongly mediated by discourses and practices around pregnancy as a time of "feminine bliss".

Turning now to a more "factual" description of my fieldwork, participants in the interviews were, on average, 39 years old. Twelve research participants were born and raised in Quebec, two were from other provinces in Canada (New Brunswick and Ontario), one identified as Aboriginal, and three were born outside of Canada and immigrated as minors. They had all been incarcerated in a provincial prison: seven participants were admitted once; five, between two and five times, and five more than 10 times (max: 81). Each participant had been incarcerated provincially, because she was either remanded to custody while awaiting trial, were provincially sentenced, or were federally sentenced and awaiting transfer to a federal prison. Eight participants had been federally sentenced, three more than once. The focus is on the common denominator among research participants, namely, their detention in a provincial prison. Interviews lasted, on average, one hour and a half.

For the focus group, five participants wanted to attend, but only three could do so due to scheduling reasons. Because some of the participants had conditions of non-association, the focus group met at the halfway house, since it was the only place in which that condition would not apply. At the focus group, participants discussed the collective project in which they wanted to be involved. After the focus groups, these three participants and I met on three other occasions in order to design and plan the collection of testimonials.

As the role of these participants changed after the focus group, another consent form was developed, in order to define roles and frame confidentiality. We made a poster for recruitment, as well as developed an interview grid to collect the testimonials. Finally, a consent form was developed for the participants providing the testimonials. Testimonials were collected on two occasions, and ten residents participated. All testimonials were immediately transcribed, so that participants could provide their input on how we transcribed their words. As suggested by participants in the focus group, additional information on community organizations was also included in the collection of testimonials, as well as one blank page, on which incarcerated women could write. Unfortunately, we were never able to secure the distribution of the collection of testimonials within provincial and federal prisons. Ongoing discussions are underway in order to enable its diffusion.

This introduction provides an overview of how I framed the issues around health in prison, as well as the methodology I used to address them. The three following articles will focus on three separate issues. The first focuses on methodological issues, as it further bridges my theoretical framework with my methodology. The second and third focus on my results, and explore how women do health while in prison, and how they undo prison upon prison release.

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Chapter 2

Through a Poststructuralist Lens:

Subjectivity and Participatory Action Research

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Abstract

An emerging literature has been building bridges between poststructuralism and participatory action research, highlighting the latter's potential for transformative action. Using examples from participative action research projects with incarcerated or previously incarcerated women, this article discusses how participatory action research is a methodology that can be enabling and restraining, with the effect of destabilising or maintaining or existing relations of power. Theorizing subjectivity as a vehicle and an effect of power, this article explores how participation and action can have normalizing and disciplinary effects, as well as be sites in which participants can interrogate and frame subjectivities in new and alternative ways.

Key words: participatory action research, subjectivity, power, poststructuralism, incarceration, women

Introduction

Participatory action research[6] (PAR) is a methodology that aims to initiate transformative action that benefits its participants (Anadon & Savoie-Zajc, 2007; Golob & Giles, 2013; Ozanne & Anderson, 2010; Reason & Bradbury, 2008; Stoecker, 2009). As Reason and Bradbury (2008) have argued, PAR can be understood as a "family" of techniques that uses different, and sometimes contradictory, approaches and methodologies, but nonetheless its practitioners see themselves "as different from other researchers (…) willing to pull together in the face of criticism or hostility from supposedly 'objective' ways of doing research" (p. 7). By involving research participants in the research process, PAR practitionners aim to uncover, acknowledge, and to include knowledges and practices of excluded and marginalized groups; by engaging with them in transformative action, it aims to intervene and address practical issues that affect their lives (Anadon & Savoie-Zac, 2007; Reason & Bradbury, 2008; Stoecker, 2009; Wallerstein & Duran 2006). That is, PAR aims to transform and change participants' lives, by not only engaging with participants in knowledge-making, but also by engaging them in implementing solutions.

Since PAR methodology aims to bring about transformative social change, substantial literature has grown up around the question of power and the empowerment of participants (Israel et al., 2005; Wallerstein & Duran, 2006). Relying on a Marxist and

[6] In this article, feminist participatory action research, action research, and community-based research are included within the PAR "family." Of course, each term has its specific nuances (Golob & Giles, 2013), but they all reflect a strong commitment to enhancing participants' lives and tackling inequalities *along with* research participants. Since this article raises theoretical considerations about key elements of these different approaches—namely, participation and action—I will employ the term PAR to include these different approaches.

structuralist definition of power[7], some studies have focused on power as a resource or a barrier in the research process, suggesting different methodological strategies to conduct research "with" and "for" rather than "about" participants (for instance, Israel et al., 2005; Wallerstein & Duran, 2006). Authors grounded in critical studies have explored different avenues to theorize and address the notion of power in PAR (Anadon & Savoie-Zac, 2007; Cameron& Gibson, 2005; Golob & Giles, 2013; Lennie, Hatcher & Morgan, 2003). In doing so, they have adopted a poststructuralist conceptualization of power, one in which power is exercised by all rather than owned by a few, infuses society and is inherent in all social relations, and is both repressive and productive of subjectivities, discourses, and practices (Foucault, 1976). Thus, a poststructuralist conceptualization of power focuses on the battlefield of rationalities and technologies of power, their strategic alliances, and their effects, rather than on the actions of individual actors.

The existing literature that employs a poststructuralist conceptualization of power has focused on two aspects of PAR. First, focus has been placed on how power relations unfold and shape the knowledge-making process (Dillon, 2014; Gaventa & Cornwall, 2004). Second, scholars have explored how research that claims to be "empowering" can have the unintended effect of reinforcing existing power relations (Henkel & Stirrat, 2004; Kothari; 2004). However, few studies have explored how power relations produce discourses and enable subjects and subjectivities (Golob & Giles, 2013).

An emerging literature has been exploring how power in PAR can be understood through its constitutive and enabling effects (Cameron & Gisbons, 2005; Golob & Giles, 2013; Lennie et al., 2003). Golob & Giles (2013) offered a more balanced account of power

[7] These schools of thoughts define power as a commodity that can be owned and redistributed.

by emphasizing how power not only constrains action, but also renders it possible. They outlined how PAR can be a site in which participants can define and work through their own subject positions since, in a Foucaldian approach to power, "the exercise of power [is] the condition of possibility for an individual's self-(trans)formation" (p. 358). Their discussion mostly focused on how PAR is both a technology of domination and of the self, with disciplining and subjectifying effects, simultaneously carrying the potential to maintain the status quo or destabilize relations of power. Lennie et al. (2003) briefly discussed how the exercise of power constrained and constituted their own subjectivities within a research project. The authors explored how they were weighed down by an "impossible burden" in which they were cast as "experts," "friends," and "motherly figures" by participants, but cast themselves following egalitarian ideals. As they elegantly concluded, a poststructuralist approach to power and subjectivity dissipates this impossible burden of being an "expert" or "mother" with egalitarian ideals, since it allowed for the consideration of subjectivities to encompass as a range of different possibilities, and for the ambivalence they bring about to be potentially constructive.

Building on this emerging literature, this article aims to deepen the discussion of the contribution of poststructuralism to PAR by focusing on the concept of subjectivity. Through the examination of participation and action, I aim to render more visible PAR's potential for destabilizing relations of power, especially in enabling the emergence of new subjectivities for participants. In order to illustrate my argument, I will draw from three PAR projects that were conducted with American and Canadian incarcerated or formerly incarcerated women—including my own. Because prison is, by definition, a coercive institution, each of these studies explicitly discussed the issue of power in relation to their

methodology. Even though they did not rely on a poststructuralist theoretical framework, they are thus a fertile ground for a discussion of the richness of a poststructuralist approach to PAR. The first section of this article will first define the concept of subjectivity from a poststructuralist approach. In order to provide some background to the studies I will use, I will briefly describe the issue of women's health and incarceration. Using subjectivity as my starting point, I will then discuss how participation and action can be reframed in line with a poststructuralist approach to power.

Poststructuralist Subjectivities: Vehicles and Effects of Power

The current literature on PAR does not explicitly define subject and subjectivity: it relies on an implicit definition of subjecthood that is rooted within the Western humanist tradition (Cameron & Gibson, 2005; Cleaver, 2004; Lennie et al., 2003). Within that tradition, the subject—the empowerable participant, the academic researcher, and so on—refers to a united self who exists by virtue of his or her consciousness. A pre-social and united entity, the subject, who is the mind, experiences the world, and it is through his or her experience that truth can be found (Cameron & Gibson, 2005; Weedon, 1997). As the subject is equated with the mind, subjectivity refers to "the conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding the world her relation to the world" (Weedon, 1997, p. 32). That is, what "I" think, feel, and experience consciously or unconsciously, how I define and identify "myself"—all these aspects are comprised within subjectivity. Subjectivity is then understood as the fixed, unique, and coherent essence of each human being that makes the subject what he or she is—true human nature, rationality, womanhood, etc. (Belsey, 2006). The purpose of PAR is thus to emancipate and liberate the subject, to free subjectivity from capitalist or patriarchal

oppression, freeing the subject from her own alienation and repression (Cameron & Gibson, 2005).

Foucault questioned and challenged the notion of the "humanist" subject (Burchell, Gordon & Miller, 1991; Dreyfus & Rabinow, 1991; Foucault, 1980; Weedon, 1997). Through his studies of madness, disciplines, sexuality, and technologies of the self, Foucault explored how subjectivity is an effect and a vehicle of power relations, stripping it from its rationality, unity, and truthfulness. Indeed, the Foucauldian subject is a multiple, disunited, porous, social, and historical entity. Our subjectivities—our inner voices, our feelings, our dreams and our actions—are the effects of our locatedness within a matrix of power relations, a matrix through which we are governed and constituted. As subjectivity is an effect of power relations, it is fragmented and dependent on context, reflecting the "non-directionality" of power. As a vehicle of power, subjectivity engages with and relies on technologies of the self to allow for self-governance (Foucault, 1980). Departing from the humanist traditions, subjectivity is thus defined in plural: it is never a fixed process or a strategic location, never a finality or an essence (Foucault, 1980, 1991; Lupton, 1995; McNay, 2000; Weedon, 1997).

Subjectivities are thus vehicles and effects of power, enabled and constrained by these power relations. As I discuss the relevance of the notion subjectivity for participation and action, I will engage with feminist poststructuralist theory in order to complement the aforementioned definition of subjectivity. I will illustrate my argument by discussing examples from PAR studies that tackled the question of incarceration and women's health, providing some background on that issue, and briefly introducing each study.

Incarcerated Women: a Brief Portrait

Recent studies and reports on the health of incarcerated women in Canada and in the United States paint a dark picture: incarcerated women are not healthy, either physically or mentally: incarcerated women have higher rates of mental and physical illnesses both compared with the general population and with incarcerated men (Ammar & Weaver, 2005; Archambault et al., 2013; Covington, 2007; Fisher & Hatton, 2009; Stewart et al, 2014). Studies have demonstrated that incarcerated women have higher rates of post-traumatic stress disorder and depression (Covington, 2007; Giroux & Frigon, 2011), as well as a higher prevalence of chronic physical conditions (asthma, hypertension, heart disease, and diabetes) and illnesses such as HIV, hepatitis B and C, and sexually transmitted infections, than non-incarcerated women (Ammar & Weaver, 2005; Koyoumdjan et al., 2015; Stewart, Sapers, Nolan, & Power, 2014; Poulin et al., 2007). Studies from Quebec suggested that half of all women who are incarcerated have been victims of sexual abuse, and seven out of ten have experienced violence in intimate relationships (Boutet, Lafond, & Guay, 2007; Frigon & Duhamel, 2006). In brief, due to their high rates of victimization, infectious diseases, and psychiatric illnesses, incarcerated women have been extensively described as a vulnerable population in terms of health (Covington, 2007; Fisher & Hatton, 2009; Martin et al. 2009).

Incarcerated women's health issues are related to the marginalization and exclusion that criminalized women experience prior to their incarceration (Giroux & Frigon, 2011; Covington, 2007), but they can also be exacerbated by confinement or even caused by experiences of incarceration. It is well known that confinement can negatively impact mental health (Kilty, 2012), and that specific disciplinary measures, such as solitary confinement, are detrimental to prisoners' mental and physical health (for instance, Giroux

& Frigon, 2011; Lhuillier & Lemiszewska, 2001; Sykes, 1958). The living conditions of prisoners have been criticized for ranging from "inadequate" to harmful in certain American and Canadian female prisons. For instance, in Canada, access to appropriate physical and mental health care services has been raised as a key health issue that women face in both provincial (Quebec Ombudsman, 2013) and federal prisons (Office of the Correctional Investigator, 2014), especially for women struggling with mental health issues. Even the physical prison living conditions can be detrimental to women's health, including hazards such as such as rat and mouse infestations, mould, and dilapidated facilities (Quebec Ombudsman, 2013). Inmate overpopulation has accelerated the deterioration of living conditions in prisons, an ongoing issue in provincial prisons (Quebec Ombudsman, 2013), and a growing issue within federal penitentiaries (Office of the Correctional Investigator, 2014). Elements of the prison "lifestyle" have also been identified as detrimental to women's health, including inactivity and a poor diet (Plugge et al., 2008; Martin et al., 2009).

Feminist scholars have critically assessed the gendered forms that confinement take and its impact on women. Isolation from one's social network and family, the need to conform and obey institutional rules in order to have basic needs met, the lack of intimacy, boredom, and the challenges of adapting to prison life may lead women to feelings of depression and anxiety (Fields et al., 2009; Frigon & Duhamel, 2007; Giroux & Frigon, 2011; Kilty, 2012; Pollack, 2004). Furthermore, some studies have argued that prison pathologizes women who struggle to adapt to the coercive institution of prison, without addressing the inherently alienating prison structure that causes women to resist or exhibit uncooperative behaviour, instead labeling them as "mentally ill" and "high risk" (Kilty,

2012; Maidment, 2006a,b; Pollack, 2005). The use of evaluation tools that rely on actuarial calculations conflate risk with needs and thus leads to an increase in the coerciveness and punitiveness of the measures that aim to deal with "problematic" and "difficult" prisoners (Hannah-Moffat, 2006; Hannah-Moffat & Shaw, 2001).

To my knowledge, few PAR studies have been undertaken that address the health of incarcerated or previously incarcerated women in Canada or the United States. As described in the introduction of this thesis, I conducted a research inspired by PAR with women who had been released from prison and who were recruited in community organizations. Martin et al. (2013, 2009) and Fields et al. (2008) worked with incarcerated participants, in Canada and the United States respectively. Despite adopting different theoretical frameworks, these three studies had the same implicit rationale: PAR would provide a space for women to collectively voice their concerns about health in prison, and to bring about changes that would benefit them.

Having briefly provided an overview of the issue of women's health in prison, the following section will reframe "participation" by focusing on embodied subjectivities. In order to do so, I will first briefly discuss how participation is defined in PAR projects, and then discuss how participation can be understood as a technology of power.

Participation and Subjectivities

In PAR literature, participation is discussed in terms of its epistemological and political ramifications. Epistemologically, participation aims to reverse the divide between the researcher and the object of research, as researchers and participants are considered to be co-researchers. PAR thus relies on a "democratization" of knowledge: through participation, all forms of knowledge—lay knowledge, experiential, academic—are at the same level, and

researchers and participants are involved in the process of knowledge-making (Gaventa & Cornwall, 2004; Israel et al., 2005; Reason & Bradbury, 2008). Politically, participation implies that not only are participants involved within the research process, but also that participants' rights and abilities are put forward, so participants can be involved in the knowledge-generating process, as well as in the process of transforming the issue at stake (Israel et al., 2005; Wallerstein & Duran, 2006). The intended effect of such participation is that participants become "empowered," as power is understood as a commodity that can be "owned" and redistributed, and, thus, effectively become better equipped with the skills and confidence to face future challenges (Reason & Bradbury, 2008; Wallestein & Duran, 2006). In brief, participation is a methodological strategy that bridges inequalities in knowledge and in roles, so the researchers can be "working towards practical outcomes, and also about creating new forms of understanding" (Reason & Bradbury, 2008, p. 4).

Relying on poststructuralist theory, Kothari (2004) and Cleaver (2004) challenged the assumptions that participation in research or in development projects necessarily benefits participants. By focusing on the connection between knowledge/expertise and power, Kothari (2004) demonstrated that participatory techniques are methods of knowledge accumulation that maintain expert knowledge, rather than challenge it. Consensus-building crystallizes what is considered "local knowledge," and, through repetition and reiteration, this knowledge acquires a "common sense" status, as the official version of the community's knowledge; ultimately, it reinforces social norms and makes them objectively "truthful." Moreover, participants are constrained by pre-scripted norms of participation: the ways in which they must take turns talking, answer questions, engage in discussion at certain times and about certain topics, take notes, or reflect on their own experiences, etc. Cleaver (2004)

challenged the rationality of participating, which is the idea that potential participants should participate, and that a failure to do so demonstrates a lack of "rationality" or "motivation." She highlighted how the engagement and disengagement of participants should be addressed by recognizing the changing and multiple identities of participants, and how they frame their choices of whether or not to participate.

Kothari's (2004) and Cleaver's (2004) critiques focused on the constraining aspects of power, as well as its effects, but they provide one side of the story. In order to excavate the creative potential of PAR, the challenge here is to simultaneously tackle power's constraining and enabling aspects, as well as its effects. As we are all produced as free subjects (Rose, 2000), taking action to preserve and foster one's health, one's environment, one's community, and one's country is considered as a "duty", and the only possible "ethical" position (Lupton, 2012). Citizens are simultaneously held accountable for the wellness and development of their environment, but also entitled to exercise their freedom by getting involved in their collectivities, their communities, or their cities (Gordon, 1991; Petersen & Bunton, 1997; Rose, 1999). Neoliberal governmentality thus produces participating subjects, with different effects. As Kothari (2004) and Cleaver (2004) outlined, it can keep participants in disadvantaged positions (e.g by excluding them from "true" knowledge) or constrain them within specific forms of subjectivities (e.g. the ideal subject). Yet— and this side of the story has been explored less—enabling participants can also destabilize relations of power and have a freeing effect for participants. In such cases, participation "create(s) a space in which marginalized individuals can invent new subjectivities by critically reworking present ones" (Giles & Golob, 2013, p. 365).

In the following papers of my thesis, I will further explore the constraining effects of neoliberal governmentality on incarcerated women, but I will focus here on their enabling effects in the context of a PAR. To illustrate that point, I will turn to Fields, Gonzàlez, Hentz, Rhee, and White (2008), who conducted PAR in the San Francisco County Jail for Women. The researchers' objective was to bring forward the concerns and insights of the participants to illuminate and challenge the roles that incarceration, criminalisation, gender, HIV, and race have on the sexual lives of incarcerated women. Their theoretical framework was informed by intersectionality, focusing on gender and race, while paying close attention to gendered inequalities that characterize women's paths to incarceration. Drawing from the popular education tradition in PAR, the researchers developed a series of four workshops on risk and HIV. The workshops were adapted by and for incarcerated participants as the study moved along. During the workshop, participants had to interview each other, take notes, identify themes, and plan the next workshop: research methods thus constituted participants as "incarcerated researchers." As a new round of workshop started, insights from past workshops were integrated in the new round. These workshops became sites to provide critical sexuality education in which academic researchers, public health workers, and incarcerated women extended the definition of HIV risk beyond bodily fluid exchanges, in order to address the different levels of vulnerability that incarcerated women must navigate and live with.

Based on Fields et al.'s (2008) account, one of the main and unforeseen effects of the workshops was that participants adopted different roles: educators, as they educated their peers; researchers, as they used various research methods to investigate HIV and risk; and students, as they learned about research methods and risk as defined by public health

experts. What Fields et al. (2008) defined as "role" can be described as various subjectivities, as they referred to not only women's behaviours, but also to their senses of self, feelings, and reflexivities. Talking about her role as a "researcher," one participant stated: "I like taking responsibility to listening to others' stories and then take a look at my own life" (p. 77). Fields et al. (2008) argued that participating in the workshops was routinely recognized as valuable and desirable by participants: as they were able to engage in alternative subjectivities within the workshop, participants felt understood, heard, supported, and connected to each other. For instance, one participant stated: "now I see we are all here not only to serve time but [also] to support each other" (Field et al., 2008, p. 80).

Subjectivities described by the participants of Fields et al.'s study (2008) clash with correctional discourses and practices of incarcerated women, as well as with the "silenced" subjectivities of marginalized groups in society. Prison studies abundantly demonstrate how incarcerated women are constituted by institutional discourses and practices as "criminal" women, "flawed" and "dangerous" (for instance, see Hannah-Moffat, 2001; Maidment, 2006b ; Pollack, 2005). They must conform to rules, orders, and procedures, and are coerced to do so if they express any form of resistance or if they are unable to conform as prescribed. Institutional rules and procedures produce a climate of insecurity and mistrust, both between prisoners and staff and among prisoners (Bosworth, 1999). Moving beyond prisons' walls, there is a need to critically recognize that the notion of "crime" is shaped by social and historical processes, and that women who are the most vulnerable—those who are street-involved, who engage in sex work, and/or who have mental health issues—are at a higher risk of criminalization and incarceration (Maidment, 2006a; Pollack, 2015; Wacquant, 2009). As in other marginalized groups, including Aboriginal peoples, homeless people, etc.,

criminalized women "take on" the weight of deprivation, inequalities, racism, and sexism, and interpret their failures to work, study, get off the street, and stay out of prison as another sign of their personal worthlessness (McNay, 2012). Through technologies of the self, neoliberal governmentality relies on the internalization of feelings of failure, shame and inadequacy when subjects fail to attain neoliberal ideals (Cruikshank, 1993; Lupton, 2012; McNay, 2012). Thus, feelings of disconnection, depression, inadequacy and anger are a sign of the locatedness of the subject within the power relations that dominate their lives. In other words, the disadvantaged position a person occupies in power relations made "invisible" and "unhearable:" what is "readable" and "apparent" instead are low self-esteem, depression, and hopelessness (Cruikshank, 1999).

By participating in research, women in the Fields et al. (2008) study were able to adopt and deploy other subjectivities, subjectivities marked by feelings of connection, of sharing common distresses, and of having the capacity to alleviate others' distress. By enabling the participants to access these subjectivities, Field et al. (2008) reconfigured the relations of power, constituting participants' subjectivities in a different matter. I observed the same pattern in my study. For instance, one of the participants involved in the development of the collection of testimonials stated: "I'm doing this [project] because we are wild animals—but we are also women who have something to say" (Nikita). In her statement, Nikita challenged her subjectification as an "animal" —instinct-driven and dangerous—by her womanhood and her voice, reclaiming the legitimacy of her voice. Although small, I think such reconfigurations can have destabilizing effects on power relations that may benefit participants—or, conversely, may continue to keep them in a disadvantaged position, as will be further discussed in the following section.

Action and Subjectivities

Surprisingly, literature on PAR seldom defines "action," though it can take many forms, ranging from the formation of therapeutic groups to micro-credit initiatives. For Reason and Bradbury (2008), PAR is characterized by the connection between research and practical actions, "in the pursuit of practical solutions in the pursuit of pressing concern to people, and more generally the flourishing of individuals persons and their communities" (p. 4). In a review of PAR and community-based research, Stoecker (2009) emphasized how action was a nebulous concept in most PAR projects. In his review, he defined action as the "output" of the project, namely, what the research project underwent during or after the research process, or what it recommended to do following the research process. Although Stoecker's critique of PAR underlined how PAR projects failed "to walk the talk" of action, he also provided a very limited definition of "action", shifting from "action" to "social change," implying structural and institutional change as PAR "outputs."

Arguing for a clarification between the calls for institutional or structural changes that are often implicit in PAR studies and action, Reid, Tom and Frisby. (2006) adopted the following definition: action "ranged from speaking to validate oneself and one's experiences in the world to the process of 'doing something,' such as taking a deliberate step towards changing one's circumstances" (p. 327). This definition of action is consistent with poststructuralism, as changes in power relations are not articulated only through changes in structure, but also through feelings, identities, and the ways of understanding the world, namely, through a person's subjectivity. Working with low-income women, Reid et al. (2006) explored how structural change was difficult to attain because the institution that

controlled women's lives—welfare—limited and constrained women's collective action, causing them to maintain passive roles. Similar to Fields et al. (2008) and to my own research, Reid et al. (2006) argued that a PAR study that allows participants to engage in alternative narratives about their own lives constitutes "action."

Such a definition of PAR raises issues that require clarification. First, as argued in the preceding section, participation in itself enables participants to deploy new subjectivities, but it does not necessarily constitute the "action" of the study. In Field et al. (2008), it was the intended outcome; in my research, it was a "side effect," as the project aimed to develop a collection of testimonials of women in prison. The second clarification is related to the effects of the action on power relations. Although the action undertaken in PAR studies may be intended to improve participants' location in the matrix of power, it may instead reinforce their starting position or shift relations of power to their disadvantage. As Bordo (1993) astutely warned us, any analysis of the "beneficial" effects in the change of power relations should carefully examine the underlying historical, social, and cultural context in which this change is embedded. The rest of the discussion will demonstrate this point.

Martin et al. (2013) conducted PAR in a Canadian provincial prison with incarcerated women, prison staff, and academic researchers. During the project, participants identified nine health goals that they considered to be essential for the reintegration of women into their communities. The research team, made up of women, administrators, and academic researchers, identified one of the goals to be "improved awareness and integration of healthy lifestyles" (p. 143). Incarcerated and non-incarcerated members of the research participants designed, implemented, and evaluated a prison pilot nutrition and fitness program after surveying incarcerated women on their perception and knowledge of nutrition

and fitness. Participants in a six-week health program were recruited on a voluntary basis. The nutrition component of the program involved educational presentations and the distribution of Canada's Food Guide, including personalized food charts that allowed participants to track their eating patterns. The fitness component was organized as follows: participants were given a facility orientation of the prison gym and were then provided with the opportunity to join a group circuit class, or to develop an individual exercise plan with a certified instructor. In both cases, participants were provided with an exercise program card to track their progress. In order to assess the impact of the pilot program, participants were involved in a pre- and post-program evaluation that included a Physical Activity Readiness Questionnaire and body measurements.

Martin et al.'s (2013) "action" addressed an important health issue in prison—weight gain and a lack of physical exercise. Many authors who have previously conducted research on women's experiences of incarceration reported that lack of physical activity, poor nutrition, and weight grain, and their long-term impacts, are key concerns for women (Giroux & Frigon, 2011; Kilty, 2012; Plugge et al., 2008), an issue that was also addressed in my study. In provincial prisons, reports from the Quebec Ombudsman (2013) noted how access to the gym is often limited due to disciplinary sanctions or a lack of surveillance staff. I assume that a project that included prisoners and staff members, and that was strongly supported by the warden, would remove such organizational constrains. Thus, the action coming out of the study run by Martin et al. (2013) was a practical solution to a health concern.

Martin et al. (2013) assessed that the program was successful in providing women with the opportunity to engage in a healthier lifestyle, although only 16 women completed

the program and pre-post assessment. The 16 participants who were involved in the whole program reported weight loss, decreased stress, improved sleep, a decreased desire for illicit drugs, and an overall feeling of health. Participants also highlighted how the peer-led nature of the program helped them to stay mobilized and focused on their goals; the social aspect of circuit classes was also greatly appreciated. As the program unfolded, more women accessed and used the gym, even if they did not participate in the study, and Martin et al. (2013) reported that more women began engaging in physical activity outside of the study.

From a poststructural perspective, the impact of the action of the study could be further developed. Smith (2000), Robert and Frigon (2006) and Robert, Frigon and Belzile (2007) have argued that the health system and the prison institution are intimately connected; they intersect to constitute the "healthy" prisoner who takes charge of her health, who is a vector of "healthy behaviours," and who does not only follow a healthy lifestyle and take responsibility for her health, but also promotes it to her community. Yet, incarcerated women's health status is produced by the intersection of poverty, abuse, racism, and incarceration: women's bodies bear the mark of this intersection in their aging, sick, and mutilated bodies (Frigon, 2012, 2003). As incarcerated women fail to attain neoliberal idealized bodies due to their life trajectories, they are constituted as engaging in "unhealthy lifestyles," as "resistant" to health promotion and practices. Through their action, Martin et al. (2013) provided not only physical access to a gym and knowledge about nutrition, but also an alternative subjectivity—prisoners involved in their own health, who conform to the neoliberal imperative of taking charge of oneself.

Martin et al.'s (2013) research can be criticized for its lack of problematization of what constitutes "healthy behaviours." A poststructural reading of "nutrition" and "fitness"

informs us that these concepts are both mechanisms of power and constitute a "healthy" gendered subject who is in shape, lean, firm, and is appropriately muscular (Bordo,1993; LeBesco, 2011; Lupton 1995, 2012). Feminist scholarships further uncovered how slenderness is associated with better self-control, health, and wellbeing, whereas fatness is associated with laziness, unhealthiness, and illness (Bordo, 1993; LeBesco, 2011; Lupton, 1995, 2012). The possibility of achieving a slender and young body is uncertain, as its scripted idealized forms are very limited in terms of age, height, race, etc. (Bordo, 1993; Lupton, 1995). Nevertheless, the measures used to access the action component were embedded within discourses of slenderness and health: follow-up questionnaires, food charts, and body measurements to assess progress in fitness and nutrition are tools for self-surveillance and self-discipline, and can provoke feelings of failure and sadness if participants are unable to conform to scripted ways of becoming healthy.

A program that implicitly promotes a certain "healthy" body may have the unintended effect of further stigmatizing the embodied inscriptions of incarceration, and holding prisoners accountable for their own failure to conform through shame, for example, in the case of prisoners with disabilities, aging bodies, obesity, etc. Thus, without a critical appraisal of "fitness" and what underlines "healthy behaviours," there is a risk that participants may feel further shamed, guilty, or powerless if they are unable to lose weight, attain a specific body shape, or increase their health status. Although Martin et al.'s (2013) project was based on women's concerns and answered women's needs, it sustained and promoted a body type and subjectivity that maintains and promotes a neoliberal governmentally of health, and this effect must be carefully taken into consideration. Rather than focusing on behavioural factors, a more critical approach to the issue of health, in

which the question of what being healthy is raised rather than predetermined, could have enriched Martin et al. (2013), and provide participants the opportunity of developing alternative subjectivities.

Conclusion

In conclusion, I attempted to explore how PAR practice and theory can be understood using a feminist poststructuralist theoretical framework. Specifically, by exploring how subjectivities are constituted through participation and action, I described how PAR can have normalizing and disciplinary effects, as well as constituting a site for participants to question and frame their subjectivities in new and alternative ways. In doing so, I aimed to describe how a poststructuralist theoretical framework can account for ways of participating and acting that are enabling and constraining, and which can have the effect of maintaining or destabilising existing relations of power. Rather than being discouraging, this article intended to invite all PAR enthusiasts to critically consider the ethical claims of PAR and to question its potential normative and coercive effects in addition to its potential to transform existing power relations—thus embracing its complexity rather than shying away from it. In the words of Foucault, "my point is not that everything is bad, but that everything is dangerous, which is not exactly the same as bad. So my position leads not to apathy, but to a hyper- and pessimistic activism" (Foucault, 1983, p. 231).

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Chapter 3

Doing Health in Prison:

the Good, the Bad, and the Ugly

Abstract

To do health refers to the imperative for the neoliberal subject to engage in maximizing his or her health. As a population, incarcerated women are considered to have a low health status; this article interrogates how previously incarcerated women did "doing health" during their incarceration. Using data from a study inspired by participatory action research, this article explores how participants adopted different embodied subjectivities that conflicted or aligned with neoliberal governmentality. Using three issues—access to health care services, smoking, and the management of body weight—it describes how, through failure to conform to neoliberal ideals of "health," mechanisms of self-surveillance and self-regulation are manifested by feelings of guilt, shame, and anxiety, even when incarcerated women attempt to conform to neoliberal imperatives to be healthy.

Key words: Prison, subjectivity, embodiment, neoliberalism, governmentality, health, healthism, incarcerated women

Introduction

The pursuit of health seems to require constant and active engagement from modern citizens. Of course, avoiding illness and being healthy have always been concerns for human beings; what is new is the inclusion of issues and practices that were at the periphery of health and that are now included within its fold (Aïach, 2009; Cheek, 2008; Lupton, 1995; Petersen & Bunton, 1997; Yaya, 2009). Comparing health to a fluid, Aïach (2009) concluded that health has permeated all sectors of society broadly and deeply: eating right, brushing one's teeth, sleeping sufficiently, and managing stress effectively, all are actions that we are required to undertake in order to preserve and foster our health. Furthermore, not only has health consciousness flooded society, the pursuit of health has been elevated to the highest moral calling (Aïach, 2009; Cheek, 2008; Lupton, 1995; Petersen & Bunton, 1997; Rose, 2007, 1999; Yaya, 2009;). This "ethicalization" of the pursuit of health is embedded in neoliberal governmentality in which citizenship is defined by a careful balance of self-discipline, self-regulation, and the gratification of desire, all of which are necessary to produce and consume commodities in abundance (Bordo, 1993; Lupton, 1995; Petersen & Lupton, 1996 Rose, 2007). In this context, being "healthy" demonstrates one's commitment to self-control, and becomes a marker of one's moral worth (Bordo, 1993; Petersen, 1997; Petersen & Lupton, 1996; Rose, 2007). Conversely, engaging in an "unhealthy" lifestyle demonstrates moral weakness and a lack of control, putting into question one's engagement with one's duties as a citizen (Lupton, 1995; Petersen, 1997; Rose, 2007). Rose (1999) argued that advanced neoliberalism creates a subject that is obliged to be free; the critical literature on healthism hints that the neoliberal subject *must* be healthy (Cheek, 2008;

Lupton, 1995; Yaya; 2009). In other words, as Lupton (1995) argued, the imperatives to be healthy[8] create a subject who wants to maximize and preserve his/her health.

Due to their high rates of infectious diseases (Poulin et al., 2007), psychiatric illnesses (Archambault, Joubert & Brown, 2013), chronic illnesses (Kouyoumdjan, Schuler, Hwang, & Matheson, 2015), and substance abuse (Plourde, Brochu, Couberte, & Gendron, 2007), women in prison have been extensively described as "unhealthy" (Covington, 2007; Hatton & Fisher &, 2009; Martin et al. 2009; Plugge, Douglas, & Fitzpatrick, 2008). As Smith (2000) argued, the "unhealthiness" of incarcerated women is often attributed to their life prior to incarceration, marked by substance abuse, victimization, "unhealthy" lifestyles, and poverty. Additionally, prison has been problematized has an unhealthy environment. Increasing overpopulation and unsanitary conditions have been on the rise in many prisons across Canada (Quebec Ombudsman 2013; Office of the Correctional Investigator, 2014), raising questions about the negative impacts on prisoners' health and wellbeing. Limited access to appropriate health care has also been regularly denounced (Hatton & Fisher, 2009; Quebec Ombudsman, 2013), as well as the prison "lifestyle" marked by inactivity and poor diet (Martin et al., 2009, 2013). Confinement itself has been problematized as a threat to women's health, as it may lead women to feelings of depression and anxiety (Fields, Gonzàlez, Hentz, Rhee, & White, 2009; Giroux & Frigon, 2011; Kilty, 2012; Pollack, 2005). In brief, as a population with a low health status in an unhealthy environment, women prisoners are, *de facto,* failing to engage with the imperatives to be healthy even prior to their incarceration.

[8] In her book on public health, Lupton (1995) assessed how citizens faced the imperative to be healthy. In order to reflect the multiple technologies and rationalities that intersect in the field of health, I chose to use the plural "imperatives."

Situated at the intersection of prison studies and the critical literature on health, this article explores how incarcerated women, who are problematized as an "unhealthy" population, engage with neoliberal "imperatives" to be healthy. Specifically, I will explore how women who are provincially[9] incarcerated resist or conform to governmental strategies for "doing" health. I use of the neologism "doing health" to emphasize the fact women are required to "act" on their health. By considering three specific issues in prison, namely, smoking, the medical encounter, and weight gain, I demonstrate how women deploy different embodied subjectivities in order to deal with the imperatives to be healthy, ranging from opposing health promotion discourses and practices to adhering to them. The purpose here is neither to assess whether women's strategies regarding their health in prison are "right" or "harmful" nor to capture all possible embodied subjectivities deployed by women: my objective is to address *how* they engage with imperatives to be healthy through embodied subjectivities. Departing from the study of programs, tools, or political rationalities (for instance, Rose (1999) on liberty; Cruikshank (1993) on self esteem), I aim to contribute to the growing field of governmental studies that aim to complement disembodied narratives of governmentality by tackling governmentality from the experiences of subjects (such as Frigon, 2003, 2012; Kilty, 2012; Moore & Hirai, 2014).

Before delving into the topic, I will first address the subjectification of incarcerated women as neoliberal subjects, and demonstrate how women's health is a field through which women are governed at a distance. In doing so, I will also discuss the inherent tensions between the subjectification of women as healthy and empowerable and the carceral environment. After defining the concept of embodied subjectivity, I will briefly describe the

[9] In Canada, adults who are serving a sentence over two years are incarcerated in federal penitentiaries. Adults who are serving a custody sentence that is less than two years or adults who are being held awaiting trial or sentencing are incarcerated in provincial prisons.

empirical fieldwork on which this article is based, as well as the methodology and methods used. I will then describe three specific embodied subjectivities and their relation to the imperatives to be healthy.

Governing Incarcerated Women through Health

In this article, I argue that "imperatives to be healthy" infuse the carceral space through their strategic alliance with neoliberal penal governance and, together, they produce a "healthy" and "empowerable" prisoner (Robert, Frigon, & Belzile, 2007; Robert & Frigon, 2006; Smith, 2000). In order to conceptualize that question, I draw on the literature on governmentality, which approaches the subject as a precondition and an effect of the exercise of government. In other words, it locates and embeds the subject within power relations, while simultaneously exploring how the subject is an effect of its locatedness (for instance, Rose (1999) on freedom; Cruikshank (1993) on self-esteem). Departing from humanist traditions, subjectivity (our feelings, beliefs, desires perceptions, etc.) is thus defined as a process, shaped and constituted by power relations, fragmented and historical. However, it is important to underline that power is deployed in terms of a triangle: "we need to see things not in terms of the replacement of a society of sovereignty by a disciplinary society and the subsequent replacement of a disciplinary society by a society of government; in reality one has a triangle, sovereignty-discipline-government" (Foucault, 1991, p. 102). Each "side" of the triangle deploys different strategies and rationalities on targeted populations and individuals, with different effects (Wilson, 20009). In other words, incarcerated women are governed, disciplined and coerced around the issue of health, and a discussion of the government of incarcerated women must examine the strategic alliances and the conjunctions and disjunctions among each form of power.

In her extensive study of reforms in Canada's federal system of women's imprisonment, Hannah-Moffat (2000, 2001) carefully examined the question of neoliberal penal governance and its relation to other forms of penal governance (such as maternal, pastoral and disciplinary). She demonstrated how the notion of "empowerment" – put forward by Aboriginal and feminist organizations from a perspective of social activism – has been appropriated as a governmental strategy by correctional authorities. Highlighting the various interpretations of "empowerment," she showed how correctional discourses and practice use "empowerment" in conjunction with strategies of responsibilization: "empowerment" is thus depoliticized, and it is recast under the realm of "self esteem" (see Cruikshank 1993 for more). Incarcerated women are thus able to exercise "power" by engaging in the improvement of their self-esteem by participating in programs and activities carefully laid out by the institution, with the ultimate objective of acquiring more control of their lives. Thus, as incarcerated women improve and work on their self-esteem, they are expected to take responsibility for their actions and behaviours: the responsibility for an eventual successful rehabilitation rests exclusively on the prisoners' shoulders, regardless of the structural inequalities they may face. In brief, Hannah-Moffat (2000, 2001) demonstrated how neoliberal penal governance constitutes "empowerable" and responsible prisoners.

The strategic alliance between neoliberal penal governance and the imperatives to be healthy are apparent in the deployment in the carceral space of health promotion interventions based on New Public Health (Robert et al., 2007; Robert & Frigon, 2006; Smith, 2000). Briefly, New Public Health is an apparatus of power that is concerned with the health of individuals and populations in order to improve health for all through evidence-

based and preventative actions (Frigon & Robert, 2006; Lupton, 1995; Petersen & Lupton, 1997). New Public Health "acts at a distance" by providing norms according to which citizens are assessed, monitored, and classified, and that are presented as indispensable, "natural," or moral, in order to attain personal health, balance and wellbeing (Lupton, 1995; Petersen & Lupton, 1997). Subjects are incited to maximize their health through "lifestyle" and "healthy habits," such as being active, eating healthily, and abstaining from smoking. The adoption of such habits is made "visible" through the firmness of one's body, fitness and slenderness (Bordo, 1993). What is constructed as choices – smoking, abusing drugs, eating junk food – becomes the reflection, the "identity" of the subject who, by jeopardizing her health, is seen as irresponsible and lacking self-control (Lupton, 1995; Petersen & Lupton, 1997; Rose, 1999). Feelings of shame, guilt, and anxiety are spurred by mechanisms of self-surveillance and self-regulation, and the "unhealthy" subject is thus incited to consult with "experts" to guide her to manage her health.

Within the carceral space, New Public Health is apparent in the proliferation of programs targeting women's health (Robert & Frigon, 2006), the constitution of prisoners as "vectors of health"(Robert, 2008, p. 358), as well as by the potential "healthification" of risk assessment tools (Robert et al., 2007). The constitution of prisoners as "vectors of health" is based on the assessment that prisoners come from groups underprivileged in terms of health status and underserved in terms of health care, and are thus deemed "resistant" to health promotion campaigns (Robert, 2008; Robert & Frigon, 2006; Smith, 2000). It proposes that incarceration become a time of opportunity during which prisoner can be introduced to healthy and beneficial health options (e.g., improved nutrition, exercise, etc.), which will eventually have trickle-down benefits for the community when prisoners are released from

prison (see, for instance, Martin et al., 2013). This objectification is even more acute for women, as their gendered roles of "carers" predispose them to be efficient vectors of change (Robert & Frigon , 2006; Smith, 2000). Finally, as the information on the health status of prisoners informally influences their correction trajectories, it raises the question of the potential inclusion of health within risks-assessment tools (Robert, 2006; Robert & Frigon 2006;). As these tools already conflate risk and needs (Hannah-Moffat, 2006; Hannah-Moffat & Shaw, 2001), Robert (2008) underlined how it could "allow for the punishment of risky health-related behaviors" (p. 359).

The congruence between New Public Health and neoliberal governance is evident in their reliance on responsibilitization as a governmental strategy. As New Public Health considers "good health" to be the result of personal choices and lifestyles, the underlying causes of and potential solutions to prisoners' poor health is situated within their behaviours, habits, and lifestyles (Robert et al., 2007; Robert & Frigon, 2006; Smith, 2000). Consequently, as incarceration is constructed as a consequence of poor and irresponsible life choices, and illness is seen as a consequence of poor and irresponsible lifestyle choices, it is up to women in prison to engage in healthy self-improvement. Incarcerated women are thus "free" to engage in healthy lifestyles from which a healthier form of their self will allegedly arise, trickling down to their families and communities upon their release.

The subjectification of women as empowerable and *wanting* to become healthier through the adoption of healthy habits raises two kinds of issues. First, the discourses on health that individualize health status ignore all evidence related to the social determinants of health, namely, that the health of individuals and populations is shaped by poverty, social exclusion, racism and sexism (Schrecker, 2013). In true neoliberal forms, it depoliticizes the

issue of health inequities (Smith, 2000). Second, prison is, by its constitution, an institution in which individuals have little control over their "lifestyles" or health habits. Prison confines women to a specific space, regulates how they spend their time, and organizes the most intimate aspects of their lives, including who they interact with, how they dress and in front of whom they will undress, what they eat, where they sleep, etc. Although medical health care is available within prison walls, women cannot choose their medical provider, and they face organizational barriers to access to health care services. They also face barriers to accessing over-the-counter medicines, vitamins, and natural products. In brief, even though some prisoners want to take care of their health, the carceral conditions limit their ability to do so (Plugge et al., 2008; Robert, 2008).

As argued earlier, it is important to stress that other forms of power, namely, discipline and sovereignty, are also deployed to govern incarcerated women in the name of their health. Analyzing neoliberal penal governance, Hannah-Moffat (2001) demonstrated how a woman who engages with "empowering" practices and discourses is "expected to constantly monitor herself and control her own risk-generating behaviour" (p. 523). Failure to follow neoliberal penal scripts of empowerment leads to the mobilization of coercive and punitive forms of power, such as the loss of privileges (including cancelled visits), institutional charges, or segregation. According to Robert and Frigon (2006) and Smith (2000), the same process is triggered when incarcerated women refuse to engage with or question the imperatives to be healthy. The issue of the (over)use of prescription psychotropic medications in prison illustrates this point. Incarcerated women are invited to take care of their mental health in provincial prison; however, there is limited access to psychological treatments (Kilty, 2012; Pollack, 2005). The main "treatment" for anxiety,

depression and general psychic "unwellness" is, in fact, psychotropic medications (Archambault et al., 2013;Kilty,2012). Kilty (2012) critically interrogated the pathologization and medicalization of incarcerated women and showed that incarcerated women who disagree with their prescriptions of psychotropic medications can be denied parole or face other penalties, such as the loss of a day pass or other privileges, and are thus left with little choice but to take medication. Kilty (2012) thus reminded us that "Despite the neoliberal emphasis on empowerment as a way to responsibilize incarcerated women, criminalized women are not truly expected to be responsible, self-governing agents of their own mental health destinies" (p. 179). In other words, incarcerated women are invited to be responsible and autonomous, but they also must follow institutional rules, respect their sentences, and seldom question the medical or correctional expertise that seeks to "empower" them. In line with Hannah-Moffat's (2000, 2001) findings, incarcerated women are thus "empowered" according to specific scripts, according to which they should seek treatment for their inherently "pathological" mental health.

In order to grasp the complexity of the interactions between relations of power, health and incarceration, Robert et al. (2007) made the case to include the question of embodiment when tackling experiences of incarceration. Through the lens of the body, Frigon (2003, 20012) showed how carceral governance is imprinted onto women's bodies and embodied in prematurely aged, sick, and mutilated bodies, and that the body remains at the heart of neoliberal penal governance. Building on Grosz (1994), Frigon (2003, 2012) argued that women's bodies "talk back" (p. 131) to carceral governance: the body can simultaneously resist carceral control through various coping strategies, such as self-mutilation or art. Incarcerated women thus resist the attacks of prison on their bodies with

and through their bodies, and their coping strategies are imprinted onto the body and embodied by scars, burns, and tattoos (Frigon, 2012, 2003; Shantz & Frigon, 2010). Building on Frigon's (2003, 2012) and Robert et al.'s (2007) work, I approach the question of the body from a critical perspective in which the centrality of the body to penal governance echoes the centrality of the body in "imperatives to be healthy." Feminist scholars have demonstrated that neoliberal "imperatives to be healthy" constitute a gendered body that is different from (and inferior to) the predominant idealized narrative of a "white," "young" and "male" body (Bordo, 1993; Grosz, 1994; Lorentzen, 2008; Lupton, 1995). Women's physical and mental health are thus pathologized and medicalized, and female bodies are considered to be "problematic" and "weaker" than those of men (Bordo, 1993; Grosz, 1994; Lorentzen, 2009; Ussher, 2010). In brief, as I explore how women do health in prison, I tackle "health," "subjectivity" and "embodiment" as effects of and vehicles for power relations. The following section will explore the data on which this analysis is built.

Methodology and Methods

The present article is built on data that were collected during a study inspired by participatory action research (PAR) methodology. Usually, when using PAR methodology, the researcher and participants jointly develop the complete research project, from establishing the research topic to analyzing and disseminating results (Gaventa & Cornwall, 2008; Reason & Bradbury, 2008; Reid, Tom & Frisby, 2006). As a doctoral student, the implementation of a full-fledged PAR methodology was difficult: the community organization I partnered with requested that I had ethics approval before I started my study, which I could not obtain without having a detailed research project. Thus, I developed a three-tiered project, inspired by PAR.

The first stage of my research was developed as an exploratory phase during which I conducted in-depth semi-structured interviews with 17 formerly incarcerated women on the issue of health during and after incarceration. Of these participants, 15 identified as women, and two as transgender men[10]. All participants were recruited and interviewed at a halfway house. Rather than pre-defining "health," I invited participants to provide me with their own accounts of what "health" meant to them. The interviews focused on participants' experiences of incarceration and how it shaped their self-described health status. Interviews ran from half an hour to two hours, with an average of an hour and a half. Each interview was tape recorded and transcribed. I conducted a first round of thematic analysis in order to highlight the commonalities among the interviews. Although all participants were invited to partake in the analysis of their interviews, only one was interested in engaging in the process.

The second stage of my research project was a focus group with the aim of jointly examining the data collected during the interviews and attempting to "make collective sense of them" (Wilkinson, 2004, p. 277). An additional objective was to develop a common vision of the issue of health in prison and to explore the possibility of conducting collective action on that topic. The initial participants were invited to participate in a focus group run at the halfway house. Of the 17 original participants, 12 could be contacted; five were interested in participating, but only three were able to participate. Using the results of the initial thematic analysis, I presented the ten most common themes in the interviews. The focus group was audiotaped and transcribed. During the focus groups, participants

[10] According to provincial and federal correctional policies, people who are transgender and considered "pre-operative" are placed in facilities according to their gender assigned at birth. These two participants identified themselves as males who are transgender, but were assigned "female" at birth, and were thus incarcerated in a women's prison, regardless of their felt gender.

determined that they were interested in developing a collection of testimonials by and for incarcerated women in order to support women during their incarceration: it was the launching pad for the last phase of the research.

The last phase of the research project was the design and the making of a collection of testimonials by formerly incarcerated women for incarcerated women. As agreed with the original participants, another round of recruitment was conducted at the halfway house in order to collect further testimonials. Ten additional participants were recruited. All testimonials were tape recorded, transcribed, and edited by the original participants and by me. Additional information on community organizations was also included in the collection of testimonials, as was one blank page, on which incarcerated women could write.

Finally, as the research project was completed, I conducted a discourse analysis of all the material collected – the interviews, the focus group, and the testimonials. I chose to use discourse analysis since it allows for an exploration of how socially produced objects, such as "health" or "embodiment," are constituted by power relations, and how they are supported or transformed by these power relations. Specifically, I used Carabine's (2001) multi-step method of conducting discourse analysis in which discourses and counter-discourses as well as discursive strategies are identified, and their effects analyzed. Carabine (2001) also underlined the importance of contextualizing the material and the analysis within the power/knowledge networks of the studied period. It is the product of this analysis that is the subject of the following section.

Results

The opening question for the interviews was about the pursuit of health in prison, and every participant interviewed either laughed or dismissed the question: health was deemed

impossible in prison. For instance, Freddy argued that "Prison made me sick and bipolar," Ange stated that "you just can't be healthy in prison, trust me," and Sydney immediately described how she was "still detoxing from prison." A variety of factors were identified as harmful to prisoners— sanitary conditions, being separated from loved ones, interpersonal conflicts between prisoners —as harmful to prisoners; these issues have previously been identified in the literature (for instance Martin et al., 2009; Plugge et al., 2008). Although all participants were critical of prison, it is important to underline that five participants also said that prison saved their lives, and explained how their life prior to incarceration was chaotic, mostly because of active drug use and periods of homelessness. In Emily's words, "my life was upside down when I went to prison… I was broken, physically and emotionally, and [prison] kinda saved my life." Yet, as she described the stabilizing effects prison had on her physical health by allowing her to eat better and rest, etc., she also questioned how it affected her mental health: "it's not like you can rebuild your emotional health in prison."

Emily's nuanced account of prison's potential to be supportive and helpful to vulnerable women is echoed by many authors, who argue that prisons are not "good" in and of themselves, but, rather, that they are sometimes better than women's chaotic lives outside of prison (see Fields et al., 2008; Giroux & Frigon, 2001; Plugge et al., 2008). In cases such as these, "(j)ail thus becomes a place to get care that is otherwise not available. The bitter injustice is that these women must be in jail and stripped of many rights in order to gain that access" (Fields and al., 2008, p. 79). In line with feminist scholarship on prison (for instance Maidment, 2006), this article tackles the question of health in prison from a critical perspective, contextualizing prison's positive effects within life trajectories marked by poverty, exclusion, homelessness, and drug use.

Although there seems to be quite a consensus on the challenges of doing health in prison, participants described in great detail the strategies they had deployed to either protect their health or attempt to improve it according to their own meanings of "health." These strategies highlighted that, despite a limited field of action due to their confinement, participants could each still find a place to negotiate and adjust to the "imperatives to be healthy." By exploring how participants' coping strategies relate to the imperatives to be healthy, I was able to explore the different embodied subjectivities participants adopted in order to negotiate these imperatives. I positioned these embodied subjectivities on a spectrum ranging from adhesion to conflict with the imperatives to be healthy. I will focus on three issues around which most participants adopted similar embodied subjectivities: weight gain, accessing health care services, and smoking. The purpose here is not here to essentialize the meanings or the experiences of participants around these issues, but, rather, to explore these fluid and dynamic embodied subjectivities, and to use them as tools to critically interrogate how subjects negotiate responsibilizing strategies with respect to their health.

The "Good:" the Imperative Concern with Body Weight

Weight gain in prison was identified as a major concern for all participants in this study, a finding in line with other research conducted with incarcerated women (for instance, see Martin et al., 2013; Plugge et al., 2008). Although their accounts of weight gain varied, as will later be discussed, participants contextualized gaining weight as an important collective problem: "I've seen someone come in skinny like "that", and in 2-3 months, you turn like this [extend her harms laterally] or have a huge belly. What is healthy in that? Why do people become like this?" described Missy. For Freddy, the tendency of incarcerated women

to gain weight was evidence that prison is bad for everyone: "You get sick there—not *sick*, like you're puking—but sick, like you are anxious, and you literally bloat up and get fatter… you just feel awful."

Although most participants argued that weight gain was "unhealthy" for them, five participants described weight gain in prison as positive and healthy. They explained that they were incarcerated at times when they were actively using drugs and had lost significant amounts of weight. In these cases, the women's time in prison and its associated weight gain were viewed positively, because the women felt they were underweight prior to incarceration, which threatened their health. For instance, Lisa said, "When I first went in, I was like a toothpick. My health was awful because I was using a lot [of drugs]. I was using every day. I was an IV user, and, to be honest, I would say it [prison] saved my life because I was way too skinny."

"Healthy" or "unhealthy," weight gain was experienced as a health issue, reflecting the congruence between discourses on slenderness and health—namely that a certain degree of slenderness is a sign of "health." As fat studies have critically assessed, the conflation of health, "fitness" and leanness on one hand, and unhealthiness, excess weight and obesity on the other, is a relatively new social phenomenon. Many authors have demonstrated that the "healthy body" is based on gendered practices and discourses that construct women's idealized bodies as slender and firm, a physical marker connected to wellbeing, health, and attractiveness (Bordo, 1993; LeBesco, 2011;, Lupton, 2012). Body shape is thus read as a function of gendered scripts, increasingly associating slenderness with fitness and self-control, and excess weight with unhealthiness, poor self-regulation and over-indulgence (Bordo, 1993; Lupton, 1995; LeBesco, 2011). Weight gain as a fact of prison life is such a

well-known part of the culture that it has a name: many participants reported carrying a "prison baby," referring to weight mostly gained around their mid-section. For these participants, the "prison baby" is the inscription of women's incarceration onto their body, and it suggests that some female incarcerated body are recognizable, shaped in typical and scripted ways (Shantz & Frigon, 2010; Munn, 2012).

Interestingly, in what seems to be a departure from the narrative of personal responsibility that is part of the imperatives to be healthy, participants did not attribute weight gain to a failure of their self-regulation: they attributed it to prison itself. As such, participants constructed the prison environment as resulting in generalized weight gain for everyone:

> Girls gain 30 pounds in one month. You see, you see them literally bloat up. It's crazy and so unhealthy! For most of them, weight gain is THE issue in prison. Everyone gets bigger, fatter… everyone… I think that is the major health issue. (Gazoula)

Participants explained the collective problem of weight gain as the results of three factors: the predominance of starchy and sugary food, the lack of physical exercise, and the (over)use of psychoactive medications. In provincial prisons, food is prepared by catering services and distributed in each prison's sector. According to participants, prison meals were heavy and starchy, and participants reported feeling bloated after eating. Thalie concluded that "they add starch so you actually gain weight." Physical exercise varied according to participants' correctional status: participants who were able to take part in the employment program were able to go outside twice per day, but the ones who were in the "psych ward," who were awaiting transfer to federal prison, or who did not get a "job" were only allowed

to go outside once per day. As for the gym, many participants reported that it was unevenly accessible due to human resources constrains. In other words, participants had limited opportunities to engage in physical activity. Finally, many participants reported weight gain when they began taking antipsychotic medications, a known side effect for some medication[11].

> Seroquel makes you blow up! And you eat so much after you had it.… You could see the line for the Seroquel, and then, half an hour later, they would be lined up for toasts, eating whatever they could find, binge eating, really. (Madonna)

Despite the fact that they described prison as an environment that causes weight gain and weight gain in prison as inevitable, participants problematized weight gain as a health issue on which they were *individually* required to act. They discussed at great length the strategies they used to control weight gain: Gazoula explained that she did not eat in prison in order to control her weight, Freddy traded cigarettes to have more fruit, Lisa did pushups in her cell, Sydney cleaned the sector many times a day to stay active, Missy used the toaster to attempt to cook food from the "canteen" to increase the variety in her diet, Thalie tried to walk as much as she could outside, etc. These coping strategies are in line with technologies of the self through which participants held themselves accountable for their weight gain. As such, they deployed a subjectivity in concordance with the imperatives to be healthy, despite the fact that they constructed the prison environment as resulting in generalized weight gain and collectively read their bodies as carrying a prison baby. As LeBesco (2011) argued, saying that the environment is causing obesity does not depathologize being overweight; it

[11] For instance, weigh gain has been associated with the use of quietapine fumarate (Seroquel®), which is mentioned in the safety information provides by the manufacturer: http://www.seroquelxr.com (accessed July 8th, 2015)

simply provides an additional etiology for weight gain, namely, the environment. As such, the desire to control one's weight and the self-regulation strategies participants engaged in are in line with neoliberal governmentality: despite an environment that is described as "unhealthy," women are still held accountable for their own health. In attempting to manage their weight, participants adopted an embodied subjectivity that is consistent with the responsible, and self-regulated, slender, and empowerable prisoner.

The "Bad:" Smoking

Whereas the attempts of participants to control their weight gain was in accordance with the imperatives to be healthy, smoking was a coping strategy that clearly contradicted the imperatives to be healthy[12]. Before delving into the topic, I want to underline that the purpose is not here to question the dangers of smoking, but, rather, to interrogate the experiences of people who smoke in prison as a way of coping and dealing with the negative effects of confinement and incarceration, much in the same way that people who self-harm or use drugs. Although smoking cigarettes has clear effects on smokers' health, " [it] may actually be seen, at the individual level at least, as health enhancing if such activities prove resistant to the efforts of health promotion then it is likely because they are an *effect* rather than a *cause* of the problem" (Smith, 2000, p. 349). In other words, as a coping strategy, smoking can help prisoners face the everyday stresses of incarceration.

In this study, all participants but one reported smoking in common areas during their time in prison, as well as smoking in their cells, thus effectively breaching prison by-laws. Participants described how smoking helped them cope with everyday stresses: "I would smoke, and then things would be OK," described Lea. For Thalie, it was a way to escape: "It

[12] It is important to note that participants were incarcerated prior to the 2014 smoking ban in provincial prisons and, although smoking was tolerated, it was allowed only outside, in the prison yard.

made me relax—it was my only escape. And then I could go back to the drama and deal with it."

Studies on smoking have highlighted how smoking is associated with a "break," a time for oneself, especially in groups who are materially deprived (Lupton, 1995). In a carceral setting, there is little opportunity to engage in relaxing activities, and cigarettes may be one of the few available and "effective" option in order to deal with anxiety, depression, and stress (Smith, 2000). Psychoactive drugs that address feelings of depression of anxiety and depression are (overly) available in provincial prisons (Archambault et al., 2013; Kilty, 2012), but they are associated with weight gain, which, as discussed previously, was a concern for participants. Moreover, as Lisa discussed, cigarettes were available for purchase and, if needed, traded on a black market, independently of health services Thus, even if smoking is defined as "bad" and "dangerous," it provided a moment in which time is suspended and stressful emotions can effectively be dealt with,

> I needed… it is like somewhere to put my energy [laugh], to, to, stress out, it does help [fakes smoking] yes, it does help, you know. [Laughter]. You know, I know, "smoking kills you," but it is the only way to the take stress away, and stress, that kills you too, man. (Missy)

Missy's account of smoking in prison underlines how smoking transfers stress from the inner world to the outside, hinting that smoking is more than a suspension of time. As Klein (1993) argued, smoking is, paradoxically, a form of release and control: by releasing the smoke and the stress, one can regain composure and control over one's emotions. Of course, the physiological effects of nicotine play a role in the pleasurable aspects of smoking, but pleasure also stems from these effects' symbolic nature: cigarettes defeat

feelings of anxiety and stress because they bind these feelings to the cigarette: as the cigarette is inhaled, consumed, and thrown away, so are these feelings (Klein, 1993). Thus, smoking is not only a way to take a break, but to discharge negative emotions or, as Missy described, to get rid of her energy "somewhere." Missy's descriptions of her smoking habits in prison also highlight that she is well aware of health promotion around cigarette use, as well as health promotion messaging around stress. As both can potentially kill, she used cigarettes to deal with stress and, in doing so, she effectively takes care of herself and her wellbeing. Thus, smoking provided her with an embodied subjectivity that allowed her to deal with stress through sensual pleasure, while, simultaneously, recognizing its harmful effects.

In health promotion messaging, the pleasurable side of cigarettes is associated with its addictive potency, and health promotion messaging around smoking assumes that smokers are "out of control" and that they cannot say "no" to cigarettes and need psychological or pharmaceutical help and support (Lupton, 1995; Snowdon, 2009). As addiction is a "disease of the will," addiction to cigarettes is a failure to self-regulate (Lupton, 1995). Yet, participants' accounts of their smoking in prison described smoking as a planned and well-thought out activity. As incarcerated women used to have access to two pack of cigarettes per week, they reported budgeting and planning their use. Moreover, as cigarettes are used as a carceral "currency," some participants demonstrated high levels of entrepreneurship in acquiring and exchanging cigarettes,

> I trained myself to smoke less. I was smoking 3 smokes a day. When you budget your smokes for the week, you know that if you have one more one day, you have one less tomorrow. I used to put my seven smokes in another pack, for

> the day. You see their number go down… Since I trained myself to smoke 3, I always had some smokes. The other girls sold me their clothes, shoes… some would even do chores for a few smokes. (Lea)

Lea's account clashes with the "out of control" narratives about smoking: she demonstrated self-regulation in managing her cigarettes, balancing her urges to smoke and her ability to acquire goods. In doing so, she engaged with technologies of the self, such as self-regulation and self-control, embodying the neoliberal ideals of entrepreneurship in her management of her cigarettes. Thus, in smoking and, in some cases, in trading cigarettes, participants adopted an embodied subjectivity that allowed them to take care of themselves and deal with their stress, as well as provided them with sensual pleasure. It also provided them with an opportunity to improve their everyday life through trade, which is also in line with neoliberal govermentality.

Although the imperatives to be healthy construct smoking as dangerous to one's health and a sign of a disease of the will, participants smoked to deal with their stress through sensual pleasure, and they managed smoking through technologies of the self that are congruent with neoliberal governmentality. Thus, what were the effects of such incongruence on participants? As smoking is considered a sign of weakness, a failure to subscribe to a healthy lifestyle, it is internalized as a *personal* failure to uphold the health imperative (Crawford, 1980; Lupton, 1995). The internalization of shame and discomfort regarding smoking was reiterated at every smoke break during the interviews, the focus groups and subsequent meetings. Whenever a cigarette break was needed, participants explained they wanted to quit, that they were in the process of breaking their "addiction." As I was pregnant at the times of the interview, many participants, significantly, stepped away

from me when they smoked, even when they were smoking outside, and expressed their concerns about second-hand smoke, assuming I was not smoking during my pregnancy.

Before going further, it is important to contextualize smoking during incarceration. Although smoking inside is clearly forbidden by prison bylaws, no participant recounted being forced to stop smoking inside her sector. As discussed earlier, other forms of power—disciplinary, coercive—could have be deployed to prevent participants from smoking, but, in fact, most participants argued that smoking was tolerated inside, if done discreetly. One can assume that, with the provincial smoking ban[13], the contexts in which incarcerated women can smoke have radically changed, and that, now, coercive techniques of power are deployed to prevent women from smoking.

The "Ugly:" the Good Patient and the Bad Patient

Whereas the previous section focused on embodied subject locations that either were counter to or in accordance with the imperatives to be healthy, this section looks at how participants alternated between discordance with to accordance to the imperatives to be healthy around one specific issue—medical care from health care services. As will be discussed, the "ugliness" stems from the effects of the balancing act participants have to engage in to get access to health care. To illustrate this point, this section will focus on Madonna's story about accessing and receiving health care in prison.

Health care services are responsible for providing all over-the-counter products and hygiene products, as well as approving any special diets, such as vegetarian food, diabetes-friendly food, etc., —and even the provision of additional pillows. For this reason, in order to take care of themselves through non-medical strategies such as the ones that they were

[13] Since June 2014, Quebec enacted a total smoking ban in all provincial prisons: smoking is since forbidden in and out of prison. It was the last Canadian province to do so (Collier, 2013).

engaging in "outside," incarcerated women have to regularly consult with and interact with the medical team[14]. Thus, although prisoners are incited to be responsible for their health, they also are deprived of the autonomy to exercise choices: strategies of self-care are thus overtly medicalized in the prison environment (Robert, 2008; Robert et al, 2007).

Madonna had been in a car accident many years ago. She compared herself to a broken jar. Since her accident, she had been dealing with severe chronic pain and she had learned to manage her pain in an "efficient" manner, with adequate medications and multiple "non-medical" tools, such as therapeutic beds and pillows. As she was transferred repeatedly from one detention center to another, her medical prescriptions did not follow along—a common issue (see Quebec Ombudsman, 2013); as for her non-medical tools, she had access to none. After a month in prison, she finally met with the doctor and described her health status to him:

> I told him about the accident, all of it, and then… he saw my scar, I showed him the scar on my hip. He told me: "I'm going to send you for an X-ray." I said: "you don't need an X-ray! Just, you know, ask for my hospital file! It's a lot simpler, you're going to get all the details about my operations!" [Yelling].

Feminist scholars have examined how women's experiences and knowledge have been discredited by the health profession (for instance, Lorenzten, 2008). As a labeled criminal woman, as an at-risk and risky body, Madonna's claim of knowledge of her medical history was discarded, even though it was imprinted onto her body. From the onset, Madonna played the role of the "good patient," who explained, discussed and disclosed her health

[14] In provincial prisons, health professionals who provide health care services are sent by the local community health center; they are not members of correctional services (contrary to federal prisons).

issues, displaying discipline in front of the medical gaze, yet the doctor still requested the use of an "objective" diagnostic tool. At the end of the meeting, Madonna obtained a prescription for acetaminophen, a medication with significantly weaker pain alleviation effects than her previous medication. Moreover, without her therapeutic bed and pillows, her pain level became significantly higher.

Later on, she experienced liver pain. She had liver issues prior to her incarceration, and she explained that she knew that acetaminophen could be harmful to people with liver issues[15]. She asked the nurse for alternative over-the-counter medication. The nurse refused and suggested something else, which Madonna claimed she could have an allergic reaction to. As she was allegedly resisting treatment, the nurse threatened to take away her access to health care services. Consequently, Madonna decided to take the medication, to show the nurse the allergic reaction,

> I took the pill, did a memo and told a guard I took it. I said: "I have to see you, the allergic reaction has started." My feet were huge like basketballs! Basketballs! I freaked out. It was hurting so much…my skin… [shows her skin stretching…]…it was crazy, just crazy! All the girls in the wing freaked out, it was absolutely crazy… so, then, she [nurse] said "ok."

In this section of her story, Madonna showed how she used her knowledge of her body to discredit the nurse's truth claims. In a study of women's experiences of medical interactions, Lorentzen (2008) examined how women counterbalance their doctors' denials of their experiences by mobilizing other forms of knowledge—knowledge from friends and family or lay knowledge—as well as by consulting other health professionals. In this case,

[15] The manufacturer warns against severe or possibly fatal liver damage in case of overdose, and warns against using acetaminophen when having major liver issues. The manufacturer's website is: http://www.tylenol.ca/adult-pain-relief/regular-strength-tylenol (accessed July 8th, 2015).

Madonna had limited access to other forms of knowledge, and she could not access other health professionals: she only had herself. In fact, she used her body as a surface on which she inscribed her experiential knowledge. Her strategy was to literally imprint on her body her own interpretation of her body to demonstrate that the nurse's interpretation was inaccurate. In doing so, she engaged with responsibilization by taking responsibility for accessing the right medical treatment. As a rational subject, she calculated the risk and minimized potential harm: she took the pill during the week, in the morning, so she could access health care services rapidly, and advised a friendly guard that she could have a reaction. In deploying that strategy of self-responsibilization, Madonna was able to prove that she was right, that her truth claims were right, using her only resource: her body. In doing so, she was also an "irresponsible" patient because she put her health at risk and "chose" to harm herself. Consequently, even if Madonna adopted an embodied subjectivity that is in line with neoliberal ideals of responsibility and self-care, she failed to convince the nurse that she was knowledgeable about her own body and health status, and thus adopted a strategy that is in opposition with the imperatives to be healthy, namely putting her health at risk. Of course, this story does not cover the complexities and intricacies of the government of women's health in prison: it does, however, illustrate the detrimental effects of engaging with responsibilization strategies in a context that thwarts and limits attempts at autonomy and self-reliance.

Conclusion

The objective of this article was to critically interrogate the imperatives to be healthy in an environment characterized by its unhealthiness by looking at the embodied subjectivities participants have deployed during their time in prison. By examining three issues (weight

gain, smoking, and accessing health care services), the spectrum of available embodied subjectivities was explored. In congruence with Moore and Hirai (2014), I thus illustrated how neoliberal technologies of government of the self do not shape one embodied subject location, but, rather, multiple embodied subject locations. Yet, I also showed that, even when they adopt embodied subjectivities that are aligned with the imperatives to be healthy, such as attempting to control weight or requesting medical care, the failure to attain neoliberal goals had serious effects on participants. In the case of weight gain, participants expressed guilt and a sense of failure at not being able to maintain a "healthy" weight; in the case of medical encounters, participants recalled not being trusted by medical staff and, in some cases, they engaged in what they considered to be dangerous behaviours order to demonstrate that they also held expertise about their own bodies and health. As participants described, acting in opposition to the imperatives to be healthy had some benefits: smoking allowed them to cope with the stress and anxiety of prison, but, as they were well aware, it could also have long-lasting, serious and negative effects on their health. This article examined the conundrum of doing health in prison. Further work is needed to explore how specific issues such as race, ethnicity, age, and sexual orientation, as well as the level of "risk" attributed to women, by correctional tools, whose experiences of the criminal justice system and their prior experiences with prison, shape and limit the field of embodied subjectivities available to incarcerated women.

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Chapter 4

Unearthing Ourselves upon Prison Release:

Corporal Practices and the Pursuit of Health

Abstract

Recent feminist scholarship on prison release has demonstrated that upon incarcerated women's release from prison, they are not quite free from the criminal justice system, as they carry with them the imprint of their time spent in prison. Using data from interviews and focus group from a study informed by participatory action research, this article explores how participants attempted to "undo" the imprint of penal governance on their bodies and health. Through the exploration of corporal practices, such as taking care of their appearance, using psychoactive medications, and defecating, this article shows how women attempt to "undo" prison in order to pursue health. It concludes that corporal practices may help them to partially unearth themselves from prison.

Key words: prison release, health, women, post-incarceration, corporal practices, governmentality, embodiment

Introduction

The expression "unearthing ourselves" comes from a focus group I conducted with women who had been released from prison. The purpose of the focus group was, among others things to better understand how incarceration hasdshaped and continued to shape women's experiences of health. As the women explored what it meant to them to preserve and maintain health in prison, one participant stated that "being in prison is like being buried alive." This statement was a turning point in the focus group: every participant nodded and all immediately adopted this figure of speech. "Being buried alive" speaks loudly to the embodied experiences of women in prison, but it also implies that time after prison is a time in which participants excavate themselves. Throughout the study, participants shared and disclosed their everyday struggles, such as finding a job, dealing with illnesses, rekindling relationships, etc. A second metaphor thus emerged; participants described their prison release as period during which they were "unearthing themselves from prison," "shaking prison off," and "getting rid of its smell, its sounds, its looks."

The image of being buried alive finds echoes within the critical literature on women, incarceration and health. Feminist scholars have explored how penal governance is gendered in Canada (Hannah-Moffat, 2001) and racialized (Brassard, Giroux & Lamothe-Gagnon, 2011; Office of the correctional investigator, 2013), and have documented its effects on women, focusing on women's bodies (Frigon, 2003, 2012; Shantz & Frigon, 2010), identities (Bosworth, 1999), and health (Robert, Frigon, & Belzile, 2007; Robert & Frigon, 2006; Smith, 2000). Critical studies on health and incarceration have problematized women's poor health status as the result of prison living conditions, including overcrowding

and a lack of appropriate medical care (Irwin & Owen, 2005), as well as resulting from the intersection of abuse, poverty, homelessness, and addiction that are, simultaneously, pathways to criminalization (Maidment, 2006) and to poor physical and mental health (Robert et al., 2007; Robert & Frigon, 2006; Smith, 2000). Frigon (2003) demonstrated how this intersection is made concrete through the "sick and mutilated [incarcerated] body" (p.145), mutilated through illnesses and victimization, as well as through the pains of incarceration—loss of intimacy, of control and agency over one's life.

Few studies have explored the "unearthing" process that follows incarceration, with the notable exceptions of Maidment (2006), Pollack (2009), Shantz and Frigon (2010, 2009), and Shantz et al. (2009). In her analysis of the different regimes of control (i.e. state and localized), Maidment (2006) showed that upon release, women are far from being "free," as they are disciplined through the criminal justice system and localized control, such as halfway houses, and governed through their personal accountability to reintegrate and surmount the structural challenges they face. Focusing on women's bodies, identities and experiences, Shantz et al. (2009) and Shantz and Frigon (2010, 2009) demonstrated that carceral rationalities and technologies are imprinted onto women's bodies and minds and continue to affect their everyday lives: "everyday reminders of the prison are chained to their bodies, which they are unable to fully reclaim as their own" (Shantz & Frigon, 2010, p. 14). In brief, studies from Maidment (2006), Shantz and Frigon (2010, 2009) and Shantz et al. (2009) showed that, although prison release is a time of emancipation, not only women are under both the direct and indirect control of the criminal justice system, but they also carry the imprints of their time in prison. In other words, the literature sheds a nuanced light

on the process of the "unearthing" of the self; prison cannot be completely shaken off by women.

In line with the aforementioned studies, this paper focuses on the issue of health upon prison release, and how women attempt to unearth themselves. In the study of health, the "body" is "evidence," as we experience health through our corporeality (Lupton, 2012). I do not approach corporal practices in terms of what is "good" or "bad" for one's health upon prison release, but, rather, as social practices that embody and are shaped by social and cultural contexts. I thus engage with the critical literature on health, which problematizes health as something we do, rather than something that is "found" or something we passively endure. Rose (2007, 1999), Lupton (2012, 1995), Aïach (2009)—to name a few—have approached health as a site for the reproduction of power relations, the construction of subjectivity, and of human embodiment. Recent work on neoliberal governmentality has stressed how, through New Public Health, technologies and discourses produce a certain type of subject—self-regulated, self-conscious and rational, and a certain type of body—a civilized body that is constrained by the will (Aïach, 2009; Lupton, 1995; Petersen & Bunton, 1997; Rose, 1999). Problematizing health as a mechanism through which neoliberal subjects are "governed at a distance" and are "required" to act, I thus explore how women engage with the "imperatives to be healthy" upon prison release.

This paper departs from other studies on incarcerated women's bodies or ex-prisoners' identities or bodies, as its object of analysis is corporal practice. Corporal practices are literally "what we do with our bodies" (LeBreton, 2010), and I will use this angle to bridge mental health and physical health, as well as the "inside" and the "outside" of the body. Before delving into the topic, I will briefly explore the theoretical ramifications of studying

the "body." and then draw a brief portrait of the governance of formerly incarcerated women. After briefly outlining the research project, I will describe and analyze corporal practices that participants used in order to face issues relating to their health upon prison release, as well as the effects of these practices in terms of the participants' unearthing themselves after prison.

Corporal Practices, Body, and Health

Corporal practices relate to a subject's corporeality, that is, essentially what one does with one's body (Le Breton, 2010); it includes practices such as etiquette, body language, expression of feelings, and sensory perceptions. Some corporal practices—body piercing, applying makeup—are obvious visual markers of how social and cultural practices imprint the body (Grosz, 1994; Le Breton, 2010). More subtly, corporal practices such as hygiene, diet, exercise, constitute the so-called biological organization of the "body" (Frigon , 2003; Grosz, 1994; Le Breton, 2010). While defining corporal practices, Le Breton (2010) constantly referred to the ambiguity and the instability of the body: its boundaries, its relations with the "self" and with "others," its movements, its shapes, and its sensations are socially constituted and mediated. The gendered, racialized, young, or old body never "presents" itself in its "natural" or "true" form (Bordo, 1993; Grosz, 1994; Le Breton, 2010): there is no "body" to define, rather, there are "bodies" that are constituted by the interplay of discourses and practices (Bordo, 1993;, Frigon, 2012, 2003; Grosz, 1994; LeBreton, 2010). Consequently, the study of corporal practices relates to a critical appraisal of how these practices are gendered and racialized, and are articulated in relation to social classes, embedded within a specific historical and cultural context.

As the body is approached as a social and historical construct, it is possible to fall into the trap that the body becomes only "text," a "blank" surface that passively awaits social inscription (For a critique, see McNay (2000) or Grosz (1994)). Feminist scholarship led to a conceptualization of the body as a cultural and social product, hence a receiver of meaning, but also as an active "transceiver," thus accounting for the material aspect of corporeality (Bordo, 1993; Frigon, 2012, 2003; Grosz, 1994; McNay, 2000). In other words, our experiences of embodiment and our bodies are not exclusively constituted by discursive articulations: "The 'body' talks back," as Frigon (2003, p. 131) argued. As McNay (2000) underlined, the main challenge in writing about the "body" as a historical and social construct and as a material object is to integrate both approaches and to account for their interactions. Relying on Grosz' (1994) metaphor of the Möbius strip (the inverted three-dimensional figure eight), I approach the culturally and socially constituted body and its materiality neither as opposites, nor as two sides of the same coin, "but somewhere in between these two alternatives" (p. xii) in which both are productive of and produced by the other. Consequently, what we "do" with our bodies is neither "natural" nor "automatic:" how we sleep, eat, walk, run—all forms of corporal practices—are embedded within specific social, cultural, and historical contexts, and embodied in a materiality that also shapes that context.

According to Bordo (1993), two angles of analysis can be used to approach bodies as social and historical constructs, as well as material entities. The first angle focuses on the "regulated body," namely, techniques and rationalities that produce bodies through programs, practices, politics, divisions of space and time, and discourses, constituting "idealized" bodies (see, for instance, Lupton (2012) for the healthy body; Frigon (2003) for

the regulated body of the prisoner). From that perspective, the study of corporal practices focuses on their rationalities or their disciplinary and/or governmental effects. The second angle focuses on the "lived body," namely "bodies that are experienced across time and space, and emerge as sites of social interaction" (Brucker & Munn, 2010, p. 237). In this approach, the focus is on the *lived* experiences of subjects in order to understand how embodied subjects negotiate, cope, follow, and resist power relations within a specific historical and social context. The purpose here is not essentialize experience, but, rather, to assess how power relations manifest themselves in the lived reality of subjects. In other words, the notion of the "lived body" is a conceptual tool that aims to emphasize that bodies are sites of experiences for subjects; corporal practices are thus approached as strategies that individuals deploy in their everyday lives, strategies that are embedded and constituted by power relations, and enacted by the subjects.

This paper departs from the experiences of formerly incarcerated women as its object of study is the "lived body." However, a study of lived bodies cannot be done without an examination of the contexts in which the bodies lived and live; thus, a description of the technologies and discourses that constitute the regulated body is necessary. As Bordo (1993) argued, the "lived body" and the "regulated body" do not constitute a dichotomy, nor are they the mirror of one another; rather, they "fold" into one another, with different effects and tensions. In other words, by exploring the regulated body, I will explore the field of power relations that shapes and constitutes women's experiences and in which different possibilities of subject positions arise. The following section will examine how women are punished, disciplined and governed at a distance upon prison release.

Prison's aftermath: "reintegration," transcarceration, and the "freed" body

Feminist scholars who have explored women's experiences of incarceration have demonstrated how penal governance is imprinted onto and enacted by prisoners' bodies (Frigon, 2012, 2003; Shantz & Frigon, 2010, 2009; Shantz et al., 2009). The coercive deployment of power, through degradation ceremonies, such as strip searches and cavity searches, dehumanize the prisoner and contribute to a sense of loss of one's bodily integrity (Frigon, 2012, 2003; Irwin & Owen, 2005), as well as (re)victimize women, especially those who have experienced abuse (Frigon, 2012; Kilty, 2012; Maidment, 2006; Pollack, 2005). Through the strict regulation of prisoners' time and space, disciplinary discourses and practices of power produce docile prisoners, who internalize disciplinary routines (Bosworth, 1999; Frigon, 2012, 2003). Additionally, prisoners are governed "at a distance" through projects of self-fashioning, constituting them as empowerable and responsible subjects (Hannah-Moffat, 2001). As neoliberal discourses and practices demand a responsibilization of citizens with respect to their own health, incarcerated women are thus made into subjects who are held to be responsible for their own health and their criminal past, as demonstrated by their engagement in listening and following professional advices, especially from those in the health field (Kilty, 2012; Pollack, 2005; Robert & Frigon, 2006). With respect to health, incarcerated women 's regulated bodies of are thus disciplined, in line with correctional routines, and held responsible and accountable for their own wellbeing: failure to behave in accordance with this ideal leads to the mobilization of disciplinary or coercive technologies of power (Hannah-Moffat, 2001; Kilty, 2012; Robert & Frigon, 2006).

Upon release from prison, according to correctional discourses, former prisoners enjoy a greater freedom than they did inside prison walls, and they can "reintegrate" into the community to live law-abiding lives. Scholars have critically dissected the concept of reintegration, underlying three key issues. First, reintegration presupposes that women were integrated into society prior to their incarceration, an assumption that is difficult to sustain since the pathways to criminalization, such as poverty, drug use, and sexual and/or physical abuse, are also pathways of exclusion and marginalization (Maidment, 2006). Thus, rather than "re-integrating", formerly incarcerated women attempt to integrate into society (Shantz et al., 2009). Second, according to Hannah-Moffat (2001), the notion of the "community" is itself embedded within neoliberal technologies: as the former prisoner is held accountable for her reintegration, so is the community, which has a shared responsibility for reintegration. The state has thus relayed part of its responsibility to community agencies and, simultaneously, established a mode of governing former prisoners at a distance, as will be later discussed. Lastly, Maidment (2006) underlined how the milestones of a "successful reintegration" have different meanings according to correctional discourses and ex-prisoners' experiences. She demonstrated how correctional discourses defined successful reintegration in terms of the absence of recidivism, whereas ex-prisoners defined it as periods of independent living that could be followed by further involvement with the criminal justice system. In brief, although women are "out" of prison, this does not necessarily equate with reintegration or, for that matter, integration into the community, as defined by correctional authorities.

The claim that women are "freed" from prison is also a problematic notion, as prison release does not necessarily equate with "freedom" from the criminal justice system. As

women are released on parole, their "freedom" is often accompanied by strict conditions, for instance, mandatory therapies, curfews, etc., as well as police surveillance (Turnbull & Hannah-Moffat, 2009). Additionally, through the "deinstitutionalization" of the management of prisoner populations through organizational agreements with other state agencies—welfare, social services, education—and community organizations, the techniques and strategies of the correctional system have spread well beyond the prison walls, a phenomenon called **"**transcarceration" (Maidment, 2006). Maidment (2006) demonstrated how transcarceration is gendered, emphasizing how specific groups of criminalized women, such as "unfit" mothers or women with psychiatric labels, are subjected to greater levels of controls.

As the research was conducted in a halfway house, it is important to emphasise that halfway houses are sites of transcarceration, despite being supportive and liberal in their approach toward criminalized women. As non-profit organizations, halfway houses are highly dependent on funding from Correctional Service Canada (CSC) and Quebec's Correction Services: they have to adopt practices that are compatible with CSC and, in certain cases, aligned with correctional practices (Kilty & Devellis, 2010; Maidment, 2006). Through documenting women's movement in, out, and within the halfway house, as well as regulating women's use of their psychiatric medications, halfway houses' staff thus engage in the surveillance and disciplining of women similar to what ex-prisoners encountered in prison (Kilty & Devellis, 2010). Thus, even after women are released from prison, they are not freed from the disciplinary and normalizing carceral gaze. Consequently, although women have lower rates of recidivism than men, both at the federal and provincial/territorial

levels, the fact remains that ex-prisoners are faced with "extended intrusion into [their] so-called private lives" (Maidment, 2006, p. 143).

The discussion about (re)integration and transcarceration has shown how the bodies of formerly incarcerated women are regulated, disciplined and governed, but it leaves open the question of how women experience prison release, namely the question of their lived bodies. As incarceration is an embodied experience, so is prison release: the former prisoner still embodies and enacts penal governance (Brucker & Munn, 2010; Shantz & Frigon, 2010, 2009; Shantz et al., 2009). In their study of the (after)effects of imprisonment in prisoners' lives, Shantz et al. (2009) used the term dislocation "to refer to the displacement, disturbance, movement, rearrangement, or shift in place, space, and time of women integrating from prison back into the community" (p. 94). The lived bodies of formerly incarcerated women are dislocated on multiple levels. First, incarcerated women (especially those who were incarcerated for long periods of time) embody and enact disciplinary routines while they are incarcerated, such as eating, sleeping, and showering at specific times. The opportunity for them to be relieved of these constrains can lead to feelings ranging from uneasiness and anxiety to depression (Shantz & Frigon, 2010, 2009; Shantz et al., 2009 Maidment, 2006). Second, women's bodies often carry visible marks of incarceration in the form of tattoos, scars, or premature aging (Shantz & Frigon, 2010, 2009; Shantz et al., 2009). As their bodies can be potentially read and interpreted as those of ex-prisoners, women feel as out of place, marginalized and excluded from society (Brucker & Munn, 2010; Shantz & Frigon, 2010, 2009; Shantz et al., 2009). Additionally, as prisoners are literally cut off from their loved ones and society for a period of time, interactions in "normal" social settings—such as while taking the bus, walking in the street, and/or grocery

shopping—can, in fact, be a source of great stress and distress for formerly incarcerated prisoners (Brucker & Munn, 2010; Shantz & Frigon, 2010, 2009). In brief, as the prisoner is released from prison, she still carries with her predetermined scripts from prison, which dictate how to behave, think, and act. As she moves back into the community, not only are these scripts not longer relevant, but they carry with them the stigma associated with being a criminal. The lived body of the formerly incarcerated women is thus dislocated, in the sense that it does not belong to prison anymore, nor does it belong to society: "like the last piece of a puzzle that does not fit in the place allotted" (Shantz et al. 2009, p. 97). Before exploring how participants in this study managed this dislocation, I will briefly describe the study.

Methodology

The data for this paper came from a doctoral research project inspired by participatory action research (PAR) methodology. The research project focused on how women who have been incarcerated have defined, constructed, and managed their health during their time in prison and upon prison release. The project took place in three stages, over the course of a year and a half, and was approved by the Research Ethics Board from the University of Ottawa. The first phase of research gathered data relative to ex-prisoners' experiences of health during and after incarceration by using semi-structured interviews. The second stage took the form of a focus group with the objective of engaging participants in a collective analysis of the material gathered during the interviews (Wilkinson, 2004), as well as brainstorming about potential collective actions that the group could undertake on the topic of health and incarceration. The rationale was to enable the focus group to be a

launching pad for a collective action. The third stage was the planning and the implementation of the collective project, as defined by the participants.

For all three phases, participants were recruited at a halfway house. For the first phase, fifteen women and two transgender men participated. Interviews ranged in length from an hour and a half to two hours. Participants were invited to analyze their interviews, but only one person engaged in the process. In order to prepare for the focus group, I conducted a thematic analysis of the interviews, as the purpose of the focus group was to collectively make sense of the material gathered during the interviews. For the focus group, I was able to contact twelve of the original participants: five were interested and three were available to participate in the focus group. As described in the introduction, it is during this focus group that the expression "unearthing ourselves" came up and, as described earlier, it permeated our talk. After two additional brainstorming sessions, participants agreed that they would reach out to incarcerated women through a booklet, which would include a collection of testimonials from women who experienced incarceration. The last phase of research thus focused on the creation of the booklet targeting incarcerated women. Following approval from the Research Ethics Board from the University of Ottawa, ten additional participants were recruited at the halfway house to provide testimonials for the booklet. As the testimonials were audio recorded, participants in the focus group and I transcribed them and adapted them for the booklet.

The data on which this article is built comes from the three phases of the research project, specifically, the interviews, the focus group, and the testimonials. Upon completion of the research project, I conducted a discourse analysis of all the material collected, interrogating not only the issues that were identified as constraining health, but also how

they were constituted as problems within a specific historical and social context. In order to conduct my analysis, I used Carabine's (2001) multi-step method of discourse analysis in which discourses and counter-discourses are identified, as well as discursive strategies and their effects. Carabine also underlined the importance of contextualizing the material and the analysis within the power/knowledge networks. The product of this analysis is the subject of the following section.

Results

The pursuit of health was one of the main issues participants reported having upon prison release, a result consistent with other studies. All participants reported being concerned with or actively attempting to alleviate health issues that were undiagnosed or untreated during their incarceration (such as cancer, dental pain, food intolerance) or which arise in the days following their incarceration (such as psychotic syndromes, back pain). They also reported that during their time in prison, health problems (such as high cholesterol, psychiatric illness, chronic pain, etc.) that were existent prior to their incarceration were not treated adequately because of prison constraints, and prison release was the opportunity to engage in treatment without the constraint of prison.

Before presenting the results, it is important to underline two key issues that underlie this discussion: "health" gendered effects, and the divide between mental and physical health. Many feminist authors have demonstrated that discourses and practices of "health" women constitutes a gendered body that is different from (and inferior to) the predominant idealized narrative of a "white," "young" and "male" body (Bordo, 1993; Grosz, 1994; Lorentzen, 2008). Women's physical and mental health are thus pathologized and medicalized by biomedical discourses and practices; female bodies and minds are

considered to be "problematic" and "weaker." Consequently, women are represented as more prone to illness than men, and as more dependent of medical care through various life stages (childbearing, menopause, etc.) (Bordo, 1993; Lorentzen, 2009; Lupton, 2012; Ussher, 2010). As I conducted my analysis, I paid specific attention to the "healthification" of the women's discourses, and I attempted to interrogate what corporal practices said about the prominent narratives on "health."

I also want to stress that I chose to discuss the topics that were emphasized by participants, namely, physical and mental health. As I engaged in a critical analysis of "health" and a theorization of the body grounded in poststructuralism and feminism, such a division may seem contradictory, as it reflects biomedical discourses that rely on the Cartesian mind-body divide, with physical health tied to corporeality and mental health stemming from illnesses of the "mind." The purpose here is not so much to reflect the distinction between corporal practices that deal with physical health or mental health separately, but rather to highlight their similarities and their groundings in the corporeality of the body—understood here as "an interface between the social and the individual, nature and culture, the physiological and the symbolic[16]" (LeBreton, 2010, p. 120). Thus, as I discuss corporal practices that tackle physical health issues, such as constipation, and mental health, such as taking medication and taking care of one's appearance, I want to highlight the relevance of relying on corporal practices in interrogating the dichotomy of the mind/body.

This paper focuses on corporal practices that participants themselves articulated in relation to their past incarceration, and which were shared by a majority of participants.

[16] Translated by the author.

Specifically, I focus on those associated with the process of "unburying" oneself in terms of health by attempting to getting rid of the health-related aftereffects of prison. In doing so, I will highlight the effects of these practices on participants. The following results are presented in term of a spectrum ranging from corporal practices that have the effect of excavating prisoners from their time in prison to those that have a mixed effect.

Getting Rid of Prison's Constraints

As reported in other studies (Giroux & Frigon, 2011), many participants in this study described constipation as health issue caused by incarceration. Although constipation may seem to be a minor ailment, chronic constipation can lead to substantial abdominal pain, vomiting, weight loss, haemorrhoids, anal fissures and, in the most extreme case, rectal prolapse, bowel perforation, and fecal impaction (Canadian Digestive Health Foundation, 2015). Participants explained that a lack of fibre and exercise contributed to their constipation but, most importantly, they complained of the lack of a private space to defecate. Participants' worries and concerns around defecation and private space are consistent with a study conducted by Weinberg and Williams (2005) in which they explored the gendered expectations around defecation and flatulence. By interviewing students, they demonstrated how these corporal practices, although inescapable biological imperatives, are mediated by gendered discourses and practices. In their study, female participants were more likely to be ashamed of these practices and engage in elaborate corporal strategies to ensure they would defecate as discreetly as possible. Participants in this study displayed similar behaviours, but were limited by the architectural setup of provincial prison: incarcerated women do not have access to private bathrooms and, when confined to their

shared cells, they have access only to a toilet bowl, without any privacy. The shame and humiliation of defecating in public was raised in the focus group,

> L: The worst, really, is when you have to poop in the middle of the night. When you take a dump, and you know your cellmate heard everything…
> T: And then, it wakes her up, and she gives you shit! [Laughter]
> N: And then you flush, and that wakes up the whole wing, and then everyone is upset. But you have no choice—what are you gonna do? It's a full door, you can't open the windows, the air doesn't move, but you just don't want to keep the smell inside.
> L: Basically, the day after, you have to apologize for the fact that you pooped at night, to your cellmate and the whole wing… Hello humiliation!

In order to avoid humiliation, incarcerated women may postpone defecation until "appropriate times," which can result in aggravated constipation. As I explained in chapter 3, many minor physical ailments, such as constipation, are overly medicalized, because incarcerated women have limited access to non-medicalized strategies of self-care, such as changing their diets, exercising more, etc. Thus, as Sydney stated, "they give your those little pills so you can go to the washroom. Everyone has them." The long-term use of laxatives, though, can lead to the loss of normal bowel function (Canadian Digestive Health Foundation, 2015).

Upon prison release, participants in this research project clearly expressed their relief in being able to defecate privately. In the interviews, while talking about feeling bloated and

being constipated in prison, participants mentioned, in passing, how that was not an issue anymore once they arrived at the halfway house: "my pipes are finally working here," as Sydney explained; "everything works well now," said Skye. In this case, the corporal practice of defecating privately has the effect of excavating participants from prison, as it allows them to be freed from one of the effects stemming from prison's constraints. The following section raises the question of the limitation of corporal practices.

Undoing Prison's Imprint

Corporal practices relating to appearance may seem unrelated to the question of health, but, in the carceral setting, appearances are closely tied to mental health. The inability to make decisions about everyday activities, including where to go, what to eat, which hygiene products to use, or what to wear, is an important source of frustration and anxiety among prisoners, and has been extensively discussed within the literature on prison (for instance, Sykes (1958); for women, Bosworth (1999)). During their incarceration, prisoners' corporal practices relating to appearances are constrained: the times during which they can access washrooms and showers are regulated, the types of products they can access are limited, and certain embodied practices of care are strictly controlled or forbidden, including shaving. Consequently, prisoners feel disconnected or alienated from themselves, which has an adverse effect on their wellbeing: "you just never feel OK, never feel right, never like yourself" explained Freddy.

The effect of the loss of control over one's appearance is particularly evident for participants who identified as transgender men[17]. As they were incarcerated in a prison for

[17] Both such participants were preoperative female-to-male trans men. As they did not have the gender reassignment surgery, they were incarcarated according to their gender assigned at birth.

women, they had limited access to hygiene products for men, and experienced these problems of access as attacks on their bodily integrity. They talked at length about their discomfort at not being able to present themselves in a way true to themselves: "when I had hygienic products for women, I felt disrespected. It was the end of me." said Jimmy. Although he underlined that, in recent years, prison staff were increasingly sensitive to trans issues, he further explained,

> Fed up, I was just fed up. But when you're in prison, you have no choice. I was just beyond myself [about not having products for men]. But what are you going to do? You are in a prison for women. Tell them to fuck off? You're going in the hole.

Jimmy's description of his feelings of rage and depression reminds us that the body is read and deciphered according to gender norms (Bordo, 2003; LeBreton, 2010). Despite Jimmy's enactment of his masculinity by his demeanour and his use of a male name—according to him, a name that was used by most prison staff and prisoners—his appearance was, in fact, confining him to femininity. Jimmy's forced femininity was a source of great pain for him yet, as he underlined, he had limited opportunities to express his anger, as he could be punished by being sent to solitary confinement ("the hole.")

Jimmy's arrival at the halfway house was a great relief for him because he regained control over his appearance. This feeling of relief was echoed by all participant in this study. Although many participants stated that they had limited financial means, they enthusiastically talked about face creams, shampoos, conditioners, razors, or waxes that they could finally use. Missy, a self-identified black woman, discussed how her hair was finally

"under control" as she could use proper shampoo: "Here [at the halfway house], it's finally the end of bad hair days," she explained. Although some dyeing products can be purchased in prison, Sydney explained that she used only one specific brand for her hair. In her first weeks at the halfway house, as soon as she could afford that specific product, she dyed her hair: "I finally dyed my hair! It was urgent, because I looked like an old lady walking around!"

Participants' narratives of corporal practices that relate to their appearance are inscribed within gendered discourses and practices. Feminist scholarship has abundantly explored how corporal practices of appearances, such as wearing makeup or shaving one's legs, are mechanisms through which women's bodies are disciplined and controlled (Bordo, 1993). Participants' narratives of taking care of themselves follow scripted and racialized forms of femininity, and clearly reflect the disciplinary effects of gendered discourses and practices. In other words, participants engaged with normalizing practices constituting "female bodies" or, in the case of the two transgender participants, "male bodies."

Beyond the use of specific hygiene products, participants also highlighted how the *opportunity* to freely engage in embodied practices relating to their appearances was, in itself, highly valued and appreciated. While talking about her multiple stays in the halfway house, Nikita explained how, although her schedule had been controlled due to her conditions, she enjoyed the simple pleasures of life: "you take a shower, you take a bath, you get dressed when you feel like it, you just enjoy it…. *It changes everything*."

Nikita shows how, by taking care of their looks, participants also reported experiencing pleasure in deploying these corporal practices, both through engaging in them and in their effects, thereby manifesting neoliberal subjectification. Taking care of one's

appearance is not only about being disciplined into scripted femininity, but also identifying with, enjoying, and wanting to look a certain way: taking care of one's appearance is inscribed and constituted by neoliberal governmentality. The concern about one's appearance is also embedded within an alleged concordance between the interior and the exterior the self and the body, which is a neoliberal construct. The body is thus the embodiment of one's true self (Bordo, 1993; LeBreton, 2010), and neoliberal subjects experience feelings of pleasure and fulfillment as they take care of their bodies (Cruikshank, 1993; Lupton, 1995). In other words, through corporal practices relating to appearance, participants can project their "inner selves" onto their bodies.

Considering that participants experience dislocation upon prison release, the effects of corporal practices of care enble them to reach a form of concordance between their appearances and their "true" selves, allowing for a sense of ontological security. Thus, the reliance on gendered embodied practices may provide ex-prisoners a sense of unity, which they have been deprived of during incarceration (Bosworth, 1999). After describing how her appearance changed and how she made various life-changing decisions, Melina recalled: "Everything fell into place, because when you feel good about how you look, you have a better handle on your situation." Melina's statement about taking care of her looks highlights how adhering to a neoliberal script provides her with a feeling of satisfaction and self-confidence, allowing her to constitute herself as responsible, united—and gendered.

Although taking care of one's appearance is a corporal practice that enables participants to unearth themselves from prison, providing them with a greater sense of ontological unity, its impact must be carefully circumscribed. First, studies have shown that incarceration may leave indelible marks on prisoners, especially those who have been

incarcerated for long periods (Brucker & Munn, 2010; Frigon, 2012, 2003; Shantz & Frigon, 2010; Shantz & al., 2009) or for aging prisoners (Shantz & Frigon, 2009). Premature aging, illnesses, tattoos and scars may prevent ex-prisoners from excavating their bodies from penal governance. Second, the body as a site of unity for the self has its limitations; Bordo (1993) agued that "we are more in touch with our bodies than ever before. But, at the same time, they have become alienated products, texts of our own creative making" (p. 288). Neoliberal practices and discourses constitute a highly regulated body, and its potential dissonance with the lived body is presented as individuals' responsibility. Any failure to conform with the ideal of the slender and healthy body is thus internalized; the corporal body thus becomes a site of disunity and alienation from the "true" self (Bordo, 1993). In brief, although corporal practices of taking care of one's appearance may support participants' unearthing of themselves, their potential for disrupting existing power relations are limited, as appearances are themselves effects and vehicles of power. The following section will further elaborate on the mixed effects that corporal practices have on "unearthing" the self from incarceration.

Psychoactive Medications

Taking psychoactive medications is a corporal practice that has effects on feelings and cognition and that, ultimately, is used to deal with feelings of pain and distress—and they are widely used in prison (Archambault, Joubert & Brown, 2013; Kilty, 2012; Lafortune & Vacheret, 2009). Participants in this study were no exception: of the seventeen participants who were interviewed, twelve disclosed taking psychoactive medications during their time in prison. All participants described in great detail how some prisoners looked like they were intoxicated by their psychiatric medication: "They were like zombies, *zombies*! Walking

around with no light in their eyes," Emilie described. All participants agreed that medications were a pharmaceutically-based form of control of prisoners, a statement echoed by empirically-based studies (Archambault et al., 2013; Kilty, 2012,). Although condemning the use of psychoactive drugs as a form of control, some participants explained that there were benefits to psychoactive medications, both in prison and out of prison, whereas others described attempting to stay away from psychoactive medications and refusing to take anything to deal with stress, anxiety, or insomnia.

Upon prison release, medical prescriptions that prisoners had in prison are not necessarily renewed, unless release conditions dictate that they should be. Some women therefore have the choice to continue, change or interrupt their medication. If they chose to stop taking their medication, it is important to stress that, when abruptly interrupted, psychoactive drugs, such as antidepressants, anxiolytics, and antipsychotics, are accompanied by discontinuation syndromes with symptoms including nausea, insomnia, fatigue, headaches, cardiac arrhythmia, convulsions, agitation, anxiety, depression, confusion, hallucinations and delirium (Rivard, 2013). Thus, any change of treatment should be accompanied by medical supervision.

Among the twelve participants who disclosed taking psychiatric medications during their time in prison, three explained that they wanted to get off them as soon as they were out of prison, but that doing so gave them multiple withdrawal effects. Sydney, who described herself as a "vegetable" in prison due to a cocktail of psychiatric medications, described in great details how she lowered her dose of psychiatric medications after she found a sympathetic doctor in the community who was supportive of her in her self-described detox regime. She described the following symptoms as the side effects of coming

off her medications: bloating, diarrhea, constipation, feeling stressed or out of control, profuse sweating, stomach aches, as well as feeling anxious and depressed—all of which align with the aforementioned discontinuation syndromes. When describing her time coming off her medications, she said: "It took a toll on my body … I caught pneumonia from it, because my defense was low". Yet, despite the pain she experienced during her detox, she felt like she was slowly beginning to be herself, both physically and mentally. For Sydney, stopping her intake of psychoactive drugs was a way to reconnect with her true self.

Unlike Sydney, Melina and Lisa wanted to continue to take psychoactive drugs in order to feel more like themselves. Melina described how she did not have access to her usual medication while she was incarcerated for a brief period. When she got out of prison, she was released far from the halfway house and had to walk there. Without her meds for two weeks, she described herself as delusional,

> I heard voices, I was hallucinating voices… It was auditory, I mean. I was sure I was right to be upset. I would have argued endlessly about anything. I got medications, and since then, I fell really well. I'm not psychotic anymore.

Rather than detoxing from medication like Sydney, Melina's main objective was to find her balance with proper medication, an objective shared by Lisa. Self-identifying as having borderline personality disorder, yet simultaneously questioning the meaning of such a diagnosis, Lisa described how she built a relationship with a psychiatrist in the community. After many tries, she finally found the medication that suited her: "I'm happy with it. Everything's okay, you know". She discussed the side effects of her medication as night eating and gaining weight, but, despite these issues, she argued that she benefited highly from her medication. Lisa's and Melina's accounts of taking psychiatric medications

reminds us that they can have a substantial effect on alleviating pain and suffering. For them, medication is thus a corporal practice that enables them to live as themselves and to alleviate their distress.

Considering participants' experiences of psychoactive medication, it appears that taking psychoactive medication can either hinder or help women upon prison release: situating it within its specific historical and cultural context can give nuance to the analysis**.** Although all women are pathologized by biomedical discourses and practices, incarcerated women are also pathologized through the criminal justice system (Kilty, 2012; Maidment, 2006; Pollack, 2005). On one hand, women are overwhelmingly criminalized for their involvement in sex work, cycles of use of drugs and alcohol, and homelessness, leading to short incarcerations within the provincial system (Maidment, 2006). On the other hand, many of these women experience pain and distress resulting from a life trajectory marked by poverty, violence, sexual abuse, drug and alcohol use, etc. Within psychiatric discourses and practices, these experiences are recast as depression, anxiety, post-traumatic stress disorder, or borderline personality (Ussher, 2010); in the context of the criminal justice system, women are thus "reconstructed as either difficult to manage or mad, both of which sanction treatment with prescription of psychotropic medication in carceral settings" (Kilty, 2012, p. 164). Moreover, Kilty and DeVillis (2012) demonstrated that halfway house staff members engage with psychiatric knowledge and discourses and are instrumental in women's medicalization, since they regulate and discipline women into taking their medication. In brief, when participants transition out of prison, taking psychiatric medication is produced as a responsible and healthy choice for participants, a corporal practice in line with carceral, transcarceral, and biomedical discourses and practices.

Throughout the interviews, Sydney, Melina and Lisa shared how they had lost loved ones during their incarceration and reported high level of distress about those losses. In her critical analysis of depression as being constituted through biomedical discourses, Ussher (2010) argued that any study that critically tackles how the specific historical and cultural context shapes the pathologization of women's distress also needs to acknowledge and take into consideration women's distress. In other words, although psychoactive medications are a pharmaceutical strategy used to regulate allegedly improper emotions, thoughts, and behaviours in women, they can also alleviate women's suffering. Psychoactive medications are constituted as the available and responsible choice in respect to alleviate psychic suffering, both in and out of prison. However, the corporal practice of taking medication can have serious side effects, and lowering the doses of medicines can also produce unwanted effects; simultaneously, such medications can also help women to live.

Conclusion

From a theoretical point of view, this paper illustrated the relevance of using corporal practices to interrogate the body in its complexity and not only in its materiality. One of the most "natural" corporal practices, defecating, was contextualized in its social and cultural context both for women inside and after they had left prison: as the constraints around this practice had serious effects on participants during incarceration, the opportunity outside of prison to defecate according to gendered practices allowed women to get rid of one ailment associated with incarceration. As such, it allowed them to unearth themselves. Yet, for these women, exercising greater agency in tending to their appearance or using psychoactive medications has not necessarily been accompanied by unearthing. With respect to appearance, participants attempted to erase the marks of prison; and the analysis of corporal

practices also highlighted how other apparatuses of power—gender and health— interact with penal governance. That point was further developed in the discussion of the use of psychoactive medications and penal governance, highlighting the concordance between the medicalization of women's distress and penal governance. In brief, this paper assessed how former prisoners still carry the weight of incarceration; corporal practices may help them to partially unearth themselves from prison.

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Chapter 5

Conclusion

In the introduction, I compared the elaboration of this dissertation to a web that weaves together theory and empirical work. In fact, the web I built is much larger and broader than that: it is a web that ties together different concepts (subjectivity and embodiment), literatures (prison studies and health studies), knowledges (experiential and theoretical), constraints (academic and penal), etc. The following conclusion examines the threads within that web and connects the three articles. However some threads are still hanging; I will therefore briefly discussed my results, their limitations and the areas that are still to be explored, as well as situate this dissertation's contributions to prison studies and population health.

The purpose of this dissertation was to analyze how women negotiated and managed their health during their incarceration and upon prison release, and to undertake a collective action on this issue with participants in the study. If I reprise Scott's (1992) metaphor on visibility, my approach to the problem of health in prison was not for me to make it visible, but, rather, to explore how power relations constituted "health in prison" as a "problem." In doing so, I distanced myself from biomedical discourses on health about the (un)healthiness of women who experienced incarceration, instead focusing on the neoliberal imperatives to pursue health. Building on the work of authors who bridged neoliberal penal governance and the imperatives to be healthy (Robert, Frigon & Belzile, 2007; Robert & Frigon, 2006; Smith, 2000), I conceptualized women's' "drive" to be healthy in and after prison—how they "do" health—as socially produced and historically embedded. Developing a multi-tiered research program inspired by participatory action research, I first explored how women did health during and after incarceration through interviews and a focus group, and

then, using the focus group as a launching pad, we worked together to develop a collection of testimonials to be distributed for incarcerated women.

There were two empirical articles in this work, found in chapters three and four. Both articles highlighted the apparent contradictions between health and prison. As participants attempted to "do" health, or sought to improve their health, they also attempted to "undo" prison, meaning that they tried to minimize or *erase* prison's effects on their health and wellbeing. Chapter three, "Doing Health in Prison", focused on the embodied subjectivities of incarcerated participants, specifically on the questions of subjects' locatedness. Similarly to Moore's and Hirai's (2014) findings about drug courts, I demonstrated how participants adopted different strategies to handle neoliberal imperatives to do health through three specific issues: weight gain, smoking, and accessing health care services. In the fourth chapter, "Unearthing Ourselves upon Prison Release", I focused on corporal practices deployed by participants upon prison release. I explored how participants mobilize their bodies to extricate themselves from prison's grip by returning to social norms of defecation and by taking charge of their mental health and their appearances. However, the effects of these corporal practices are necessarily limited, as participants continue to embody penal governance through their appearances and their use of psychoactive medications, even upon prison release.

Both empirical articles discussed how participants, who are at the receiving end of neoliberal technologies of governance, respond to subjugation. As I discussed in the introduction, Foucault's and governmentality scholars' discussions of subjugation seem to preclude any form of agency from subjects beyond a "mechanical" form of resistance. Feminist poststructuralist scholars have demonstrated through theory how the multiplicity

and disunity of the subject, as well as generative interactions of materiality, discourses, languages, and the psyche, allow the subject a certain agency in adopting various subjectivities (Braidotti, 2011; McNay, 2012). In other words, the subject is not only subjected to power relations, but can also enact various strategies to cope with them, and thus manifest agency, within a field of possibilities determined by a specific context. These two articles empirically demonstrated how subjects could exercise agency, using two different concepts: those of embodied subjectivities and corporal practices. Each concept involves the interaction between the material and the discursive, the corporal and the subjective, in an attempt to capture the "generative" substrate of agency. Of course, the purpose of these two articles was not to state that the embodied subjectivities and corporal practices adopted by participants were the only ones available to them, or that they are universal: it was to uncover that a diversity of subjectivities are possible, even in social institutions that are saturated with power relations, as prison.

The first article of this thesis, *Through a Poststructuralist Lens* (chapter two), focused on bridging my theoretical framework and my methodology. Specifically, I made the case that participatory action research has the potential to enable participants to adopt alternative subjectivities, potentially destabilizing power relations. However, I did not explore that question in either of my empirical articles, and this constitutes one of the main threads I have left hanging. As I focused on data gathering during stages 1 and 2 of the study, and then the elaboration of the collective action, I did not include a feedback mechanism in the research design through which participants could engage in reflecting on the process of engaging in PAR. The exception would be the focus group in which participants discussed briefly why they were participating and reflected on their common

motivations. In order to document participants' subjectivities, I could have done interviews before and after the study, as well as interview how participants who provided testimonials felt as "informants". However, I could explore the subjectivities I have deployed throughout the research process: this may be the topic for another article.

Another aspect of my dissertation that could be expanded is my focus on prison. As I explained in my introduction, the seed from which my thesis grew was my professional experiences with street-involved youth and criminalization. From the start, I focused solely on experiences of "prison". However, as Foucault (1975) demonstrated, prison is not isolated from society, but instead is very much a part of it. Consequently, even if my theorization brought down prison's walls, my empirical fieldwork focused on incarceration and the first few months after prison release. Participants' focus during that time was on resisting and "getting rid of" prison's adverse effects on health, as reflected in the title *Doing Health, Undoing Prison*. However, as I discussed in the third article, transcarceration stretches well beyond the time a person spends *in* prison. Thus, data collected over a longer period of time may have enriched the discussing on "undoing" prison, as incarceration stretches beyond the prison's walls and beyond the first months after prison release.

Finally, I also want to stress the specific context in which my research is embedded. Participants were recruited at a halfway house. As women in halfway houses necessarily must have demonstrated their willingness to engage in the (re)integration process and to reflect on their "criminal" trajectories, participants in this study had already engaged with technologies of responsibilization through having been admitted to the halfway house and were already participating in therapy groups, meetings with counsellors, etc. In describing this situation, I do not want to question whether participants were "authentic" or not in their

interactions with that process, but instead simply highlight that participants in this study were already engaged in neoliberal technologies of self-governance with an intensity that women released from prison directly into the community may not encounter. Thus, conducting the same study with women who are not involved with the halfway house's services may have yielded different results. Moreover, as this study focused on the experiences of being incarcerated in provincial prisons, its extrapolation to federal prisons may be limited, as prisoners in federal prisons have greater control over their everyday lives, for example, they cook for themselves, do not share cells, etc. Finally, I also want to underline that, although some participants identified themselves as Black or Aboriginal, I did not explore how gender and race intersected with doing health and undoing prison, a topic that absolutely merits greater attention.

Despite these unexplored areas, this dissertation has also made various contributions to prison and health studies. With respect to theoretical contributions, I have demonstrated the pertinence of including the body and corporeality in poststructuralist accounts of subjectivity. Building on previous work on embodiment and incarceration (Frigon, 2012, 2003), the inclusion of corporeality has deepened the empirical and theoretical debunking of the Cartesian divide between the mind and the body. As the third article explicitly focused on what participants did *with their bodies*, I attempted to explore how corporal practices melt into subjectivity as well as constitute it. In other words, I aimed to illustrate how what participants did with their bodies flowed from their subjectivity as well as shaped it: through corporal practices, participants claimed greater control over their selves while, simultaneously, embodying penal governance. Thus, by including corporality, I

demonstrated how power is not only deployed discursively, but also corporally and materially.

Moving to the field of prison studies, I believe this study added to the literature confirming the pains of incarceration. Since Sykes (1958) developed the concept, multiple authors have reprised the notion that incarceration brings about various sorts of pain (for instance, Crewe, 2011). In a recent analysis, Crewe (2011) has argued that contemporary penal governance is marked by a "lighter" touch: prisons are more comfortable, more hygienic, and safer from brutality by guards or fellow prisoners than they used to be, although violence remains an ever-present reality. As argued by Hannah-Moffat (2001), contemporary neoliberal penal governance constitutes subjects: it deploys technologies of the self such as self-examination, self-care, and self-improvement to enable prisoners to become active citizens—"entrepreneurs of their own life" (Gordon, 2001). As prisoners are enticed to examine, care for and improve themselves, they are addressed as though they *want* to improve themselves, to take responsibility for their lives in specific ways (Crewe, 2011; Hannah-Moffat, 2001; Rose, 1999). Thus, Crewe (2011) argued that prison "does not so much weigh down on prisoners and suppress them as wrap them up, smother them and incite them to conduct themselves in particular ways" (p. 522). He used the image of the harness to convey how neoliberal governance directs, shapes, and constrains the prisoner, attempting to foster responsible and governable subjects and bodies. The study of the pains of incarceration thus moved from the study of how prison weighs prisoners down or how it is a "heavy" experience to focus on how penal governance harnesses prisoners to feel, think, and act in scripted ways. As the first article specifically addressed how women manage the imperatives to be healthy in prison, it also demonstrated how health is an additional harness

point for penal governance, another space that can be invested with relations of power. In brief, this thesis provides some traction to the exploration of how penal governance harnesses prisoners in every aspects of their lives.

In regard to health studies, I argued in the introduction that my research could contribute to the theorization of power in the field of population health, and, more specifically, critically interrogate the responsibilization technologies increasingly deployed in the field of health. Reflecting on my results, I think they show the adverse effects that the imperatives to be healthy can have on populations on which they are deployed by uncovering the dark side of the ethicalization of health. As health promotion is presented as the ultimate value, the greatest social goal, it constitutes an idealized moral subject, and failure to adhere to or, more importantly, uphold this value implies amorality, irresponsibility, and inadequacy. In other words, this thesis questions the imperative to be healthy. That questioning, of course, does not preclude interventions that aim to tackle health inequities, but, rather, should remind us that those who do not seek to "do health" are not demobilized around health or unwilling to seek health, but instead fail to engage in scripted ways of "doing health" or are not benefiting from the alleged effects of "doing health." Thus, this thesis is not only aligned with critiques of health promotion (for instance, Schrecker, 2013), but it also complements that body of work, as it explores and documents the lived experiences of those failing to attain health, bridging the material (social determinants of health) and the discursive (i.e. interrogating health).

Finally, I believe that one of the main contribution of this dissertation is the illustration that subjects who are constrained and enabled by power relations can still negotiate and manage various embodied subjectivities. In other words, although facing real

constraints and limited options, neoliberal subjects can, in fact, enact agency by adopting embodied subjectivities that differ from the prescribed subjectivities, as discussed in articles two and three. This demonstration may be one of the most important contributions of this work, and the one that can be applied in other social settings or used with other disadvantaged or disenfranchised populations, such as refugees, or populations in care, such as people with severe disabilities, mental illnesses or addictions, or the elderly.

However, I want to reiterate that one has to be careful in concluding that these embodied subjectivities bring about destabilizing effects to power relations—they may, in fact, reinforce power relations, or increase the grip of more repressive forms of power on subjects. Rose (2000) made the case that neoliberal subjects are managed through circuits of inclusion and exclusion, each circuit invested by different forms and technologies of power. As Moore and Hirai (2014) underlined, Rose (2000) associated engagement with neoliberal technologies of responsibilization with the circuits of inclusion, while "failed" neoliberal subjects are consequently managed through circuits of exclusion, such as the criminal justice system. Moore and Hirai (2014) critiqued Rose's (2000) position by arguing that, regardless of their subject locations, criminalized subjects can seldom integrate into the circuits of inclusion, arguing that responsibilization, understood here as neoliberal governmental technology, is rather a "complex arrangement of hierarchical and self-governance in which some individuals actively perform but ultimately, at least in regards to the hyper-marginalized who populate the criminal justice system, are mostly ingested only to be later expelled by society" (p. 6). Although the analysis I conducted does not allow me to conclude that, in fact, participants are excluded upon their supposed reintegration, I want to stress how women's feelings of failures and inadequacies with respect to their weight, their appearance,

and the struggles they face upon their prison release (Maidment, 2006) may, in fact, hint at the fact that incarcerated women remain in circuits of exclusion, constantly failing to properly engage with their health and take care of themselves. In other words, as participants followed, partially adopted, or rejected the scripted ways in which one is compelled to do health, neither Rose's (200) nor Moore and Hirai's (2014) position can guarantee that the subject will fulfill the imperatives to be healthy and fall within the circuit of inclusion. Rather than focusing on the adherence of participants to the imperative to be healthy and its effects, I demonstrated that although participants are harnessed into doing health in and out of prison, they negotiate these imperatives within a field of possibilities by adopting various embodied subjectivities.

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Appendix A

Grille d'entrevue individuelle

Ce projet de recherche vise à mieux comprendre comment les femmes qui ont été incarcérées ont vécu leur incarcération et agi sur leur santé durant cette période. En d'autres mots, cette recherche vise à mieux comprendre les défis liés à la santé auxquels font face les femmes durant leur incarcération et ce, de leur point de vue.

La santé est souvent définie en termes d'absence de maladies et/ou d'accès à des soins de santé de qualité. Dans le cadre de cette recherche, la santé est abordée d'une façon plus large: la santé réfère ici au « bien-être », ce qui inclut le bien-être émotif, physique, mental et spirituel. Autrement dit, cette recherche cherche à comprendre ce que veut dire « être bien », « se sentir bien » dans son corps, sa tête, son cœur, ou, au contraire, ce que veut dire « ne pas être bien », se sentir mal, durant une période d'incarcération.

Cette entrevue individuelle constitue le premier volet de la recherche, le second volet étant une discussion de groupe (focus group) qui vise à définir, à planifier et à réaliser une action collective sur le thème de la santé et de l'incarcération. Toutes les participantes au groupe auront d'abord participé à l'entrevue individuelle avec la chercheure.

Cette entrevue va commencer par quelques questions plus précises qui visent à mieux comprendre votre parcours et elles sont suivies de questions ouvertes. L'entrevue est enregistrée et elle ne sera accessible qu'à la chercheure et ses superviseurs. Il est important de rappeler qu'il n'y a pas de bonnes ou de mauvaises réponses aux questions et que vous pouvez refuser de répondre aux questions à tout moment de l'entrevue.

Suite à l'entrevue, la chercheure vous invitera à participer à l'analyse de votre entrevue. Elle vous remettra une version retranscrite de l'entrevue et vous pourrez discuter avec elle du contenu. Cette participation à l'analyse est optionnelle et elle ne sera pas enregistrée.

Renseignements généraux

➔ cf. Fiche signalétique

Consignes de départ

Parlez-moi de votre santé lors de votre incarcération, et suite à votre incarcération.

Quelles seraient vos recommandations (aux service correctionnels, au service médical, etc.) par rapport à la santé des femmes et à l'incarcération ? Si vous considérez que certains changements doivent être apportés, quelles actions aimeriez-vous entreprendre pour changer les choses ?

Questions additionnelles

Comment définir la bonne santé / la mauvaise santé (se sentir bien/se sentir mal) durant l'incarcération ? Y a-t-il des distinctions avec la vie hors de la prison ? Pouvez-vous me donner un exemple ? Y a-t-il des distinctions avec la vie hors de la prison ? Si oui, lesquelles ?

Quelle était votre relation avec le service médical ? Étiez-vous satisfaite de leurs services ? Exemple ?

Comment agit-on sur sa santé en prison, c'est-à-dire comment peut-on se sentir bien, dans sa tête, son corps, son cœur, durant l'incarcération ? Exemple ?

Quels sont les plus grands défis par rapport à la santé durant l'incarcération ? Y a-t-il des facteurs facilitants ? Exemple ?

Avez-vous adopté des stratégies personnelles pour préserver / améliorer votre santé en prison (ex: médications, thérapie, etc.)? Si oui, quelles sont-elles ? Si oui, quelles sont-elles ? Exemple

En préparation de la rencontre de groupe, pensez-vous qu'une action collective sur la question de la santé en prison est nécessaire ? qu'avez-vous le goût de changer / de voir changé par rapport à la santé en prison ? qui voudriez-vous rejoindre avec une action collective ?

Appendix B

Formulaire de consentement

Titre du projet: **Agir sur sa santé en prison: une recherche participative avec des femmes qui ont été incarcérées dans une prison provinciale**

Chercheure:

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Superviseurs:

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Je suis invitée à participer à la recherche nommée ci-dessus qui est menée par Catherine Chesnay (chercheure), Bastien Quirion (superviseur) et Sylvie Frigon (superviseure).

But de l'étude: Le but de l'étude est de mieux comprendre comment les femmes qui ont été incarcérées ont vécu leur incarcération et agi sur leur santé durant cette période. De plus, avec la collaboration active des participantes, l'étude vise aussi à mener une action collective sur la question de la santé et de l'enfermement.

L'objectif de cette recherche est donc double: elle vise à mieux comprendre la réalité de l'enfermement et de la santé, et d'autre part, elle vise à entreprendre une action collective sur ce sujet, action qui sera déterminée par les participantes.

Participation: Ma participation consistera essentiellement en une entrevue individuelle d'1 heure, ainsi qu'en une rencontre de groupe de 2 heures.

L'entrevue individuelle consistera à répondre à des questions qui portent sur l'incarcération et la santé. La rencontre se tiendra dans un lieu de mon choix (café, organisme communautaire, etc.). La date et l'heure de l'entrevue seront établies selon ma disponibilité.

Le focus groupe, c'est-à-dire une rencontre de groupe, consistera d'abord à discuter des données qui ont été récoltées durant les entrevues, dans le but de dégager une vision commune de la santé et de l'incarcération. De plus, cette rencontre visera à définir, à planifier et à réaliser une action collective sur le thème de la santé et de l'incarcération. Cette action peut être réalisée dans le cadre d'une rencontre ou sur plusieurs rencontres, selon le désir des participantes. Il est important de noter que toutes les participantes à la rencontre auront d'abord réalisé une entrevue avec la chercheure.

Suite à l'entrevue individuelle et de la rencontre de groupe, la chercheure vous invitera à participer à l'analyse de votre entrevue et de la rencontre de groupe. Elle me remettra une version retranscrite de l'entrevue/de la rencontre de groupe et je pourrai discuter avec elle du contenu. Cette participation à l'analyse est optionnelle et elle ne sera pas enregistrée.

Risques: Je comprends que ma participation à cette recherche implique que je parle de mon expérience personnelle en prison. Il est possible qu'elle suscite des réflexions ou des souvenirs émouvants ou désagréables. J'ai reçu l'assurance de la chercheure que tout se fait en vue de minimiser ces risques. Si je sens que j'ai besoin de soutien psychologique suite à l'entrevue ou à la rencontre de groupe, la chercheure me référera à des services appropriés.

Bienfaits: Ma participation à cette recherche aura pour effet de contribuer à l'avancement des connaissances sur la santé des femmes et des réalités de l'incarcération. De plus, ma participation à cette recherche me permettra de prendre part à une action collective avec d'autres femmes qui ont elles aussi vécu une période d'incarcération dans une prison provinciale.

Confidentialité et anonymat: J'ai l'assurance de la chercheure que l'information que je partagerai avec elle restera strictement confidentielle. La présentation des entrevues lors de la rencontre de groupe sera aussi confidentielle (i.e. la chercheure n'indiquera pas qui à dit quoi durant les entrevues). Je m'attends à ce que le contenu de la recherche soit utilisé pour des articles scientifiques, des colloques, ainsi que pour la thèse de la chercheure. La nature et le contenu de l'entrevue et de la rencontre en groupe demeureront en tout temps strictement confidentiels et ils ne seront accessibles qu'à la chercheure et ses superviseurs.

La seule exception est celle de l'action collective. L'action collective sera définie lors de la rencontre de groupe. Si l'action collective est de nature publique (par exemple, rencontrer les services correctionnels, pétition, etc.), chaque participante pourra choisir si elle veut s'engager ou ne pas s'engager dans cette action. Un formulaire de consentement additionnel sera alors fourni. Si la participante désire collaborer à l'action collective mais demeurer anonyme, la chercheure fera alors tout ce qui est en son pouvoir pour maintenir et protéger son anonymat.

Mon nom n'apparaîtra en aucun temps dans les publications. Je m'attribuerai un nom fictif et seule la chercheure et ses superviseurs auront la liste des participantes et de leurs

noms fictifs. Si mes propos sont cités de manière intégrale dans le cadre de cette recherche, mon nom fictif sera utilisé.

Conservation des données: Les enregistrements et les informations récoltées lors des entrevues individuelles et de la rencontre en groupe seront conservés dans un classeur sous clé situé dans un bureau fermé à l'Université d'Ottawa et ne seront consultés que par la chercheure et ses superviseurs. Les enregistrements et les informations récoltées seront détruits après cinq ans.

Compensation: Il est entendu que je ne retire aucun avantage direct pour participer à ce projet et je ne percevrai aucune compensation financière. Par contre, des billets d'autobus, de la nourriture et une compensation symbolique (un coupon pour un café) me seront remis pour me remercier de ma participation.

Participation volontaire: Ma participation à la recherche est volontaire et je suis libre de me retirer en tout temps, et/ou refuser de répondre à certaines questions, sans subir de conséquences négatives. Si je choisis de me retirer de l'étude, les données recueillies jusqu'à ce moment seront détruites.

Acceptation: Je,_____, accepte de participer à cette recherche menée par Catherine Chesnay, étudiante au doctorat en santé des populations, de la Faculté des études supérieures et postdoctorales, laquelle recherche est supervisée par Bastien Quirion et Sylvie Frigon.
Pour tout renseignement additionnel concernant cette étude, je peux communiquer avec la chercheure ou ses superviseurs.

Pour tout renseignement sur les aspects éthiques de cette recherche, je peux m'adresser au Responsable de l'éthique en recherche, Université d'Ottawa, Pavillon Tabaret, 550, rue Cumberland, pièce 154, (613) 562-5387 ou ethics@uottawa.ca.

Il y a deux copies du formulaire de consentement, dont une copie que je peux garder.

Signature du participant: _____ Date: _____

Signature de la chercheure: _____Date: _____

Consent Form

Project Title: Doing Health in Prison: Participatory Research with Women who Have Experienced

Researcher:

Catherine Chesnay
Researcher – PhD student
Population Health
Faculty of Graduate and Postdoctoral Studies -
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XXX-XXX-XXXX
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Supervisors:

Bastien Quirion
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I am invited to participate in the abovementioned research study conducted by Catherine Chesnay (researcher), Bastien Quirion (supervisor) and Sylvie Frigon (supervisor).

Purpose of the study: The purpose of the study is twofold. First, this research aims to better understand how the experience of incarceration shapes and impacts the health of women who have been incarcerated in a provincial prison, and how women consequently "act" on their health in prison. Second, this research intends to undertake transformative action with previously incarcerated women on the question of health and incarceration.

Participation: My participation will consist essentially of an individual interview of approximately one hour, as well as a focus group of 2 hours.

In the individual interview, I will have to answer questions on incarceration and health. The time and the location (community organization, coffeehouse, etc.) of the interview will be determined according to my convenience and availability. The interview will be recorded.

The focus group (i.e. group meeting) will consist of discussing the data collected in the interviews, in order to develop a collective understanding of health and incarceration.

The purpose will also be to define, plan, and implement a collective action on the issue of health and incarceration. The collective action may unfold during the focus group or over a number of meetings, according to participants' wishes. It is important to emphasize that all participants to the group meeting will have been interviewed by the researcher. The group meeting will also be recorded.

Following the individual interview and the group meeting, the researcher will invite me to discuss the analysis of the individual interview, as well as the group meeting. She will hand me a transcript of the interview or the group meeting, and I will be able to discuss its content with her. This meeting is optional and will be not recorded.

Risks: My participation in this study will entail that I talk about my personal experience in prison, and this may cause me to feel sad or depressed. I have received assurance from the researcher that every effort will be made to minimize these risks. If I feel like I need psychological support during or after the interview or the group meeting, the researcher will refer me to appropriate services.

Benefits: My participation in this study will contribute to the advancement of knowledge on women's experiences of health during incarceration. Moreover, this study will enable me to take part in a collective action on that issue, with women who have also experienced incarceration in a provincial prison.

Confidentiality and anonymity: I have received assurance from the researcher that the information I will share will remain strictly confidential. When the data from the interview will be shared in the group meeting, the information will remain confidential (i.e. the researcher will not disclose who said what).

At the group meeting, I will meet other participants: personal information and opinions will be shared. I will commit to respect the confidentiality of what has been shared during the meeting (participants' names and any other information).

I understand that the contents of the interview and the group meeting will be used only for academic articles, conferences and the researcher's thesis. The nature and the content of the interview and the group meeting will remain confidential at all times and will only be accessible to the researcher and her supervisors.

The only exception is the collective action. The collective action will be defined and planned during the group meeting. An additional consent form will be developed in order to ensure that every participant will have adequate information to choose to participate in the collective action. If the action is public in nature (for instance, meeting with correctional services), each participant will have the opportunity to choose to participate. If the participant wants to remain anonymous, the researcher will try to ensure that she remains anonymous.

My name will never appear in publications. I will choose a fictitious name. Only the researcher and her supervisors will have the list of participants' real and fictitious names. If I am cited in this study, only my fictitious name will be used.

Conservation of data: The data collected in the interviews and the group (recordings, consent forms, notes, etc.) will be kept in a locked cabinet in an office at the University of

Ottawa and will only be accessible to the researcher and her supervisors. After a 5-year period, all material will be destroyed.

Compensation: I understand that I will not receive any direct benefits from participating in this study. Nonetheless, snacks, 2 bus tickets and a token gift (a gift card for a coffee) will be given to me thank me from my participation, even if I withdraw from the study.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any question, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be destroyed.

Acceptance: I, _____, agree to participate in the above research study conducted by Catherine Chesnay, PhD student in population health of the Faculty of Graduate and Postdoctoral Studies, under the supervision of Bastien Quirion and Sylvie Frigon.

If I have any questions about the study, I may contact the researcher or either of her supervisors.

If I have any questions regarding the ethical conduct of this study, I may contact the

Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550

Cumberland Street, Room 154, tel.: (613) 562-5387 or ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

Appendix C

Fiche signalétique

Nom:

Prénom:

Pseudonyme:

Âge:

Statut civil:

Enfants:

Lieu d'origine:

Lieu d'habitation:

Nombre et durée de(s) période d'incarcération (prisons provinciales):

Nombre et durée de(s) période d'incarcération (prisons fédérales):

Si en maison de transition, combien de temps avant libération conditionnelle totale:

Nombre et durée de séjour (s)en maison de transition:

Appendix D

Guide du focus group

1. Tour de table: comment ça va ?

2. « Règles de vie » pour le groupe
   -> que faire en cas d'absence ? ou si quelqu'un veut se joindre au groupe ?

3. Retour sur le dernier groupe: projets suggérés

- Ce qui a été identifié la semaine passée: maison de 'transition'/temps d'arrêt suite à bri de condition avec ex-détenue et staff d'expérience ; maison pour les institutionnalisés (appt supervisés) ; changement des lois adoptées par Harper ; feuillet 'prison 101' pour faire un temps constructif/mise à jour du book de référence ; personne-ressource pour jaser et pour faire de l'accompagnement et de la réinsertion ; mieux faire connaître CFAD ; préparer transition de transition ; plus de sorties hors prison à Joliette ; plus de sorties dans la cour et dans la cafétéria à Tanguay ; sensibiliser public à la réalité des femmes via internet ;
- autres idées ?
- si nécessaire, voir ce qui a été identifié durant les entrevues

Suggestions pour l'animation: j'écris au tableau ? Elles écrivent ? On met le papier sur la table ? Je suggère qu'on fasse un tour de table pour voir les idées de chacune…

4. Sélection du projet
   - Faisabilité (temps) et matériel nécessaire
   - Disponibilités et aptitudes de chacune
   - Qui veut-on rejoindre ? Comment ?
   - Objectifs ? Comment on sait s'ils sont atteints ?
   - Alliées ? (p. ex., Efry ?)

5. Planification
   - Déterminer les actions à prendre pour réaliser l'action (en terme de matériel, de tâches, de personnes à mettre à contribution, etc.).
   - Établir lignes directrices pour second formulaire de consentement
   - Distribuer les tâches et établir les délais, prochaines rencontres, etc.

Appendix E

Guide pour témoignages

Qu'aurais-tu aimé savoir avant d'être incarcérées ?

Qu'aurais-tu aimé entendre lorsque tu étais en-dedans ? En particulier dans les moments les plus difficiles ?

As-tu des leçons, conseils, mots d'encouragements pour les femmes qui sont incarcérées ? que voudrais-tu leur dire ?

Appendix F

Formulaire de consentement

Projet: Agir sur sa santé en prison: une recherche participative avec des femmes qui ont été incarcérées dans une prison provinciale

Volet 3: recueil pour les femmes qui sont incarcérées dans les centres de détention de Joliette et de Tanguay – participantes au comité de rédaction

Chercheure:
Catherine Chesnay
Chercheure-Étudiante au doctorat
Santé des populations
Faculté des études supérieures et posdoctorales-
Université d'Ottawa
XXX-XXX-XXXX
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Superviseurs:

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sylvie.frigon@uottawa.ca

Je suis invitée à participer à la recherche nommée ci-dessus, recherche menée par Catherine Chesnay (chercheure), Bastien Quirion (superviseur) et Sylvie Frigon (superviseure). Ce projet de recherche est financé par le Fonds de recherche du Québec - société et culture (FRQSC) et a été approuvé par le Comité d'éthique de l'Université d'Ottawa.

But de l'étude:

Le but de l'étude est de mieux comprendre comment les femmes qui ont été incarcérées ont vécu leur incarcération et ont agi sur leur santé durant cette période, ainsi que d'entreprendre une action collective sur le thème de la santé et de l'incarcération.

Suite au volet 1 (entrevues) et volet 2 (focus groupe), les participantes à la recherche (dont je fais partie) ont décidé de développer un recueil de témoignages qui sera distribué aux femmes qui sont actuellement incarcérées à l'établissement de détention de Joliette et de Tanguay. Une fois le recueil complété, il sera soumis aux services correctionnels du Canada (pour l'établissement Joliette) et du Québec (pour l'établissement de détention Tanguay) pour approbation. Il sera ensuite distribué aux femmes par chaque établissement.

Participation: J'ai déjà participé au volet 1 et 2 de la recherche, soit une entrevue individuelle et une rencontre de groupe. Suite à ces rencontres, j'ai décidé de m'impliquer dans une action collective visant principalement à développer un recueil de témoignages pour les femmes qui sont actuellement incarcérées à l'établissement de détention de Joliette et de Tanguay.

Ma participation consistera à être membre du comité de rédaction. Ce comité a pour objectif de développer le contenu du recueil, c'est-à-dire sélectionner et modifier les anecdotes recueillies par la chercheure, ainsi que de développer le visuel du recueil. Les rencontres du comité de rédaction prendront la forme de focus groupe animé par la chercheure et ils seront enregistrés (audio). Le nombre de rencontres nécessaires sera déterminé par le comité, mais je peux à tout moment interrompre ou mettre fin à ma participation, sans subir de conséquences négatives.

Si je le désire, je pourrai moi aussi partager une anecdote qui sera incluse dans le recueil. Mon anecdote pourra être modifiée ou adaptée par le comité de rédaction. Elle ne sera pas nécessairement publiée dans son intégralité: elle pourra être coupée ou légèrement modifiée.

Risques: Je comprends que ma participation implique que je discute de la question de l'enfermement. Il est possible qu'elle suscite des réflexions ou des souvenirs émouvants ou désagréables. J'ai reçu l'assurance de la chercheure que tout se fera en vue de minimiser ces risques. Si je sens que j'ai besoin de soutien psychologique par rapport à ma participation au comité de rédaction, la chercheure me référera à des services appropriés.

Bienfaits: Ma participation à cette recherche aura pour effet de contribuer à l'avancement des connaissances sur la santé des femmes et des réalités de l'incarcération. De plus, ma participation à cette recherche me permettra de contribuer à briser l'isolement des femmes incarcérées en développant un recueil pour elles.

Confidentialité et anonymat:

En tant que membre du comité de rédaction, 3 choix me sont offerts:

1. M'identifier avec mon nom prénom et la première lettre de mon nom famille (p. ex. Catherine C.). Mon prénom et la première lettre de mon nom de famille seront

indiqués sous l'anecdote que j'aurais racontée dans le recueil qui sera distribué dans les prisons de Joliette et de Tanguay. Si je choisis cette option, je comprends que je pourrai être identifiée comme l'auteure de l'anecdote et que la chercheure ne peut garantir ma confidentialité.

2. Utiliser un nom fictif comme membre du comité de rédaction. Mon nom fictif sera: _____

3. Indiquer que ma participation est anonyme. La mention « anonyme » identifiera ainsi ma participation au comité de rédaction.

SVP, encerclez l'option retenue

Comme ce recueil est réalisé dans le cadre d'un projet de recherche, je m'attends à ce que son contenu soit utilisé pour des articles scientifiques, des colloques, ainsi que pour la thèse de la chercheure. La chercheure me citera de la façon que j'ai plus haut.

Pour le volet 1 et 2 de la recherche, je m'étais attribuée un pseudonyme. Je comprends que la chercheure va utiliser ce pseudonyme lorsqu'elle va citer du matériel provenant de ces volets. Cependant, lorsqu'elle va citer du matériel (extrait de rencontre de groupe ou anecdote du recueil) du volet 3, la chercheure utilisera l'option qui me convient (cf. plus haut). *Je comprends qu'on ne pourra pas faire le lien entre ma participation au volet 1 et 2 et ma participation au volet 3, à moins que je n'utilise le même pseudonyme pour les volets 1, 2 et 3.*

Conservation des données: les formulaires de consentement, les enregistrements et les notes prises par la chercheure durant les rencontres du comité de rédaction seront conservés dans un classeur sous clé situé dans un bureau fermé à l'Université d'Ottawa et ne seront consultés que par la chercheure et ses superviseurs. Les enregistrements et les informations récoltées seront détruits après cinq ans.

Compensation: Il est entendu que je ne retire aucun avantage direct pour participer à ce projet et que je ne percevrai aucune compensation financière.

Participation volontaire: Ma participation à la recherche est volontaire et je suis libre de me retirer en tout temps, et/ou refuser de répondre à certaines questions, sans subir de conséquences négatives. Si je choisis de me retirer de l'étude, les données recueillies jusqu'à ce moment seront détruites.

Acceptation: Je,_____, accepte de participer à cette recherche menée par Catherine Chesnay, étudiante au doctorat en santé des populations, de la Faculté des études supérieures et postdoctorales, laquelle recherche est supervisée par Bastien Quirion et Sylvie Frigon.

Pour tout renseignement additionnel concernant cette étude, je peux communiquer avec la chercheure ou ses superviseurs.

Pour tout renseignement sur les aspects éthiques de cette recherche, je peux m'adresser au Responsable de l'éthique en recherche, Université d'Ottawa, Pavillon Tabaret, 550, rue Cumberland, pièce 154, (613) 562-5387 ou ethics@uottawa.ca.

Il y a deux copies du formulaire de consentement, dont une copie que je peux garder.

Signature de la participante: _____Date: _____

Signature de la chercheure: _____ Date: _____

Formulaire de consentement

Projet: Agir sur sa santé en prison: une recherche participative avec des femmes qui ont été incarcérées dans une prison provinciale

Volet 3: recueil pour les femmes qui sont incarcérées aux centres de détention de Joliette et de Tanguay – participantes au recueil

Chercheure:
Catherine Chesnay
Chercheure-Étudiante au doctorat
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Superviseurs:

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Je suis invitée à participer à la recherche nommée ci-dessus, recherche menée par Catherine Chesnay (chercheure), Bastien Quirion (superviseur) et Sylvie Frigon (superviseure). Ce projet de recherche est financé par le Fonds de recherche du Québec - société et culture (FRQSC) et a été approuvé par le Comité d'éthique de l'Université d'Ottawa.

But de l'étude: Le but de l'étude est de mieux comprendre comment les femmes qui ont été incarcérées ont vécu leur incarcération et ont agi sur leur santé durant cette période, ainsi que d'entreprendre une action collective sur le thème de la santé et de l'incarcération.

Suite au volet 1 (entrevues) et volet 2 (focus groupe), les participantes à la recherche ont décidé de développer un recueil de témoignages qui sera distribué aux femmes qui sont actuellement incarcérées à l'établissement de détention de Joliette et de Tanguay. Une fois le recueil complété, il sera soumis aux services correctionnels du Canada (pour l'établissement

Joliette) et du Québec (pour l'établissement de détention Tanguay) pour approbation. Il sera ensuite distribué aux femmes par chaque établissement

Participation: Ma participation consistera essentiellement à raconter une anecdote sur mon expérience d'enfermement. La rencontre se tiendra à la maison de transition Thérèse Casgrain, selon ma disponibilité. L'anecdote que je raconterai sera enregistrée ou alors immédiatement retranscrite par la chercheure.

Toutes les anecdotes recueillies par la chercheure seront lues par le comité de rédaction, constitué par la chercheure et des femmes qui ont été incarcérées et recrutées dans la phase I de la recherche. Mon anecdote pourra être modifiée ou adaptée par le comité de rédaction. Elle ne sera pas nécessairement publiée dans son intégralité: elle pourra être coupée ou légèrement modifiée.

Par ailleurs, si mon anecdote est sélectionnée par le comité de rédaction, elle fera partie d'un recueil qui sera distribué aux femmes qui sont incarcérées aux centres de détention de Joliette et de Tanguay. Les personnes incarcérées et le personnel de chaque établissement auront donc accès au recueil et pourront en obtenir une copie.

Risques: Je comprends que ma participation à cette recherche implique que je parle de mon expérience personnelle en prison. Il est possible qu'elle suscite des réflexions ou des souvenirs émouvants ou désagréables. J'ai reçu l'assurance de la chercheure que tout se fera en vue de minimiser ces risques. Si je sens que j'ai besoin de soutien psychologique suite à ma participation, la chercheure me référera à des services appropriés.

Bienfaits: Ma participation à cette recherche aura pour effet de contribuer à l'avancement des connaissances sur la santé des femmes et des réalités de l'incarcération. De plus, ma participation à cette recherche me permettra de contribuer à briser l'isolement des femmes incarcérées en partageant avec elle mon vécu par le biais de ce recueil.

Confidentialité et anonymat:

Dans le cadre du recueil, 3 choix me sont offerts:

1) M'identifier avec mon nom prénom et la première lettre de mon nom famille (p. ex. Catherine C.). Mon prénom et la première lettre de mon nom de famille seront indiqué sous l'anecdote que j'aurais racontée dans le recueil qui sera distribué dans les prison de Joliette et de Tanguay. Si je choisis cette option, je comprends que je pourrai être identifiée comme l'auteure de l'anecdote et que la chercheure ne peut garantir ma confidentialité.

3. Utiliser un nom fictif pour accompagner l'anecdote. Mon nom fictif sera:
   _____

3. Indiquer que mon anecdote est anonyme. La mention « anonyme » accompagnera ainsi mon anecdote.

SVP, encerclez l'option retenue

Comme ce recueil est réalisé dans le cadre d'un projet de recherche, je m'attends à ce que son contenu soit utilisé pour des articles scientifiques, des colloques, ainsi que pour la thèse de la chercheure. La chercheure me citera de la façon que j'ai choisie plus haut.

Conservation des données: Les enregistrements et les formulaires de consentement récoltés lors de l'entrevue seront conservés dans un classeur sous clé situé dans un bureau fermé à l'Université d'Ottawa et ne seront consultés que par la chercheure et ses superviseurs. Les enregistrements et les informations récoltées seront détruits après cinq ans.

Compensation: Il est entendu que je ne retire aucun avantage direct pour participer à ce projet et que je ne percevrai aucune compensation financière.

Participation volontaire: Ma participation à la recherche est volontaire et je suis libre de me retirer en tout temps, et/ou refuser de répondre à certaines questions, sans subir de conséquences négatives. Si je choisis de me retirer de l'étude, les données recueillies jusqu'à ce moment seront détruites. De plus, ma participation ou mon retrait de l'étude n'auront aucun impact sur les services que je reçois de la Société Elizabeth Fry.

Acceptation: Je,_____, accepte de participer à cette recherche menée par Catherine Chesnay, étudiante au doctorat en santé des populations, de la Faculté des études supérieures et postdoctorales, laquelle recherche est supervisée par Bastien Quirion et Sylvie Frigon.

Pour tout renseignement additionnel concernant cette étude, je peux communiquer avec la chercheure ou ses superviseurs.

Pour tout renseignement sur les aspects éthiques de cette recherche, je peux m'adresser au Responsable de l'éthique en recherche, Université d'Ottawa, Pavillon Tabaret, 550, rue Cumberland, pièce 154, (613) 562-5387 ou ethics@uottawa.ca.

Il y a deux copies du formulaire de consentement, dont une copie que je peux garder.

Signature de la participante: _____Date: _____

Signature de la chercheure: _____ Date: _____

Appendix G

Grille d'analyse

1. Identifier les thèmes, catégories et objets des discours
    a. ce qui est évident
    b. ce qui est naturel
    c. ce relève du gros bon sens
    d. ce qui relève de l'expérientiel

2. Identifier les non-dits et les silences

3. Identifier les liens entre les discours: contradictions (identifiées par partcipantes ou non), les inter-dépendnces

4. Identifier les contre-discours

5. Effets du discours et ses dimensions

6. Contextes des discours

Appendix H

Numéro de dossier: 05-12-08 **Date (mm/jj/aaaa):** 06/27/2012

Université d'Ottawa University of Ottawa
Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Certificat d'approbation déontologique

CÉR Sciences sociales et humanités

Chercheur principal / Superviseur / Co-chercheur(s) / Étudiant(s)

Prénom	Nom de famille	Affiliation	Rôle
Catherine	Chesnay	Sciences sociales / Autres	Chercheur principal
Bastien	Quirion	Sciences sociales / Criminologie	Superviseur
Sylvie	Frigon	Sciences sociales / Criminologie	Co-chercheur

Numéro du dossier: 05-12-08

Type du projet: Thèse de doctorat

Titre: Doing Health in Prison: A Participatory Research with Women who have Experienced Incarceration in a Provincial Prison

Date d'approbation (mm/jj/aaaa)	Date d'expiration (mm/jj/aaaa)	Approbation
06/27/2012	06/26/2013	Ia

(Ia: Approbation complète, Ib: Autorisation préliminaire de libération de fonds de recherche)

Conditions Spéciales / Commentaires:

Le certificat est valide pour les phases I (entrevues) et II (groupes d'entretien). Un nouveau certificat sera émis lorsque la phase III (action collective) sera approuvée.

550, rue Cumberland 550 Cumberland Street
Ottawa (Ontario) K1N 6N5 Canada Ottawa, Ontario K1N 6N5 Canada
(613) 562-5841 • Téléc./Fax (613) 562-5338
http://www.research.uottawa.ca/ethics/index.html
http://www.recherche.uottawa.ca/deontologie/index.html

File Number: 05-12-08B **Date (mm/dd/yyyy):** 04/14/2014

Université d'Ottawa University of Ottawa
Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Ethics Approval Notice

Social Science and Humanities REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

First Name	Last Name	Affiliation	Role
Bastien	Quirion	Social Sciences / Criminology	Supervisor
Sylvie	Frigon	Social Sciences / Criminology	Co-Supervisor
Catherine	Chesnay	Health Sciences / Population Health	Student Researcher

File Number: 05-12-08B

Type of Project: PhD Thesis

Title: Doing Health in Prison: Participatory Action Research with Women who Have Experienced Incarceration in a Provincial Prison- Phase 3

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
04/14/2014	04/13/2015	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:
N/A

550, rue Cumberland, pièce 154 550 Cumberland Street, room 154
Ottawa (Ontario) K1N 6N5 Canada Ottawa, Ontario K1N 6N5 Canada
(613) 562-5387 • Téléc./Fax (613) 562-5338
www.recherche.uottawa.ca/deontologie/ www.research.uottawa.ca/ethics/

Appendix I

As-tu le goût de t'impliquer pour aider
des femmes qui sont en détention?
As-tu été incarcérée pour une période de plus d'un mois dans
les deux dernières années ?

La recherche « Agir sur sa santé » s'adresse à toi !

Sur une base volontaire, une collecte d'anecdotes
est organisée pour contribuer à un recueil
destiné aux femmes de Tanguay et de Joliette.

Ces anecdotes seront aussi utilisées pour mieux comprendre
l'expérience des femmes durant l'incarcération.

La collecte aura lieu à la Maison Thérèse Casgrain

C'est ton vécu qui aidera une détenue !

Si tu as des questions ou si tu désires participer, contacte
Catherine Chesnay au XXX-XXX-XXXX
Ou par courriel à catherine.chesnay@uottawa.ca

Cette recherche est supervisée par Bastien Quirion (613-562-5800 poste XXXX; courriel bastien.quirion@uottawa.ca) et Sylvie Frigon (613-562-5800 poste XXXX ; courriel sylvie.frigon@uottawa.ca), professeurs de criminologie à la Faculté des sciences sociales de l'université d'Ottawa.

Appendix J

Objet: Demande de participation à une recherche universitaire qui porte sur la santé des femmes durant l'incarcération dans une prison provinciale

Madame,

Mon nom est Catherine Chesnay. Je suis doctorante en santé des populations à l'université d'Ottawa et je mène actuellement mon projet de thèse. Je suis supervisée dans mes travaux de recherche par Bastien Quirion et Sylvie Frigon, tous deux professeurs au département de criminologie de la Faculté des sciences sociales de l'Université d'Ottawa.

Le but de mon projet de recherche est de mieux comprendre comment les femmes qui ont été incarcérées ont vécu leur incarcération et agi sur leur santé durant cette période. La santé est souvent définie en termes d'absence de maladies et/ou d'accès à des soins de santé de qualité. Dans le cadre de cette recherche, la santé est abordée d'une façon plus large: la santé réfère ici au « bien-être », ce qui inclut le bien-être émotif, physique, mental et spirituel. Autrement dit, cette recherche vise à comprendre ce que veut dire « être bien », « se sentir bien » dans son corps, sa tête, son cœur, ou, au contraire, ce que veut dire « ne pas être bien », se sentir mal, durant une période d'incarcération.

Avec la collaboration active des participantes, l'étude tend aussi à mener une action collective sur la question de la santé et de l'enfermement. L'objectif de cette recherche est donc double: elle vise à mieux comprendre la réalité de l'enfermement et de la santé, et d'autre part, elle vise à entreprendre une action collective sur ce sujet, action qui sera déterminée par les participantes.

Dans le cadre de cette recherche, j'ai l'intention de réaliser des entrevues et un focus group avec des femmes qui ont été incarcérées dans un établissement carcéral provincial pour une période d'un mois ou plus et ce, durant les deux dernières années.

La participation à la recherche se fera en deux volets:

1. *Entrevue individuelle*: Entretien enregistré et ouvert d'une durée de 60 à 90 minutes avec les participantes.
2. *Focus groupe*: Le focus groupe sera d'une durée de 2 heures et seules les participantes du premier volet pourront y participer. Les participantes feront un retour sur le matériel récolté durant les entrevues. L'objectif de ce volet sera de définir et de planifier une action collective sur le thème de la santé et de l'incarcération. L'action collective peut être réalisée durant cette rencontre (ex: podcast, pétition) ou lors de rencontre(s) subséquente(s) (ex: rencontre avec services correctionnels, sondages).

La participation à la recherche à l'aide de l'entrevue se fera sur une base individuelle, libre et volontaire. La rencontre aura lieu à la maison Thérèse Casgrain ou dans un autre

organisme communautaire de votre choix. Lors de l'entrevue, je demanderai à la participante de signer un formulaire de consentement. En tout temps, elle pourra se retirer de l'étude librement (et ce, même après l'entrevue ou le focus groupe) ou simplement refuser de répondre à certaines questions.

Ce serait un plaisir pour nous de pouvoir compter sur votre collaboration. Si vous avez des questions concernant votre participation, ou besoin de renseignements supplémentaires concernant l'entrevue, n'hésitez pas à entrer en communication avec moi à l'adresse courriel suivante catherine.chesnay@uottawa.ca ou par téléphone au XXX-XXX-XXXX.

Si vous avez des questions concernant le projet de recherche, vous pouvez aussi communiquer directement avec le professeur Bastien Quirion 613-562-5800 poste XXXX ou par courriel bastien.quirion@uottawa.ca ou avec la professeure Sylvie Frigon au 613-562-5800 poste XXXX ou par courriel sylvie.frigon@uottawa.ca.

Finalement, pour tout renseignement sur les aspects éthiques de cette recherche, vous pouvez vous adresser au Responsable de l'éthique en recherche, Université d'Ottawa, Pavillon Tabaret, 550, rue Cumberland, salle 154, Ottawa, ON K1N 6N5, au (613) 562-5387; courriel: ethics@uottawa.ca.

Au plaisir de vous rencontrer,

Catherine Chesnay