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The imprisoned body : women, health and imprisonment.

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THE IMPRISONED BODY : WOMEN, HEALTH AND IMPRISONMENT

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I was never allowed to forget that being a prisoner, even my body was not my own (Maybrick, 1905 :112).

The idea that law has the power to right wrongs is persuasive. Just as medicine is seen as curative rather than iatrogenic, so law is seen as extending rights rather than creating wrongs (Smart, 1989 : 12)

Abstract

Problems affecting the female prison population have become increasingly acute. In response to a spirit of 'toughness' in penal policy, the number of women prisoners has grown sharply and more women are being sent to prison despite arguments in favour of decarceration and alternative sanctions.

In prison, women make greater demands on prison health services and are generally considered to carry a greater load of physical and mental ill-health than their male counterparts. However, a gender-sensitive theory based on an understanding of the relationship between women's health and women's imprisonment has not been formulated.

Health is a complex phenomenon of inseparable physical, mental and social processes. Research conducted in three women's prisons in England set out to explore the relationships between these processes. Data were generated from group discussions, in-depth interviews, a questionnaire survey and observation and participation in 'the field'. The findings suggest that women's imprisonment *is* disadvantageous to 'good' health.

Deprivations, isolation, discreditation and the deleterious effects of excessive regulation and control all cause women to suffer as they experience imprisonment. These are not *medical* problems. Yet, they often become so once they cause, as they inevitably do, stress and anxiety. The woman prisoner who finds herself unable to cope is likely, eventually, to come into contact with the prison medical enterprise where a medicalised view of suffering de-politicises the significance of women's distress.

Social and cultural factors in women's pre-prison and prison lives interact to influence their health and their freedom to choose 'correct' health behaviours. While different in degree, the problems facing women prisoners are of the same kind as those they face in their outside lives and the same kinds of 'solutions' are adapted to deal with them. Such solutions often have unforeseen consequences which can intensify the pains of imprisonment and be further prejudicial to health.

These findings raise questions about the philosophies underpinning current models of prison health care where the benevolent aims of 'health promotion' may become extremely punitive.

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IMPRISONMENT MAY DAMAGE
WOMEN'S HEALTH

Women prisoners have been receiving a lot of attention of late : mothers shackled at funerals; pregnant prisoners chained in labour wards; hangings at Holloway; Inspection teams beating a hasty retreat; women banged-up for 23 hours a day; 'battery-hen' cells; jail drug abuse shocks, *et cetera, et cetera.* For journalists, 'this is such stuff as dreams are made on'. *Coronation Street, Brookside* and *Eastenders* have all had their fair share of 'jail-birds'. The popular imagination, it seems, has been captured. At the centre of the debate rests one fundamental issue : how best to deal with women law-breakers.

This debate is by no means new. Feminists have been theorising about women and crime and women's imprisonment for the past couple of decades and it is no longer possible to introduce a study such as this with the assertion that there is virtually *no* information on the subject.

In this thesis I hope to extend and build upon feminist work by analysing women's health and imprisonment. The thesis is about a particular group of women who do not fit a certain stereotype. It is about the ways in which doctors, psychiatrists, police officers, members of the judiciary, probation officers and prison officers seek to control those women who will not or cannot conform to conventional categories of womanhood. It is about women's bodies and the ways in which the social construction of femininity affects women's health. The constraints and contradictions within notions of appropriate femininity make the achievement of healthy womanhood problematic.

The thesis tells the stories of women prisoners. However, these are also the stories of women and, in this respect, the thesis is about *all* women. Women prisoners suffer the same problems as the rest of us. Once you get over the awesome fact of imprisonment itself, the difference may not be so much in nature as in degree. The greatest problems for women - the problems which may or may not lead to them offending - are social and are widespread. However, the tendency in Western societies has been to address social and political issues as problems of individual pathology. As a result, women in general and women prisoners in particular have been increasingly exposed to the gaze of those whose 'expert' knowledge informs our criminal justice, health care and social systems. That gaze, which captures women prisoners in a medico-legal niche, effectively leaves their offending behaviour unexplained. While they are probed, tested, treated, punished, they are rarely understood. What I hope to reveal in this thesis is that what women prisoners need is not 'treatment', 'therapy' or medical intervention in their lives, but rather 'healthy' public and penal policies.

Acknowledgements

One changes a lot in the course of an academic apprenticeship such as this : you develop new patterns of thought, new sources of hope as well as cynicism. I would like to thank all those individuals who directed me, and distracted me, along the way. First of all, I would like to thank all the staff and prisoners who gave of their time, their trust and their histories. Two women prisoners, in particular, gave me hope through their good humour and perseverance : you know who you are.

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INTRODUCTION

Words from within

Energy coursing through my veins
I feel as if I'm connected to the mains
With no acceptable outlet, I'm going to explode
Yet again I'm travelling that same destructive road

Locked in my cell, there's no way out
So I'll smash things up and scream and shout
I know it's not the way to deal with my pain
So why do I travel this road again

Mixed up feelings come to a head
Reach for a razor, wish myself dead ...

(Jez, HMP Styal, 1994)

In July 1994, I spent some time 'on' Styal prison's 'Muppet House', where, according to Prison Service-speak, 'inadequate' women are accommodated. Here, I got to know a woman I shall call Jez, aged 29, who was serving her fifth prison sentence for shoplifting. Her story, told with candour and studded with humour, is one of the oral histories upon which this thesis is based.

For much of Jez's 'childhood' she was physically abused by members of her family, particularly her father. She frequently 'wagged' school and spent much time alone. Her institutional career began in her early teens when she was taken into 'care' having been sexually assaulted by an uncle. This incident and the events which followed marked a significant turning point in her life, opening it up for the first time to the formal intervention of disciplinary agents, mainly men :

> I can honestly say that what's happening to me now, the cutting up and everything, is down to him. It's down to what he did to me. It's not as if I was naughty as a little girl or anything. But

> since that happened, I've been in trouble ever since. He really hurt me and I trusted him. I kind of made a pledge after that never to trust a man again ... All my life since that happened, it's been men telling me to do that, to do this, to do the other. It drives you mad ...

Like many other state-raised children, Jez soon learned that survival was the name of the game :

> I remember being taken to a big, old, dark building - it probably wasn't like that at all, but that's how I remember it. There was no light, no sense of anything going on there ... I remember feeling really frightened but I didn't want to show anyone how scared I was. I remember chattering away, thinking, 'Don't let them see how scared you are'. So I put on this big brave face. I tried to make out I was hard. There were some other kids there, a bit younger than me which was OK because I could boss them about a bit [laughs] ...
>
> ... I hated it there, in some ways it was worse than prison. In here, you can shout off and that. You might end up on the block but at least you can do it. There, you were scared to even breathe. They were so strict ... a bunch of us ran away once and I remember them coming after us. It's quite funny now, but we were terrified at the time.

It was at this time that she started drinking heavily, experimented with drugs, got involved in minor criminal activities and first came into contact with the agencies of criminal justice. She describes the past fourteen years as being 'one long round of crime, drugs and trouble', leading, perhaps inevitably, to prison. She describes prison life :

> They call this the cutting house, the muppet house ... [Pointing to a large mural of a tropical island] Welcome to the Costa del Styal! ...
>
> I didn't find prison, it found me ... I've been at Risley, New Hall and now here. The first time I went to Risley I just felt like I was in hospital for two weeks. I spent all my time crying and sleeping. I was on the block at New Hall...
>
> I suppose you get used to it after a while, the routine and things. The screw will open the door at 7.45 and go 'morning'. So you go 'morning' [laughs]. Then you think 'Oh shit, another day, I've

got to get up'. Then I wait till about 8 o'clock because at about 8.15 they shout roll call and do a security check. Now I don't know why they do that at 8.15 when at 7.45 they've just checked you but ... I guess they think you might top yourself or escape at the sight of breakfast [laughs]. For the rest of the day we're pretty much stuck in here, which is horrible when the weather's good. They say that we can't go out because someone has to watch over us. They're always watching over us because of the cutting-up and that ... At the end of the day, though, I think they make it worse because there is nowhere you can go to be alone, to have some space. Whenever I go to my room I'm followed, either by a screw or by one of the others [nods towards the other women]. It does your head in after a while...

We usually do education until 12 o'clock, that's the lunch break. We have lunch and watch T.V. Then there's usually something going on in the afternoon. Sometimes people come in and give us talks about make-up, hair, cooking and that. Then we have tea and put the telly on, have a bath and that's about it. It's pretty boring really. We have a laugh, well as much of a laugh as you can have...

The rules get to you ... well I get wound up about it. They have petty rules and its very much if your face fits. There's one rule for one and one for someone else. I know there has to be some rules, but in here you've got no control, you don't know who will put you on report for what because one officer will say one thing and another will say something else. So you're left totally confused because you see some of them getting away with things and you think 'Oh I'll have a go at that', and it's down the block ... you can't win in here.

Jez wears the visible and permanent reminders of disaffection which seem to characterise those with a history of institutional care - tattoos and self-inflicted scars - with a mixture of pride and embarrassment. She has a long history of cutting-up, which dates back to her first custodial sentence :

I remember when I was in Risley the first time, taking needles and just scratching away at my arms, my legs, my face, my stomach [shows me the scars] ... I know it's stupid and I've tried to work out why I do it but I can't. I think that sometimes I just feel so out of it (I don't mean in a kind of stoned way) but out of control, do you know what I mean? I feel as if I have no say in what goes on, and if I did what could I do, and so I'm just watching other people make decisions, telling me what to do all

> the time ... it sometimes just gets to you, pushes you that little bit too far ... I think

She made a 'very bad attempt at suicide once' :

> When I first came in here I tried to slash my wrists but I couldn't because it was a plastic knife anyway [laughs] ... now I keep a piece of glass just in case ...
>
> One of the officers found me ... They wanted to keep me on the hospital, but I hated it. The nurses are OK but they don't understand about cutting-up and that. They were just firing questions *at* me rather than talking *to* me. I think that's all I needed ... someone to talk to rather than someone talking at me. If I could have gone somewhere quiet it might have helped. But they were just making so much hassle ... So I tried to run away and so it was down the block - it's really dirty there, but I guess it's quite a good way to get your head together ... you've got no choice, but after a day you're climbing the walls, well I was...
>
> Because I'd attempted it I had to see a counsellor and a psychiatrist but they were both men ... there's a lot of women on here and on the other houses who've had problems with men and what do they do? They expect you to talk about your problems with a man - the doctor's a man too ... and in any case, all they want to talk about is [the rape] and the offence. It's as if they are trying to put it all down together ...

During her time in prison she has repeatedly self-harmed, attacked a member of staff and set fire to a cell. Jez recognised that her behaviour meant that she now had a reputation as a tough and/or difficult prisoner, a reputation which she often 'live[s] up to'. As a consequence, she has spent much time 'alone, but never alone' and in strip conditions. She has had few visitors or contacts with the outside world.

In talking about herself, Jez articulates the injured sense of self she has experienced :

> I think they think I'm mad, I've seen that many shrinks ... But not many people see the real me. You have to show that you're the toughest, tougher than all the rest. But I'm not like that, not really.

> I sometimes wonder who I am, what I'm doing here, do you know what I mean? People often get the wrong impression about me ... because of the way I look - full of bravado, couldn't give a shit - but I often want to let on that that's not me, that's not what I'm like ... but at the end of the day sod it. I don't care what anybody thinks.

She recognises that in prison, not only is she denied any control over her life but that she is also increasingly subject to the punitive control of others. She describes an incident where she wanted to get out of the house for a while and so, egged on by the other women, she stormed the fire exit and was chased by officers :

> It was quite funny really. I was running and they were running and all the women were shouting. I guess I was seen as the ring leader, but all I wanted was some space. So I had a week down the block for storming the fire door. I think it was because they felt that I'd made them look stupid, having to run after me and that [laughs]. At the end of the day I only wanted some space ... I was on the block for a week and I didn't eat or drink. In the end [the doctor] - do you know they call him the vet? - came down and forced my mouth open ...

Her attempts to define some space for herself are met with denial. Not only does prison deny her her liberty, it also seems to deny her the freedom to develop as an independent being. When she challenges the lack of personal (and physical) space, she is subject to further control.

In another incident at New Hall, Jez ended up in more serious trouble, when she assaulted an officer :

> New Hall was OK apart from the screws... This one officer called us up for our showers and she pushed me so I hit her. I was only defending myself but they didn't see it like that. I was shipped out eventually, but not before they'd made my life hell, do you know what I mean? Life was bad enough before that, but after it I couldn't move without being followed, I couldn't breathe without permission.

Jez describes herself as a 'big bad dyke (and proud of it)'. At the time of the interview she was having a 'relationship' with another woman prisoner, a woman serving a life sentence. She recognised, however, that this was not an unproblematic relationship, largely due to what she describes as 'an institutional fear of affection' :

> Prison's full of lesbians (most of them on the staff) but they act like it doesn't exist, like it's wrong or abnormal ... Most women, well the majority, will try it out. Most of them are what we call 'jail gay', they just try it out while inside and then go out back to their boyfriends, husbands, dogs, whatever! It's really difficult to form a relationship as such and, if you do, you're likely to get split up or shipped out.

To pass the time in prison, Jez writes poems :

> I've got nothing else to do. They're [the poems] not very good, but I've found that I can sometimes say things better in poems than in real life ... it's as if I don't have to keep up an act but can say what I really feel.

As well as writing poems to pass the time, Jez also regularly 'blanks everything out' with drugs, usually marijuana, and in her description of her drug usage, both in prison and outside, I am reminded of Steve Jones, of the Sex Pistols, who was once quoted as saying, 'ordinary life is so dull that I get out of it as much as possible'. Jez comments :

> Life is so shitty, it's the only way I can cope at times. I used to sniff glue, solvents and that ... but being asthmatic [laughs] it used to really affect me. It used to be one sniff of the glue and two puffs of my inhaler. Then I moved onto pills and stuff but now it's really only blow ... and smack ... I think I just need that feeling, it's like a security ... it helps me to forget everything, evens everything out. When life is really shitty, I think it makes things a little bit, not better, but bearable.

Originally from the North West of England, but now homeless, Jez has had no contact with her family for over ten years. She has spent much of the past few years sleeping on friends' floors and living 'rough'. Like many others, this has

had an impact on her physical health - she suffers from chest problems, eczema and other skin disorders.

She also describes times when she feels really emotionally low :

> At times things really get on top of you and you find that some days you can get up and you think 'Oh god I've got to put up with that again'. In the past, even when things have been really rough, I would never have thought of committing suicide but quite a few times I have because I've been so down. That might have something to do with the cutting up and that...
>
> I'm still under the psychiatrist because of before. But you get the psychiatrist saying 'the reason you are doing it is because of this or that'. It's not what you're feeling inside as far as they're concerned, it's what else has happened in your life. That's their thing and if you ask for something to calm you down it's 'Why do you want calming down?' It's not that they want to help you. On the other hand, you go to see the doctor and he's only too happy to give you a pill for this, a pill for that ... that's the standard response - pills - and sometimes, well most of the time, that's not what you want.

The last time I saw Jez was shortly before she was due to be released. I expected her to be excited and anxious to get out. However, she recognised that, while she did not want to come back to prison, it would be hard for her to assimilate back into the community and lead a 'normal' life, 'whatever that might be' :

> I haven't really got anything to look forward to. I don't know if I've got a future ... My problem is that I haven't got anywhere to go. I'm officially homeless, my friends have all moved on, or died ... I don't fit in anywhere. I'd love to get a job working with children but [points to herself and laughs] would you trust your children with someone like me? I don't think so... I don't want to come back here, but sometimes I think, well, we'll see ...
>
> The thing is, you go shoplifting when you're hard up. When I get out of here I'm still going to be skint. I'm going back to square one, well minus square one. I'll have no money ...

Jez is just one of the women prisoners I interviewed in the course of the fieldwork upon which this thesis is based[1].

My aim in conducting the research was, at its broadest, to explore women's experiences of health and imprisonment and to locate the oral biographies of women prisoners in some theoretical context. While relatively few women go to prison and, proportionately, they make up a minority of the total prison population, I was conscious of the fact that more and more women were being sent to prison despite arguments in favour of decarceration and alternative sanctions. Moreover, I was also aware of the persistent negative imagery of such women in both popular and professional discourses.

I set out on my doctoral studies, somewhat naively, fresh from an MSc. in health promotion, keen to explore the operation of the newly fashioned health promotion policies in the newly formed Health Care Service for Prisoners. It was the happy coincidence between the needs of the service and the needs of the researcher that greatly eased the familiar problems of access. But, once ensconced in 'the field', I quickly began to question whether the laying of a health promotion veneer on the policies of punishment would produce an improvement in the health and welfare of the female prison population. I thus found myself employed on an odyssey which would take me through the very processes, policies and practices of women's imprisonment and from which women prisoners' health and well-being cannot be divorced. This thesis is the outcome of that journey.

The research was conducted between January 1994 and May 1995 in three women's prisons in England : Styal in Cheshire, a closed prison for sentenced adult women and young offenders; Askham Grange in Yorkshire, an open prison for adult women, and Low Newton in Durham, a remand centre for male and female young offenders and adult women. A detailed discussion of the research methods and the process of 'doing' the research is provided in

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[1] Throughout the thesis, the women are all referred to by fictitious names.

Appendix I. However, brief details are as follows : the study employed a mixed-method strategy developed around a three-stage research design. The first two stages involved a semi-participant approach. I wanted to talk to and, more importantly, to listen to, women prisoners and also to those who come into contact with them. The study began with the collection of data from a series of one-off tape-recorded discussion groups involving thirty-nine women prisoners. The groups comprised women of a wide range of ages from 16 to 63. Participants were asked to discuss various issues : from general definitions of health to perceptions of being in prison to more focused topics such as self-harm and suicide. An analysis of the data secured in these discussions formed the basis for the subsequent stages of the project.

In the second stage of the project I conducted sixty in-depth, semi-structured, tape-recorded interviews with fifty women prisoners. The interviews were loosely structured to cover the women's experiences and perceptions of imprisonment, prison health care services, health and illness (past and present), as well as general background details. While these topics were discussed with all women, they were encouraged to tell their own stories (brief details of the women's biographies are provided in Appendix II). In this part of the study I also conducted twenty semi-structured, in-depth interviews with members of prison staff : including, discipline, education, nursing and medical staff. These interviews covered career history, current duties, perceptions of service provision and priorities for future development.

The final stage of the project involved a simple questionnaire survey. Brief self-completion questionnaires were distributed to all women prisoners present in each of the three fieldwork establishments on a specific day. The questionnaire was largely formulated on the basis of the interview data and contained indicators of health status, indicators of perceived needs for services, patterns of service use as well as questions to elicit general socio-demographic and criminological details. Questionnaires were completed and returned by two

hundred and fourteen women (approximately ten per cent of the total female prison population in England).

The thesis is based predominantly on the oral accounts of the women prisoners themselves, although it draws upon the interviews with prison staff and my own observations and participation in 'the field'. Selected findings from the questionnaire survey are also provided to offer some context within which the more qualitative materials can be interpreted (a more detailed summary of the survey findings is provided in Appendix III).

Each of the women interviewed has her own story to tell. However, the compelling nature of each individual account should not deflect attention away from their similarities. Like Jez, many of the women's lives have been characterised by exclusion (from the circumstances that might facilitate the development of an independent self and from the decisions affecting their lives), and uncertainty (about money, where they will live, whether their children will live with them, whether they will face violence and/or abuse). Jez, like many of the other women, has in crucial respects been failed : by her family; by social and education services; by a lack of appropriate treatment for substance use; and by a system which responds punitively to her distress. With Jez, and with many of the other women in this study, we can clearly see the damage that can result.

For these women the goal was to 'survive' prison, to minimise the challenge to their sense of self-identity and, hopefully, to achieve enough control over their lives to avoid returning to prison in the future. In the chapters which follow, I seek to provide a theoretical commentary on the women's own accounts and to show the extent to which 'the system', of which prison is a part, impacts upon the lives, health and well-being of women, how they react to this, and the patterns of institutional response. In so doing, the analysis is driven, somewhat eclectically, by a number of distinct, although not mutually exclusive, perspectives on the body, self-identity, adaptation, resistance, medicalisation

and social control. Chapter one provides the theoretical context within which the subsequent chapters can be understood.

Chapters two and three respectively tell the story of *becoming* a prisoner and *being* a prisoner. Women are taken out of society and away from the people and places that characterise their daily lives. Once in prison, the prisoner is subjected to the full rigours of formal social control. She is initiated into a regime intended to structure every aspect of daily living - from when she gets up to when she goes to bed and beyond. Inside prison, women experience restricted and regulated lives, isolation and social discreditation. These processes and conditions, which seek to control women prisoners (in a formal sense), are, however, similar to those in which all women are controlled and constrained. The difference is one of degree. A fundamental form of suffering that results, however, is the damage to the self : whatever sense of self a woman brings in with her is severely challenged as she assumes the identity 'prisoner'. Individuality is challenged and conformity sanctioned.

No matter how much prison authorities may seek to control them, however, prisoners are not merely passive subjects. Indeed, it would be surprising if there were not some response from the self and the ways in which women do respond to imprisonment is the subject of chapter four. From the experiences of the women in this study, five main strategies can be recognised : 'cutting-off'; 'making good'; 'kicking-off'; 'substance use' and 'self-harm'. A woman might use one or more of these strategies at different times and in different contexts. For most women, their response represents an attempt to construct and maintain a viable sense of self and they adopt a coping strategy about which they are able to talk quite objectively. For some, however, the mode of adaptation becomes a more central aspect of their sense of self, to the extent of ruling their lives : they become their coping strategy.

While the constraints of femininity may make the achievement of healthy womanhood problematic, imprisonment in and of itself seems further

prejudicial to health. This raises the question, rhetorically at least, of whether it is possible to be healthy in what might be seen as a 'sick society'? Chapter five explores women's health and imprisonment by looking at a number of key issues : women's health status; the utilisation and organisation of prison health services and the relations and power structures involved in the doctor-woman/prisoner/patient relationship.

Prison health services have received a lot of 'bad press' in recent years. One reason for this is the inherent incompatibility between the role of providing *care* in conditions which seek to *control*. As a result, prison health care is currently undergoing significant change. Current developments promise enhanced health benefits for prisoners and the promotion of health has become a central feature of prison health care policy. The concluding chapter presents the background to these changes, reviews what they are likely to mean in practice and explores the policy implications of what has been reported in the preceding chapters. It provides a description of the emergence of health promotion within the prison context at the level of both rhetoric and implementation, and offers a critical analysis of these developments, locating them within the context of wider socio-cultural changes. In particular, it argues that health promotion cannot be divorced from prevailing ideologies about women's role in society and about the needs of women prisoners.

CHAPTER 1

Women, health and imprisonment : Some theoretical considerations

Consider her ways, and be wise (*Proverbs* 6 : 6)

This thesis is concerned with women, health and imprisonment. While a number of sociological studies have focused on women and health[1] and studies of women's imprisonment have expanded greatly in recent years,[2] there is no detailed sociological analysis which combines perspectives on each, although, as I hope to demonstrate, women's imprisonment *is* a health issue.

The purpose of this chapter is to set out some theoretical considerations in an attempt to understand what is meant by women's health and women's imprisonment. In addressing these issues, the chapter draws upon the work of a number of writers on the body, power and resistance. The chapter is divided into three key sections :

- **The body, power and self-identity;**
- **Women, medicalisation and social control;**
- **Power, legitimacy, adaptation and resistance**

For purposes of clarity, these issues are considered separately. However, there is much theoretical overlap and the broader aim of the chapter is to begin to explore the ways in which women (and men) act as both *constructing* and *constructed* subjects both inside and outside prison.

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1 See, for example, Miles (1991); Wilkinson and Kitzinger (1994).

2 Howe (1994) provides a discussion of the feminist analytical approaches to women's imprisonment which have emerged over the past 10-15 years.

The body, power and self-identity

The human body, explicitly or implicitly, is ultimately the subject of all research directed towards analysing the social dimensions of health and health care. However, it is easy to ignore the importance or even existence of bodies, simply because they are so taken-for-granted. As Turner (1984) points out :

> We have bodies, but we are also, in a specific sense, bodies; our embodiment is a necessary requirement of our social identification so that it would be ludicrous to say 'I have arrived and I have brought my body with me' (Turner, 1984 : 8).

It is now something of a truism within sociology to state that the body is more than a purely biological phenomenon and that it can not, therefore, be analysed solely at a biological level. However, until recently, social and political theory tended to adopt a *disembodied* approach, ignoring the body and placing emphasis instead upon social structures and individual subjectivity with little discussion of where the corporality of the *lived* body fitted in (Turner, 1984, 1991)[3]. One reason for this relative neglect of the body within social theory was the desire to avoid the biological determinism characteristic of the 'pure' human sciences. Moreover, sociology as a discipline has been guilty of following the Cartesian mind/body, culture/nature split. As a consequence, for many years *macro*-sociologists tended to focus on the structural, political and economic dimensions of social control, while *micro*-sociologists were concerned with individual behaviour as socially constituted.

There has, however, in recent years, been an increase in academic interest in the body. The body has emerged as an important social issue and for many academics it now represents *the* social issue *par excellence.* Frank (1990 :131), for instance, has argued that it is now the case that bodies 'are in academia as well as popular culture'. This growing 'body bandwagon' can, in many respects,

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[3] While sociology has tended to ignore the inter-relationship between bodies and the social order, anthropologists have long taken an interest in the way in which body symbolism is used in small-scale societies to integrate communities and define social and spatial relations (see, for example, Douglas, 1966).

be explained in terms of modern social movements such as feminism, the growth of consumer culture and the influence of post-structuralism (Turner, 1991). These movements have, according to Lupton (1994), focused new attention upon the body, its role in human subjectivity and its constitution by both elite and popular discourses.

Lupton (1994) argues that the body can no longer be considered a given reality. Rather, it is seen as the product of certain kinds of knowledge which are subject to change. Similarly, Haraway (1989 : 10) claims that bodies 'are not born : they are made'. This, however, is not to suggest that the human body possesses no physical reality or that it is solely a social construct. To do so would be to deny any acknowledgement of the sheer physicality and inevitable social consequences of physiological experiences such as childbirth, menstruation or clitoridectomy. Rather, the body may be conceptualised as an 'admixture of discourse and matter, one whose inseparability is a critical, though complex, attribute' (Rothfield, 1992 : 102). Bodies are regarded as not simply shaped by social relationships, but as entering into the construction of these relationships, both facilitated and limited by historical, cultural and political factors (Lupton, 1994).

The ways in which the state and its agencies undertake surveillance and control of bodies, and how in turn individuals come to self-regulate and discipline their bodily deportment have become of particular academic interest. Turner (1992), for example, has developed the concept of the 'somatic society', which he defines as :

> a social system in which the body, as simultaneously constraint and resistance, is the principal field of political and cultural activity. The body is the dominant means by which the tensions and crises of society are thematised; the body provides the stuff of our ideological reflections on the nature of our unpredictable time. We live in a world that is out of joint ... our major political preoccupations are how to regulate the spaces between bodies, to monitor the interfaces between bodies, societies and cultures, to legislate the tensions between habitus and body... The

> somatic society is thus crucially, perhaps critically, structured around regulating bodies (Turner, 1992 : 12-13).

The writings of Goffman and Foucault, as well as feminist critiques, have exerted a considerable influence on contemporary analyses of the body as a socially constructed phenomenon. The work of these two writers has traditionally been seen as radically different from one another. This is because Foucault tends to be categorised as a post-structuralist, concerned with how bodies are *controlled* by discourses, while Goffman has been seen as a symbolic interactionist, interested in the body as a component of *action.* However, on closer analysis and for the purposes of this study, their work has much in common. Despite their different theoretical positions, both writers conceptualise the body as significant to the lives of the embodied (that is, us), while also maintaining that it is determined ultimately by social structures which exist beyond the reach of individuals. A number of sociological dimensions arise from the work of Foucault and Goffman which, taken together, provide an important theoretical context for the study of women, health and imprisonment.

Foucault : the disciplined body

Foucault has argued that the body represents the meeting point of a range of discourses,[4] including medical, epidemiological and criminological (Smart, 1989). He is concerned with an examination of the relationship between certain discourses and the use of power in society and his analysis is organised around an enquiry into the body (of individuals) and bodies (of populations). He is concerned, therefore, with the *processes* by which power is exercised in society and the *effects* of that exercise (Sim, 1990).

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[4] Discourse is a central concept in Foucault's analysis of knowledge/power. Foucault thinks of discourse in terms of bodies of knowledge. His use of the concept moves it away from the linguistic sense and towards the concept of discipline. Here, the term 'discipline' is used in two ways : as referring to academic *disciplines* such as medicine and psychiatry; and as referring to *disciplinary* institutions such as the prison and the hospital. Foucault's concept of discourse thus reveals the historically-specific relations between disciplines (that is, bodies of knowledge) and disciplinary mechanisms (that is, forms of social control). See McHoul and Grace (1993) for a more detailed discussion of Foucault's analysis of discourse, power and knowledge.

For Foucault (1973, 1977, 1979), the body constitutes the link between daily practices on the one hand and the large scale organisation of power on the other (Dreyfus and Rabinow, 1982). He argues that, since the eighteenth century, the body has been the ultimate site for the exercise of disciplinary power, ideological control, surveillance and regulation. Through the body and its behaviours, state apparatuses such as medicine and the law define the limits of behaviour and record activities, punishing those bodies which violate the established boundaries.

In his analysis of the development of medical knowledge (and hence power) in France, Foucault identifies the establishment of the medical clinic and teaching hospital in the late eighteenth century as a pivotal point for ways of conceptualising the body. Medicine, he argues, is a major institution of power in labelling bodies as deviant or normal, as controlled or in need of control :

> [Medicine] set itself up as the supreme authority in matters of hygienic necessity, taking up the old fears of venereal affliction and combining them with the new themes of asepsis, and the great evolutionist myths with the recent institutions of public health; it claimed to ensure the physical vigour and the moral cleanliness of the social body; it promised to eliminate defective individuals, degenerate and bastardised populations. In the name of a biological and historical urgency, it justified the racisms of the state ... it grounded them in 'truth' (Foucault, 1979 : 54).

In *The Birth of the Clinic* (1973) Foucault argues that changes in medical practices in the late eighteenth century all served increasingly to exert power upon the body, as processes of surveillance, normalisation and individualisation became key features in the professionalisation of medicine. The medical encounter thus became a prime site for the surveillance of bodies. Here, the body is objectified, prodded, tested and probed and the owner is expected to give up his or her jurisdiction of the body to the 'expert' doctor.

For Foucault, these processes were also clearly evidenced in prison - the institution *par excellence* for the control of bodies. The emergence of the

prison at the end of the eighteenth century and of the 'expert' groups who staffed it was built around discipline, surveillance and individualisation and where, 'the body of prisoners was broken down and fragmented into individual cellular spaces' (Sim, 1990 : 9). Sim (1990) argues that the consolidation of medical knowledge at this time reinforced this fragmentation :

> The prison became a laboratory in which the advice and expertise of the medical profession, both physicians and psychiatrists, was geared to reintegrating the confined back to normality. Domination through observation objectified the prisoner as 'diagnoses began to be made of normality and abnormality and of the appropriate procedures to achieve a rehabilitation ... to the norm'. In this way probing, testing, studying and examining the body and mind of the confined was intrinsic to the development of power relationships (Sim, 1990:9).

At its most general level, Foucault's work represents an analysis of a period of change, centred on the transition from traditional to modern societies (*circa* 1780 - 1820), in which individuals are produced as embodied subjects and connected to 'scientifically' managed institutions. This transition brought with it a shift in the *target* of discourse, 'as the fleshy body gave way to the mind as a focus of concern' (Shilling, 1993 : 75). Subjects were no longer formed by discourses which directly constituted the body as flesh but, increasingly, by discourses which indirectly controlled the body by constructing it as a 'mindful body'. The mindful body is controlled less by brute force, as in traditional societies, and more by surveillance : 'Our society is one not of spectacle, but of surveillance' (Foucault, 1977 : 217).

In *Discipline and Punish* (1977), Foucault's analysis of systems of punishment, the transition in the target of discourse from the 'body as flesh' to the 'mindful body' is clearly evident. In traditional societies the most serious forms of judicial punishment took place in public where offenders were ritually burned, assaulted and dismembered in a symbolic display of authority (Sharpe, 1990). Here, the body was a highly visible target of penal repression (Foucault, 1977). In contrast, with the development of the prison system, there was a movement

away from punishments aimed at the bodies of offenders to those directed at their souls. This shift was part of a process in which control over offenders, and society in general, passed increasingly into the hands of 'experts'. Physical force and punitive public ceremonies were replaced by a form of power based on bureaucratic knowledge of offenders (Sharpe, 1990).

The physical confinement of offenders, against their will but in the name of their improvement, in houses of discipline and punishment provided a means of accessing their *minds*. State violence was redeployed from public sites of punishment, sanitised and camouflaged within the walls of the prison (Keane, 1996). This was epitomised by the Panopticon, a prison design advocated by Jeremy Bentham. The Panopticon was a circular building of cells where prisoners were always subject to surveillance from a central watchtower. While never built in the UK, the Panopticon serves as a metaphor for a particular form of surveillance : Panopticism.

Panopticism is the exemplary disciplinary technique through which power is able to function (McHoul and Grace, 1993). Reliant on surveillance, it is intended to encourage the prisoner (and others) to *self*-monitor and to exert *self*-control over their behaviour : to discipline him- or her*self* :

> Hence the major effect of the Panopticon : to induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power. So to arrange things that the surveillance is permanent in its effects, even if it is discontinuous in its actions; that the perfection of power should tend to render its actual exercise unnecessary; that this architectural apparatus should be a machine for creating and sustaining a power relation independent of the person who exercises it; in short, that the inmates should be caught up in a power situation of which they are themselves the bearers (Foucault, 1977 : 201).

Foucault has argued that the shift from traditional to modern societies was accompanied not only by a change in the *target* of discourse (the flesh/mind transformation), but also by a change in the *object* of discourse, as

governments displayed a growing concern with power over the life and welfare of people, rather than their death. This included a preoccupation with health and illness, the fertility of populations, patterns of diet, concern with corporeal habits and customs (Foucault, 1979). For example, while punishment in traditional society was a negative affair, concerned with the repression of the body, the modern prison system was more concerned with productivity and sought to stimulate 'useful' and 'productive' forms of living (Shilling, 1993 : 77).

The *scope* of discourse also changed as the attention of governments shifted from a concern with controlling the individual body, to regulating bodies : whole populations. Foucault argues that the types of instruments and techniques used by the operations of disciplinary power can be used by *any* institution : hospitals, schools, psychiatric institutions, bureaucratic agencies, military establishments, as well as prisons. This provides a context within which detailed control can be exerted over much larger areas of society. Foucault (1984) views the modern state's preoccupation with controlling bodies *en masse* as developing in the eighteenth century conjointly with the emergence of the medical clinic and concerns about the preservation and upkeep of the labour force. At that time, he argues, a new discourse emerged which problematised disease as an economic and political problem for societies, which therefore required some degree of collective control (Foucault, 1984). By the end of the eighteenth century, charitable and religious institutions set up to deal with a range of problems among the poor had begun to be supplanted by state apparatuses directed towards policing behaviours believed conducive to the spread of disease.

The public health movement in the late nineteenth century further developed the rationale for the surveillance of bodies. Disease became constituted in the *social* body rather than the individual body, and deviant types were identified as needful of control for the sake of the whole population. As a result, by the

early twentieth century everyone became a potential victim requiring careful monitoring. As David Armstrong points out :

> The new social diseases of the twentieth century, tuberculosis, venereal disease and problems of childhood, had been reconstrued to focus medical attention on 'normal' people who were nevertheless 'at risk' (David Armstrong, 1983 : 37).

In the late twentieth century, the concerns of public health have remained firmly fixed on the surveillance and control of bodies, but have moved from containing infectious disease to exhorting people to take responsibility for maintaining personal bodily health (Armstrong, 1995). Contemporary public health measures directed at 'health promotion' narrows its focus on the individual by associating the so-called lifestyle diseases (such as heart disease and cancer) with individual behaviours. Health promotion rhetoric maintains that the incidence of illness is diminished by 'persuading' members of the public to exercise control over their bodily deportment. Health education is now a form of pedagogy, which serves to legitimise ideologies and practices by making statements about how individuals *should* conduct their bodies, including what type of food should go into the body, the amount of physical exercise the body should engage in and the nature of sexual expression (Lupton, 1994).

The dialectic of health promotion is that of the freedom of individuals to behave as they wish pitted against the rights of society to *control* individuals' bodies in the name of health. The rhetoric of health promotion discourse is such that the individual does not know that the discourse is disciplinary - health is deemed as a universal right, a fundamental good, and therefore measures taken to protect one's health must necessarily be the concern and goal of each individual. Initiatives to encourage individuals to change their behaviour, to know the 'risks' are therefore seen as benevolent. Thus, in being aware of the public gaze, the individual unconsciously exerts disciplinary power, both over others and over him- or herself, through self-regulation (Lupton, 1994).

The transition to modernity was, according to Foucault, therefore accompanied by a change in the means by which control is accomplished. There was a shift away from the achievement of control through repression, and an increased focus on maintaining control through the stimulation of desires. In the twentieth century, more discriminatory forms of control over the body became widespread. As Foucault (1980a : 57) argues :

> We find a new mode of investment which presents itself no longer in the form of control by repression but that of control by stimulation. 'Get undressed - but be slim, good looking, tanned!'

Goffman : the interactive body

While Foucault focuses on how the body is invested with powers that *control* individuals, Goffman's writings place more emphasis on the body as integral to human *agency*. Goffman is primarily interested in how the body enables people to intervene in, and make a difference to, the flow of daily life.

Goffman examined the role of the body in social interaction through his work on behaviour in public and private places, the presentation of the self and the management of stigma (Goffman, 1963, 1968, 1969) In his work, the management of the body is central to the maintenance of encounters, social roles and social relations. It also mediates the relationship between an individual's self-identity and their social identity.

There are three key strands to Goffman's analysis of the body. First, there is a view of the body as the 'property' of individuals. Here, Goffman argues that individuals usually have the capacity to control and monitor their bodily performances in order to facilitate social interaction. The body, in this context, is associated with the exercise of human agency, and it appears in Goffman's work as a resource which both *requires* and *enables* people to manage their movements and appearances.

Secondly, while the body is not actually produced by social forces, as in Foucault's work, the meanings attributed to it are determined by 'shared vocabularies of body idiom' which are not under the immediate control of individuals and which guide people's perceptions of bodily appearances and performances (Goffman, 1963 : 35). 'Body idiom' can be conceptualised as a form of non-verbal communication which, according to Goffman, is an important component of behaviour in public. At its most general level, it refers to 'dress, bearing, movements and position, sound level, physical gestures such as waving or saluting, facial decorations, and broad emotional expressions' (Goffman, 1963 : 33). Shared vocabularies of body idiom not only allow us to classify information 'given off' by bodies, they also provide categories which label and grade hierarchically people according to this information. Consequently, these classifications exert an influence over the ways in which individuals seek to manage and present their bodies.

These first two features of Goffman's analysis suggest that while human bodies are the property of *individuals*, they are defined as significant and meaningful by *society*. This formulation lies at the heart of the third main premise of Goffman's approach to the body. Here, the body plays an important role in mediating the relationship between a person's self-identity and his or her social identity. The social meanings which are attached to particular bodily forms and performances tend to become internalised and exert a powerful influence on an individual's sense of self.

The body is central to the most basic units of the interaction order in Goffman's work : the structuring of encounters (Shilling, 1993). Much of daily life involves established routines around work, leisure and family life where individuals initiate, enter and leave encounters with others. At every stage of these focused or unfocused encounters, the movements and appearances of the body send messages between people. For example, in our culture regular eye contact is an integral part of maintaining focused encounters, while frequent glances at a wrist watch signal a desire to leave (Shilling, 1993).

Encounters are important to social life as they are occasions in which people are concerned to 'act out' specific social roles (for example, daughter, sister, partner, lecturer, researcher). Goffman argues that if people are to appear convincing in these roles, they need to observe the *corporeal* rules which govern particular encounters. For example, in the doctor-patient encounter, the doctor may seek to convey the appearance of concern and interest while the patient may be concerned with presenting him- or herself in the 'sickest' light (Stimson and Webb, 1975).

The body also enters into the maintenance of social relations of power and powerlessness, dominance and subordination in ways which are far removed from the brute force of physical violence. For example, bodily expressions of deference, such as when a man opens a door for a woman, can be seen as not merely *symbolic* but as *constitutive* of gender inequalities (Goffman, 1979).

The management of the body, furthermore, enters into what Goffman describes as the morally 'neutral' act of 'civil inattention', the basic and most frequent type of interaction between strangers in contemporary societies. Civil inattention involves both a willingness to be seen and a sign of deference to those present. Goffman's standard example of this is behaviour in lifts where people struggle to avoid eye contact and stare at the floor numbers as they ascend or descend. Civil inattention involves not simply the use of the face but also the positioning of the body. In many senses, it is the respect we owe to, and expect from, strangers (Manning, 1992). It is most poignantly brought to light in situations where it is withheld : for example, when an individual is stared at by strangers.

The importance of *managing* the body in contemporary social life can lead to what Goffman (1969) has termed the 'bureaucratisation of the spirit'. This results from the amount of time individuals are required to produce consistent performances during encounters with others (Featherstone, 1982). It suggests that individuals have a need for relaxation within 'back-regions' where they can indulge in 'creature releases' which 'provide a brief release from the tension

experienced by the individual in keeping himself steadily and entirely draped in social clothing' (Goffman, 1963 : 68).

Bodily management, then, is central to the smooth flow of encounters, the acting out of roles and, more generally, to a person's acceptance as a full member of the interaction order (Shilling, 1993). In Goffman's work, this acceptance is also vital to a person's self-identity. This is because the vocabularies of body idiom used by people to classify others are also used for the purposes of *self-classification*. It is generally the case that if a person's bodily appearance and management categorises them as a 'failed' member of society by others, they will internalise that label and incorporate it into what becomes a 'spoiled' self-identity (Goffman, 1968). Goffman (1968), in his analysis of stigma, argues that we tend to perceive our bodies as if looking into a mirror which offers a reflection framed in terms of society's views and prejudices.

Goffman provides a number of examples of how the body mediates the relationship between self-identity and social identity. Embarrassment, for example, tends to be caused when people display inconsistencies in their character - when they fail to 'act out' their social roles proficiently - or when individuals fail to maintain the smooth flow of interaction - when the rules governing encounters are broken (Schudson, 1984). While the body is central to these failures of interaction, it also *communicates* these as embarrassment. Bodily manifestations include blushing, stuttering and making awkward gestures (Goffman, 1963).

Embarrassment signifies a threat to a person's *social* identity and their *self*-identity as a competent member of society because it reveals the gap between what Goffman terms their 'virtual social identity' (how they see themselves) and their 'actual social identity' (how others see them). Our virtual social identities tend to be governed by a general desire to appear 'normal', worthy of playing an active role in society. However, it is often the case that,

over time, our actual social identities impinge on our virtual social identities. Gaps which arise between the two social identities, and which occasionally lead to episodes of embarrassment, are usually reparable. The divergence between them is not usually significant enough to 'spoil' our self-identity as competent members of society. However, Burns (1992) points out that if our virtual social identity is found to contain features which are significantly disapproved of, then our social identity is likely to undergo a dramatic shift. As Goffman (1968 : 12) argues, from being a whole and usual person, we will become a 'tainted, discounted one'.

Stigmatised individuals (that is, those with attributes which have been labelled as discrediting) confront problems in social interaction with 'normal' individuals which can have damaging consequences for their self-identity. Goffman (1968) argues that, if they attempt to pass for 'normal', they run the risk of having the discrepancy between their virtual and actual social identities 'discovered'. This can have the effect of spoiling their social identity and cutting them off from society and themselves so that they stand alone as a 'discredited person facing an unaccepting world' (Goffman, 1968 : 12-13). Goffman points out that :

> [The] stigmatised individual tends to hold the same beliefs about identity that we do ... the standards he has incorporated from the wider society equip him to be intimately alive to what others see as his failing, inevitably causing him, if only for moments, to agree that he does indeed fall short of what he really ought to be (1968 : 17-18).

Goffman's analysis of the interaction order is of great importance for an understanding of the *manageable* body, because of the insights it provides into how individuals *control* and *monitor* their bodies and the relationship between the body, *self*-identity and *social* identity.

Foucault and Goffman provide us with contrasting views of the body and I will return to the work of both these writers in the section on adaptation and resistance (below). In their different ways they bring society into the body as a

way of investigating its significance for sociology and criminology. For both these writers, the body becomes significant only in so far as it is deemed to be by factors *external* to the body, be they discourse or shared vocabularies of body idiom. Their views provide important insights into how bodies may be affected by power relations, how the body enters into social definitions of the self, and how the body can function as a social symbol. They also highlight the ways in which the body can be used to legitimise social inequalities and it is these insights which have informed the current study.

Neither Foucault nor Goffman, however, adequately address the gendered nature of embodiment (that is, the relationships between femininity and the female body and masculinity and the male body). However, as I hope to reveal, the way in which women (and men) *experience* their bodies is fundamentally related to how being female (and male) is *constructed* within the society we live in.

Women, medicalisation and social control

Since Parsons' (1951) analysis of the sick-role as deviance, a succession of writers have drawn attention to a trend in industrialised societies for the expansion of the sphere of medicine : the increased encroachment of the medical profession and the power of medicine into wider and wider fractions of the public and private domains.[5] This trend, referred to as 'medicalisation', is described by Zola (1975) as follows :

> [M]edicine is becoming a major institution of social control, nudging aside, if not incorporating, the more traditional institutions of religion and law. It is becoming the new repository of truth, the place where absolute and often final judgements are made by supposedly morally neutral and objective experts. And these judgements are made, not in the name of virtue or legitimacy, but in the name of health. Moreover, this is not occurring through the political power

[5] See, for example, Zola, 1975; Navarro, 1976; Illich, 1977; Ehrenreich, 1978; Crawford, 1980; Sim, 1990.

> physicians hold or can influence, but is largely an insidious and often undramatic phenomenon accomplished by 'medicalising' much of daily living, by making medicine and the labels 'healthy' and 'ill' relevant to an ever increasing part of human existence (Zola, 1975 : 170).

Medicalisation can be understood as having two broad meanings. The first links an ever increasing range of social phenomena with the institution of medicine (that is, the profession of medicine, therapeutic practice and medical diagnosis). Here, medicalisation is usually described as an expansion of professional power over wider spheres of life, especially *deviant* behaviours. Zola (1977 : 42) argues that medicalisation in this sense is connected with two attributes of the medical profession : 'their control of their work and their tendency to generalise their expertise beyond technical matters'.

The second meaning of medicalisation refers to the extension of the range of social phenomena mediated by the concepts of 'health' and 'illness', often focusing on the importance of that process for understanding the *social control* of deviance. Illich (1975 : 118), for example, has argued :

> By naming the spirit that underlies deviance, authority places the deviant under the control of language and custom and turns him from a threat into a support of the social system.

The medical naming of that 'spirit' means that deviant behaviours increasingly become defined in terms of illness and 'normalcy' in terms of health (Crawford, 1980). Thus, alcoholism, child abuse, drug addiction, sexual problems, obesity and violence have all variously become matters for medical diagnosis, and the label of illness has been attached to them (Conrad and Schneider, 1980).

The two meanings of medicalisation are clearly linked. The health/illness category has been promoted by professionals and either directly of indirectly this enhances professional power. Medicalisation in the first sense, therefore, fosters medicalisation in the second. As Freidson (1972) explains :

> The medical profession has first claim to jurisdiction over the label of illness and anything to which it may be attached, irrespective of its capacity to deal with it effectively. In such a fashion do we see the rise to social prominence of a social value such as health is inseparable from the rise of a vehicle for the value - an organised body of workers who claim jurisdiction over the value. Once official jurisdiction is gained, the profession is then prone to create its own specialised notions of what it is that shall be called illness. While medicine is hardly independent of the society in which it exists, by becoming a vehicle for society's values it comes to play a major role in the forming and shaping of the social meanings imbued with such value (Freidson, 1972 : 253-254).

Freidson further argues that many kinds of 'disapproved behaviours' have moved into the realm of medicine and re-interpreted as sickness, as opposed to 'sin' or 'crime' :

> The medical mode of response to deviance is thus being applied to more and more behaviour in our society, much of which has been responded to in quite different ways in the past. In our day, what has been called crime, lunacy, degeneracy, sin and even poverty in the past is now being called illness (Freidson, 1972 : 249).

Hence, heavy alcohol consumption becomes alcoholism, shoplifting becomes denotative of mental illness and crime in general becomes an epidemic, indicative of a 'sick' society.

Critics of the trend to medicalise aspects of daily living have pointed to the crucial role played by health professionals, particularly doctors, in social control (Parsons, 1951; Szasz, 1961; Zola, 1975; Conrad, 1979). They argue that, by regulating who can/should deviate from their usual role and obligations and adopt the sick-role, the medical profession functions to ensure conformity to social norms. Moreover, the profession is influential in *establishing* norms of behaviour, *reinforcing* existing sexual, racial and class structures and *minimising* behaviour which deviates from social norms (Ehrenreich, 1978).

Szasz (1961), tracing the historic development of the medical profession, argues that in the past doctors were involved with conditions relating solely to the anatomy and physiology of the human body, but that more recently they have focused their attention on suffering of all kinds :

> [W]ith increasing zeal, physicians and especially psychiatrists began to call 'illness' anything and everything in which they could detect any sign of malfunctioning, based on no matter what norm. Hence, agoraphobia is illness because one should not be afraid of open spaces. Homosexuality is an illness because heterosexuality is the social norm. Divorce is an illness because it signals the failure of marriage (Szasz, 1961 : 44-45).

When the 'illness' label is applied to some types of behaviour it legitimises what follows as 'treatment', as prescribed by health professionals. When doctors define standards of health, health-promoting activities and health-debilitating behaviours, they are centrally in the business of *creating* and *establishing* norms and it becomes their function to control behaviour in a way that ensures conformity. As Freidson (1972) argues :

> The consequence ... is the strengthening of a professionalised control institution that, in the name of the individual's good and of technical expertise, can remove from laymen the right to evaluate their own behaviour and the behaviour of their fellows (Freidson, 1972 : 250).

For women in general and for criminal women in particular, the impact of the growth of medical influence has been considerable. Four inter-related aspects of the increasing medical control of women's lives will be discussed in the following pages : first, the interpretation of female criminality in terms of individual pathology. Secondly, the intervention of health professionals in the lives of criminal women. Thirdly, the interpretation of women's distress in terms of psychiatric problems, and fourthly, the medicalisation of non-medical, natural biological processes[6].

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[6] See Miles (1991) for a discussion of other aspects of the medical control of women's lives, including the medicalisation of the domestic domain and the intervention of health professionals in the spheres of childcare and socialisation.

Medicalising female criminality

Criminal women have long been a central concern for criminal justice, medical and psychiatric professions. Women entering 'the system' are so few so as to be 'incongruous' or 'out of place' (Morris, 1988 : 3), they present an anomaly in need of explanation. Historically, such explanations have been firmly located within the women themselves (see, for example, Lombroso and Ferrero, 1895; Thomas, 1923; Pollak, 1961; Cowie *et al.*, 1968; McLeod, 1982). Women's crime is viewed as a consequence of individual women failing to conform to their innate biological and/or socio-sexual subjections. It is seen in terms of the pathological and the irrational : 'menstruation, mental illness, poor socialisation, broken home and so on' (Morris, 1988 : 3).

The 'illness' response has often involved linking women's criminality with female reproductive processes, particularly with the hormonal changes that occur throughout a woman's life-course. Thus, all events associated with women's reproductive cycles - menstruation, suspension of the menses, conception, pregnancy, birth, lactation, cessation of lactation and menopause - have all variously been used in courts to argue that women were not *responsible* for the crimes they had committed (Morton *et al.*, 1953; Showalter and Showalter, 1972; Bullough and Voght, 1973; Smith-Rosenberg, 1974; Laws, Hey and Eagan, 1985; Martin, 1987; Lloyd, 1995). As a consequence, shoplifting, for example becomes associated with the stereotype of *the* menopausal woman, and violence with pre-menstrual tension or postnatal depression.

Biological explanations for women's crime owe much to the work of criminologists such as Lombroso and Ferrero (1895), Thomas (1907, 1923) and Pollak (1961), whose ideas remain influential.

Carlen (1985) has described Lombroso and Ferrero's 1895 monograph, *The Female Offender,* as containing most of the stereotypical elements responsible for the subsequent characterisations of women criminals. In prison- and

asylum-based research, Lombroso and Ferrero conducted detailed measurements of the skulls, brains and bones of women criminals, notably prostitutes. On the basis of their findings, the writers define distinctive sub-species of women as 'good' and 'bad', 'natural' and 'abnormal' and equated these with conformity and crime. Women's crime was seen as particularly unnatural and was the antithesis of all those qualities which distinguish a normal woman, namely passivity, dependence and sexual stoicism. For the good woman, love was a 'species of slavery' (cited, Jones, 1991 : xxii). The good woman gladly sacrificed her personality for her loved one and nobly killed herself at his death. Criminal women, on the other hand, were scarcely women at all, approximating more to males than to normal women.

The work of Lombroso and Ferrero was reinforced by Thomas (1907, 1923), who, in a series of case studies, presented a heavily stereotyped view of women, defined according to domestic and sexual roles, emotional and irrational. Thomas largely equated female delinquency with sexual delinquency and individualised female crime, urging that women criminals should be individually readjusted to their role in society. Thus, women who were unadjusted in Thomas's terms - who wished for 'freedom in the larger world' - were to be detained for indefinite periods and psychologically adjusted to their original 'interest in human babies' (cited, Jones, 1991 : xxiv).

Pollak's (1961) concept of female criminality was similarly based on women's aberrant sexuality. He maintained that women commit as many crimes as men, but rarely find their way into official statistics. He asserted that women who conceal monthly menstruation and who routinely fake orgasms can lie about anything. Moreover, he saw all women as vengeful - ready to lie, cheat, connive, manipulate, and kill - because 'all have suffered the trauma of first menstruation which blasted forever their hope ever to become a man' (cited, Jones, 1991 : xxiv).

Lombroso and Ferrero, Thomas and Pollak all used the notion of inherent female pathology to explain the *feminine* character and behaviour. In feminist critiques of the tradition of male criminology such explanations are defined as 'biologistic'[7]. Biologism refers to the belief that 'women have a physically determined nature that makes them inherently different and inferior to men, mere creatures of their bodily drives and derangements' (Brown, 1990 : 41). It is associated with the presumption that women are inherently maternal, passive and domestic and, at the same time, 'driven by uterine ailments of excessive or repressed sexuality and tendencies to hysteria and psychological instability' (Brown, 1990 : 41). Women's behaviour is thus not rational or self-governing. Women's deviance, according to this premise, must necessarily also be determined by a biologically-based criminal nature with all the associated implications of irrationality, sexual excess, determinism and pathology.

Biologism, therefore, not only postulates a 'male' and 'female' type, each ascribed distinct characteristics and patterns of behaviour, it also firmly locates women within the realm of nature while men are placed on the other side of the boundary that separates nature from culture, determinism from freedom of will, irrationality from rationality, emotion from reason (Brown, 1990). Biologism can thus be seen as a set of representations of women - stereotypes, images, propositions, beliefs, assumptions - which influence not only the way female criminality is *constructed* within professional and popular discourse, but which also seem to influence women's processing through the criminal justice system.

What is important here, is that male and female criminal behaviour seems to be explained in different ways. For men, it is more likely to be viewed as a rational response to such factors as boredom, peer pressure, necessity, greed and so forth. Positioning women's criminal behaviour as 'irrational' effectively dismisses it. It removes any element of reason from the woman herself and any onus on society to reflect upon why it occurred. It individualises and compartmentalises the problem, transforming it into its most immediate

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[7] See Brown (1990) for a discussion of the critique of biologism.

property : the biological and physical manifestations of the individual body. The answer to the problem is then logically held to be found in professionalised and individualised treatment, rather than in the reordering of the social, political, and environmental context in which the individual exists.

Criminal women : a history of medical interventionism

Medicine has long played a crucial role in perpetuating and legitimating biological explanations of female criminality. Indeed, as Edwards (1984) points out, historically it has been the medical profession which has had a vital role not only in defining women's deviance, but also in determining the patterns of response :

> The real and pragmatic influences on the criminal law and the administration of justice during the nineteenth century were in fact medical and gynaecological theories on women and crime. They ... were based on the tenets of biological positivism [and] were exerting an influence in the courts... From the beginning of the nineteenth century, medical practitioners, mental health physicians and gynaecologists conceded rather more specifically that criminality in women could be explained by the physiological episodes to which they were subject (Edwards, 1984 : 82).

To take a biological stance on women's crime inevitably leads to the position that the appropriate dispositions should be physical; dispositions which may in reality have little medical justification. As Smart (1976) has asserted :

> [T]heories of female criminality ... serve to legitimise the trends in penal policy, giving scientific justification for the treatment of female offenders as 'sick' (Smart, 1976 : 144-145).

Sim (1990), in a detailed exploration of the relationship between medicine and the confined, describes a legacy of medical interventionism in the lives of deviant and otherwise unconventional women. He asserts that criminal women have long been 'studied, probed and tested not only because of their supposed uniqueness but also because of the threat they posed to the social order of stable, family relationships' (Sim, 1990 : 129). Drawing upon the work of

Foucault, Sim (1990) argues that since the emergence of the modern prison system, male and female prisoners have been subject to processes of 'regulation, discipline and normalisation'. Here, normalisation includes the acceptance of dominant norms by which masculinities and femininities are constructed and censured. For criminal women, however, it is a process quite different to that experienced by men, at the centre of which, Sim (1990 : 129) argues, stands the 'figure of the medical man'.

The Victorian era, for example, marked an important change in the discursive regimes which constructed, confined and controlled women. It was in this period that 'the close association between femininity and pathology became firmly established within the scientific, literary and popular discourse : madness became synonymous with womanhood' (Ussher, 1991 : 64). It was at this time that *madness* also became defined as mental *illness*, opening the door to a whole gamut of medical interventions in the lives of the socially deviant.

One of the most severe and disabling interventions was the surgical practice of clitoridectomy, performed as a 'cure' for female insanity as represented by unnatural sexuality. In the late nineteenth century a number of such operations took place. Women's madness, it was believed, was caused by masturbation, so that the surgical removal of the clitoris, by *helping* women to govern themselves, could halt a 'disease' which would otherwise 'proceed inexorably from hysteria to spinal irritation and thence to idiocy, mania and death' (Showalter, 1987 : 75).

Showalter (1987) cites a Dr. Issac Baker Brown, who, between 1859 and 1866 conducted a number of such operations at his 'sexual surgery' in London :

> [H]e operated on patients as young as ten, on idiots, epileptics, paralytics, even on women with eye problems. He operated five times on women whose madness consisted of their wish to take advantage of the new Divorce Act of 1857, and found in each case that his patient returned humbly to her husband (Showalter, 1987 : 76).

Such fierce intervention into women's lives[8] was based on the conflation of female deviance and sexual deviance, with the result that offences which might have had little to do with sexuality became transfigured into expressions thereof. The control and regulation of female sexuality, therefore, became a central concern for the male medical profession. While criminologists like Lombroso and Ferrero (1895) conducted studies of the *external* characteristics of women criminals, it was doctors who extended the argument to include women's *internal* physiological make-up.

Biologistic concepts of female criminality have had serious implications for the lives of imprisoned women. Here, as Sim (1990) points out, prison medical attendants have historically served an important penal function, often in the guise of benevolent 'care' and 'treatment'. Medical interventions in the lives of women prisoners have, to a large extent, been devoted not to improving their health, but rather to controlling their behaviour. This was clearly evidenced in the medical treatment of imprisoned suffragette women in the early part of the twentieth century, particularly those on hunger strike. Here, it was argued that the Government had been 'bolstered up in their anti-woman policy by the medical profession' (Women's Social and Political Union leaflet, 1909). The medical profession had become a 'police force', whose task it was to break the spirit of the suffragettes.

Tickner (1987 : 107), in a detailed discussion of the 'spectacle' of the suffrage campaign, argues that the militant suffragettes committed criminal damage for political ends, but, in so doing, 'they sacrificed their respectability and their femininity', and hence their liberty.

By August 1909 hunger striking was a normal practice of imprisoned suffragettes. The institutional response, however, was individualised pathologisation : the women were treated as hysterical and psychiatrists were

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[8] Surgical clitoridectomy is still performed in some non-western societies. The procedure, which effectively eliminates a woman's sexual pleasure, is symbolic in its control of female sexuality.

brought in to examine the suffragette prisoners for signs of mental disturbance (Showalter, 1985). Under medical supervision, women were forcibly fed by means of a rubber tube passed through the nose and into the stomach, a process described by Masterman in a parliamentary reply as 'hospital treatment' (Tickner, 1987 : 105).

Forcible feeding was a torturous procedure, likely to cause pain in various organs, vomiting and lacerations to the resisting patient. Romero (1990) describes Sylvia Pankhurst's experience of being forcibly fed whilst on hunger strike in Holloway :

> After refusing to eat for three days, Sylvia was forcibly fed. She tried to fight off the six wardresses and two doctors, but they overwhelmed her and she succumbed to the ordeal which she found degrading and 'shattering to one's nerves and one's self control' ... Days wore on, with always the same routine : doctors and wardresses arrived to force sometimes one, sometimes two, steel gags between her teeth. Someone would seize her and 'thrust a sheet' under her chin. She closed her eyes and set her teeth against the intruder, and then 'a man's hands' forced his way into her mouth with a 'steel instrument' puncturing her gums. This symbolic rape, carried out with superior strength, was always met with a writhing body which resisted for as long as possible the probing tubes until finally, giving way to the inevitable, it allowed the unwanted nourishment to enter (Romero, 1990 : 78).

Forcible feeding could not have been inflicted upon women, whose crime it was to demand political freedom, unless the medical profession had intervened 'to do the torturers role' (WSPU leaflet, 1909). Showalter (1987) has argued that the representation of the forcible feeding of suffragettes - a struggling woman held down by nurses while an elegantly dressed male doctor assaults her with funnels and tubes - anticipates the clinical photographs of electro-convulsive therapy (ECT) to come.

Women and psychiatric control

In the latter half of this century, probably the most striking example of the medical control of women generally, and of deviant women specifically, has been the psychiatrisation of women's behaviour and the use of psycho-physiological interventions for control purposes.

Epidemiological studies reveal a preponderance of women amongst those diagnosed as suffering from psychiatric problems (Miles, 1991). Women are more likely than men to be admitted to hospital for psychiatric care and are more likely to consult a general practitioner for psychological distress, especially depression (Ussher, 1991; Arnot and Jackson, 1996). However, it is unclear whether this indicates that women are more mentally ill than men or whether women are more likely to be classified as such.

As has been suggested, there is an influential body of thought which considers that women are *naturally* more unstable than men. Other writers, however, have argued that in our society women do indeed have more mental health problems than men, but that this is because of gender inequalities and tensions, not because of any natural difference. Women, according to this argument, experience stresses and hardships to a greater extent than do men and are, literally, 'driven mad' by oppressive social structures (Gove and Tudor, 1972; Oakley, 1974, 1981; Land, 1981; Sharpe, 1984). A further argument is that women are more likely than men to be labelled mentally ill by professionals and lay people because of the widely held stereotypes of female inferiority and weakness and because of women's relative lack of power to reject the application to them of adverse labels (Chesler, 1972; Barrett and Roberts, 1978; Ehrenreich and English, 1979).

Each perspective has its exponents, and the subject has been fiercely debated in the pages of the academic press during the past couple of decades[9]. However, given that a significant number of women *do* receive medical treatment for

[9] See Busfield (1988) for a detailed review of this debate.

mental health problems, it is important to look briefly at the ways in which such women are treated. Here, it has been argued by many critics of the practices of psychiatry (and medicine generally) that it effectively functions to *silence* the protest of the mad (Szasz, 1961; Scheff, 1966; Laing, 1967). Laing (1967), for example, has called madness 'a perfectly rational adjustment to an insane world' (cited, Ussher, 1991 : 147). Feminists have built upon and extended this argument : they have suggested that most traditional 'treatments' for mental health problems stifle the complaints women may have about the circumstances of their lives, and so ensure that women adjust to the domestic role that is expected of them (Barrett and Roberts, 1978; Cooperstock and Lennard, 1979; Ussher, 1991).

Women are more likely to be prescribed psychotropic drugs than men and the harmful effects of such preparations have been well documented (see, for example, Gabe and Lipshitz-Phillips, 1984; Wheeler, 1994). Women are also more likely than men to receive ECT and to undergo surgical lobotomy, procedures which, while in diminished usage, are still performed in late twentieth century Western societies despite serious questions about their therapeutic efficacy and ethics[10]. Breggin (1979) has argued that women are more likely than men to receive such treatments because 'they are judged to have less need of their brains' (cited, Showalter, 1987 : 207).

Psychiatrists' power includes the giving of compulsory treatment, and the taking away of a person's liberty. While these powers are used only in extreme cases, there still remains the potential threat. Miles (1991) argues that the potential (and dangerous) power of psychiatry has been evidenced in the 'treatment' given by psychiatrists to dissidents in oppressive regimes.

Arnot and Jackson (1996 : 176) argue that 'women who are not white, middle class and heterosexual can face additional problems'. Lesbian women, for example, can be faced with therapists who seek to 'cure' them by re-orientating

[10] As a student nurse in the 1980s, I routinely witnessed electric shock treatment performed on post-natal women at a psychiatric mother and baby unit.

their sexuality. Working-class women are three times more likely than professional women to suffer from depression (Whitehead, 1992), and, if they seek help, they are more likely to be given a prescription for psychotropic drugs (Gabe and Lipshitz-Phillips, 1984; Ussher, 1991). Black women have a greater likelihood of admission to psychiatric hospitals than white women (Wheeler, 1994).

Treatments for mental health problems seldom provide unmitigated benefits for those who use them. From a broader perspective, the application of a psychiatric label to a problem which may have little or no aetiological basis and seeking to alleviate it by the administration of 'appropriate treatment' is open to criticism. The effect of the process may be that the underlying causes are ignored, particularly where they are rooted in the social structure. Here, the controlling function of psychiatry becomes clear : medicalised and medicated, women are thus able to continue in domestic roles or as care providers.

If we take an historical example, the 'rest cure', we can see how notions of appropriate femininity have contributed to definitions of women's mental health, to the creation of different 'cures' for alleged mental illness and to a process which has sought to ensure that women maintain their domestic roles.

The 'rest cure', invented in the nineteenth century by Silas Weir Mitchell, was administered to patients who showed symptoms of 'neurasthenia', a condition found only in women. Symptoms included weight loss, depression and anxiety. A description of the 'cure' is provided by Showalter (1987). The women received :

> 'a combination of entire rest and of excessive feeding, made possible by passive exercise obtained through steady use of massage and electricity'. For six weeks the patient was isolated from her family and friends, confined to bed, forbidden to sit up, sew, read, write, or to do any intellectual work, visited daily by the physician, and fed and massaged by the nurse (Showalter, 1987 : 138).

The 'rest cure' was simply an exaggerated notion of appropriate femininity, a version of the life that all middle-class women were supposed to lead. Showalter (1987) argues that Mitchell 'cured' women by :

> 'restoring them to their femininity' ... Forced back into 'womblike dependence', the patient was reborn, re-educated by the parental team of subservient female nurse and godlike male doctor, and 'returned to her menfolk's management, recycled and taught to make the will of the male her own' (Showalter, 1987 : 139).

Critics have thus argued that psychiatric practice does not always work in the interest of patients, any more than medicine in general does. Illich (1977), for example, has asserted that doctors generate needs while ensuring that only they can supply the remedies. Navarro (1976) has argued that medicine has developed in response to the needs of capitalism rather than the needs of patients. From a feminist perspective, Chesler (1972) has viewed psychiatry not only as an oppressive institution, but as a male oppressive one, dominated by men who adhere to traditional stereotypes of female weakness, passivity, dependence and inferiority. She argues that psychiatrists typically devalue women's behaviour and see women as psychiatrically impaired and unbalanced.

While psychiatrists in particular, and doctors in general, may work with established diagnostic categories, their diagnoses are influenced by cultural expectations about what it is to be 'healthy' and what it is to be 'sick'. Thus, as Busfield (1988) points out :

> Defining excess fear as pathological is not neutral to gender in a culture where expressions of fearfulness are more acceptable amongst women than men, since women are more likely to manifest all degrees of fearfulness. Simply by acting in ways considered more appropriate to their gender women are closer to and more in danger of being phobic than men. The same is true of depression and anxiety, since the expression of these emotions is considered more appropriate in women than men (Busfield, 1988 : 533-534).

It can thus be argued that under current psychiatric practice, women are more likely than men to be labelled as psychiatrically ill because female role prescriptions locate them closer to the kinds of behaviour that psychiatrists define as mental illness. Moreover, women who do not conform to the feminine stereotype are also vulnerable to psychiatric labelling (here, it seems that women are in a no-win situation). Women who appear more aggressive, less passive, less dependent, in fact, anything less than the female stereotype leads people to expect, may also be called 'unnatural' and/or 'pathological' by professionals. The general stance being that 'normal women don't behave like this, so you must be crazy' (Miles, 1991 : 190).

Medicine and female reproductive processes

It is not only psychiatrists who are in the business of applying diagnostic labels to women. Other health professionals may act similarly and for similar reasons. Stereotyped expectations are strongly held and medical views are pervasive and persuasive, influencing both professional and lay thinking.

Several writers have explored the functioning of medicine in relation to women's natural bodily mechanisms, notably their reproductive health. Here, particular attention has been drawn to the medicalisation of normal biological processes such as pregnancy and childbirth (Oakley, 1984); the control and dominance over decision-making exerted by the medical profession (Scully, 1980), and the lack of communication between women patients and their predominantly male medical attendants (MacIntyre, 1982).

Pregnancy and childbirth, of all the female reproductive processes, have become most completely medicalised in late twentieth century Western societies. Writers have pointed to the processes whereby ante-natal care and childbirth have been transferred from the private domain of the home to the very public domain of the hospital, from their *management* by lay midwives to *control* by (male) professionals, and from being 'natural' biological processes to

a highly technological, medical ones (Donnison, 1977; Arney, 1982; Turner, 1987; Ehrenreich and English, 1979).

From conception to after delivery, a pregnant woman finds a regime of care laid down for her. She is expected to report regularly to a clinic or surgery to undergo medical examinations and quite early on in the pregnancy arrangements are made for where the birth is to take place. Preference is now given to hospital births where the baby can be delivered under professional *surveillance* and with whatever medical monitoring and *intervention* is thought appropriate. What a pregnant woman eats and drinks (and God forbid if she smokes or uses illegal drugs), how she works, rests and plays have all become the concern of health professionals. In the name of 'health', the activities of a pregnant woman are *controlled*, as is her labour and the delivery of her baby.

While other parts of women's reproductive processes have not been so completely medicalised, an increase in medical control is taking place. Take, for example, the medicalisation of the menopause, which is particularly interesting in that it brings into the medical orbit an area of the life of older women, just as the medicalisation of pregnancy has done in respect of younger women.

Bell (1987) argues that the medicalisation of the menopause began in the late 1930s with the development of synthetic oestrogen. Once available, hormone replacement therapy (HRT) offered the potential of treating *all* women and not just those experiencing adverse symptoms. In this way, all women became potential patients.

There is little doubt that endocrinological changes associated with the cessation of the menses can have certain physiological consequences for some women. However, the only symptoms clearly linked are hot flushes and sweats. For many women, these can be troublesome symptoms for which HRT seems to be an appropriate answer. However, for the menopause to be defined as a treatable physical problem draws all menopausal women into the medical

domain. The menopause, as a problem which produces symptoms becomes defined as 'bad' in the sense that disease is bad, rather than being seen as a normal phase of the life cycle.

While certain physiological symptoms have been linked with the menopause, much emphasis within the medical literature has been placed on the psychological problems experienced by menopausal women. Feelings of insecurity, depression and anxiety have variously been attributed to the menopause, although, as Kaufert (1982) points out, the link between biological changes and such 'symptoms' is not clear-cut.

Medical explanations for the psychological problems of women in the middle years firmly locate both problem and solution within the individual. While it is likely that some women are depressed or anxious quite independently of their menopause, others may indeed have negative feelings about life evoked by the cessation of their menstrual periods. However, all this takes place within a specific arena where the menopause is *negatively* evaluated. Doctors, locating the 'problem' within the individual, reinforce notions of women as potentially unbalanced by their biological make-up. The menopause becomes 'proof' that women are vulnerable to hormonal influences (Miles, 1991).

The above examples highlight a number of key issues which will be developed in the chapters to come. In particular, they draw attention to the ways in which doctors medicalise everyday life by defining patients' problems in terms of a medical model and an individualised aetiology. In so doing, they encourage dependency - on the medical profession itself and on the various forms of treatment - and make little attempt to help individuals to handle their own lives or to become aware of the links between social structure and ill health. From this discussion two central issues arise : First, it is important in understanding health and illness as being socially produced to look at where *power* lies in medicine. Secondly, the social construction of femininity affects women's health. The constraints and contradictions within notions of appropriate

femininity - both historical and modern - make the achievement of 'healthy womanhood' effectively beyond reach.

Power, legitimacy, adaptation and resistance

Feminist approaches to power and social control have often focused on male oppression of women in public and private settings and by formal and informal mechanisms. Much of this work, while influential, has been based on fairly simple categories of male and female (which may themselves derive from gender *assumptions*). In particular, *male* dominance (power) and *female* subordination (powerlessness) tend to be explained in terms of the structural inequalities between men and women, especially in economic and political terms. Implicit in much of this work is the assumption that it is men who carry out control and that they control women.

Recently, writers, influenced by the work of Foucault, have begun to explore the *use* of gender as a mechanism for social control, the relationship between gender and power in institutions, and the ways in which women and men come to see themselves as 'bodily beings' (see, for example, Turner, 1987; Savage and Witz, 1992; Heidensohn, 1992; Sim, 1994; Hollway, 1996). Such studies raise a number of key issues : First, they reveal that power is productive and its effects are not necessarily oppressive. Secondly, power has many dimensions and, in its multiplicity, different expressions of power can contradict as well as reinforce each other. Thirdly, women, as well as men, exercise power (although this is not to claim that it is equal or symmetrical to men's) as well as undergoing the effects of others' exercise of power and their actions may, therefore, serve to challenge power differentials or to legitimise them. In this final section these issues will be explored, first, in terms of power and the question of legitimacy, and secondly, in relation to modes of adaptation and resistance.

Power and legitimacy

Foucault's critique of power, as discussed above, locates power throughout the whole of a particular social body. It shifts the focus of political analysis away from the relations of production to the study of power *relations*. For Foucault, the question is not who is in power? Rather, he is concerned with how power installs itself and produces certain effects. For example, the construction of a particular kind of subject - the lunatic, the criminal, the prisoner, the patient, the homosexual and so forth :

> Let us not ... ask why certain people want to dominate, what they seek, what is their overall strategy. Let us ask, instead, how things work at the level of those continuous and uninterrupted processes which subject our bodies, govern our gestures, dictate our behaviours etc. In other words, rather than ask ourselves how the sovereign appears to us in his lofty isolation, we should try to discover how it is that subjects are gradually, progressively, really and materially constituted through a multiplicity of organisms, forces, energies, materials, desires, thoughts, etc. We should try to grasp subjection in its material instance as a constitution of subjects (Foucault, 1980b : 97).

Power is thus not conceptualised in terms of one individual's domination over another, nor even as that of one class over another, nor yet as that of one sex over another. Rather, the subject which power has constituted becomes part of the mechanisms of power : 'it becomes the vehicle of that power which, in turn, has constituted it *as* that type of vehicle (McHoul and Grace, 1993 : 22, emphasis in the original). The important point here is not to lose sight of the subject but rather to examine *subjection* as a collection of *techniques* of power which exist throughout the body of society.

For Foucault, many different forms of power exist in our society : legal, medical, penal, economic, bureaucratic and so forth. What they have in common is a shared reliance on certain techniques or modes of application which attempt to *know* particular kinds of subjects : the Panopticon, for example. McHoul and Grace (1993 : 22) refer to a 'terrain of power' which, for Foucault, is not to be taken as merely ideological in the sense that the term

refers to any aspect of the individual or collective consciousness. Rather, the effects of power are *material* and are potentially *empowering*.

Several social and political commentators have argued that at the heart of all systems of power in ordered societies rest questions of *authority* and *legitimacy* (see, for example, Beetham, 1991; Sparks, 1996). Sparks (1996 : 205) has argued that questions of legitimacy arise whenever that state claims the right to exercise power over its citizens, be it in terms of upholding the law or in terms of the 'general good', such as the maintenance of public health, crime prevention and so forth. *Legitimacy*, in this sense, can be seen as the justified *authority* to use power, without which it would not be possible to impose sanctions nor to achieve redress for wrongs. Beetham (1991) has argued that power can be considered to be legitimate if :

(i) it conforms to established rules;

(ii) the rules can be justified by reference to beliefs shared by both dominant and subordinate;

and, (iii) there is evidence of consent by the subordinate to the particular power relation (Beetham, 1991 : 16).

Power differentials in the doctor-patient relationship, for example, may be considered a legitimate part of the medical encounter. Both the roles of *the* doctor and *the* patient are constituted by the discourses and practices of medicine, which rest on the doctor remaining in the position of 'expert'. Why else would people seek medical advice? While power may be used abusively in the medical encounter, it is also often used positively to facilitate the needs and expectations of both patient and doctor. Furthermore, May (1992) argues that the emphasis on *knowing* the patient in medical discourse in fact provides patients with a greater locus of power because 'the truth of the subject cannot be exposed without the explicit permission of the subject concerned' (May, 1992 : 600).

Lupton (1994) argues that power within the context of the medical encounter should thus not be seen necessarily in terms of *domination* but rather should be seen in terms of the way in which *conformity* is maintained through voluntary means. Here, Foucault's (1988) concept of the 'practices of the self' may be useful. Foucault, as we have seen, was concerned not only with power as formulated and disseminated by institutions and agencies, but also with the modes of *self*-government engaged in by individuals. He thus became interested in the 'practices' of the self : ways in which individuals act on their bodies, thoughts and conduct in order to 'transform themselves ... to attain a certain state of happiness, purity, wisdom, perfection, or immortality (Foucault, 1988 : 18). Foucault reflected on the ways in which disciplinary power is internalised, in an attempt to explore the manner in which dominant ideologies may be taken up, negotiated or resisted in the individual's fashioning of the self. The practices of the self, according to Foucault, involve largely subliminal socialisation rather than active, conscious decisions. Thus, patients *usually* give their bodies up voluntarily to the doctor's 'gaze' because that is what people are socialised to expect. Both the patient and the doctor *usually* subscribe to a belief in the importance of medical testing, monitoring and invasive and/or embarrassing diagnostic techniques in the patient's 'best interests' and in the name of 'health'. Explicit coercion is *usually* not required.

Surveillance of the body may, of course, occur compulsorily, such as in prisons, police stations and psychiatric institutions where individuals are confined under conditions not of their own choosing and are minded by those with the power to regulate their lives in the minutest detail. Beetham (1991 : 40) argues that such forms of power, based on organised physical coercion, stand supremely 'in need of legitimation'. This issue has been taken up by several writers in relation to penal affairs, particularly imprisonment (see, for example, Mathiesen, 1990; Scraton *et al.*, 1991; Cavadino and Dignan, 1992; Sim, 1992; Sparks, 1994; 1996; Sparks and Bottoms, 1995).

Scraton *et al.* (1991) argue that *all* forms of incarceration imply the use of force :

> Regardless of the outward appearance of compliance few people taken into custody would accept their loss of liberty so willingly if the full potential of state coercion was not handcuffed to their wrists (Scraton *et al.*, 1991 : 61).

The authors question the legitimacy of a system in which the authority imposed is not a 'consensual authority'. Sparks (1996), similarly, states that prisons raise fundamental questions of legitimacy because they 'assume an especially high degree of power over the lives of their inmates, and that power is in the last instance buttressed by the right to use sanctions, including physical force, to secure prisoners' compliance' (Sparks, 1996 : 205).

Sparks argues that questions of legitimacy in prison are compounded by two further considerations. The first relates to the extent to which prisoners are necessarily located in a position of dependency *vis-à-vis* the prison authorities. In this respect, in claiming the *authority* to imprison an individual, the state also undertakes a *responsibility* 'for the prisoner's health, safety and physical and psychological well-being which is qualitatively greater than that which it owes to the free citizen' (Sparks, 1996 : 205).

Secondly, the question of legitimacy also arises in relation to discipline and the maintenance of 'good order' in prisons (Sparks, 1996 : 206). While prisons do erupt under violent protest (see Scraton *et al.*, 1991), and some commentators argue that this is a risk inherent in any process of confinement (see King, 1985), radical ruptures are relatively infrequent. This then raises the question : what factors render it more or less likely that prisoners will accept (albeit conditionally) the authority of their custodians? Answers to this are likely to encompass a complex interplay of issues involving the ideological functioning and defences of the prison (see Mathiesen, 1990); the nature of the material conditions and regimes within which prisoners are confined (see King and McDermott, 1989); distributive and procedural justice (see Woolf, 1991); the

relationships between staff and prisoners (see Sparks and Bottoms, 1995), as well as prisoners' own individual strategies for adaptation and resistance. It is with the latter of these issues - adaptation and resistance - that the remainder of this chapter is concerned, although questions of power and legitimacy run throughout the whole of this study.

Adaptation and resistance : the 'theatre of struggle'

Foucault has argued that individuals are not merely the passive or consenting targets of power. Rather, they are in the position of simultaneously undergoing, resisting and exercising power. He argues that, as disciplinary power increased its centres and localities, it produced, in the process, sites of resistance. He points to the different forms of opposition which have emerged in western societies to challenge the imposition of power, which includes the opposition to the power of men over women, of psychiatrists over the mentally ill, of doctors over patients, of bureaucrats over citizens and so forth.

Resistance, in Foucault's conception of it does not refer solely to purposive, collective action directed towards political ends and/or the overt challenging of power, although this is not to imply that such acts do not occur. Such notions of resistance, however, tend to assume :

> [A] model of power as always repressive, invested in institutions intent on domination, and the concept of the unified self, a self that has an exclusive allegiance to a certain group or subculture (Lupton, 1995 : 133).

Foucault is more concerned with the mobile and transitory points of resistance - the mundane or everyday acts - the 'codification' of which make radical change possible. Resistance, in this sense, includes methods of challenging the here-and-now dictums of day-to-day life : the ways in which individuals fail to comply, conform or consent to the imperatives imposed on them, be they compliance with medical or penal regimens, for example. These points of resistance cannot be reduced to a unified set of positions or objectives because, as Henriques *et al.* (1984) point out, individuals are neither totally powerless

nor powerful, but continually positioned and repositioned in relation to power. A person may, thus, have an allegiance to one particular group or sub-culture in one context, and have conflicting loyalties in another, depending on the subject positions he or she is in. This point has been taken up by Sawicki (1986, 1991) :

> Depending on where one is and in what role (eg. mother, lover, teacher, anti-racist, anti-sexist) one's allegiances and interests will shift. There are no privileged or fundamental coalitions in history, but rather a series of unstable and shifting ones (Sawicki, 1986 : 30).

At an individual level, resistance to certain imperatives may be conceptualised as resulting from a *conscious* sense of frustration, resentment or anger or a drive for more pleasurable practices of the self, or as resulting from an *unconscious* impetus towards alternative subject positionings and bodily practices (Lupton, 1995). Moreover, these rationales for non-compliance may operate simultaneously or variously within the context of an individual's life course.

Given the influence of dominant discourses in constructing subjectivity, from where does the potential to resist emerge? Shilling (1993) argues that people are never completely socialised into shared meanings. A conflict between external governmentality strategies (that is, policing, surveillance and regulatory activities conducted by agencies of the state) and the image of themselves that individuals hold may thus lead to resistance at an individual level and possibly at a collective level (Burchell, 1991). A whole range of formal and informal institutions and social settings contribute to bodily regulation : medicine, the legal system, the school, the family, the media and so forth. These are all to some extent part of the governmentality efforts of the state. However, they also have rationales beyond those of the state and on occasion contradict or even directly oppose state imperatives. Thus, different discourses around the construction of the subject contradict each other and out

of this contradiction potentially *empowering* patterns of behaviour develop as a challenge to the 'networks of domination and subordination' (Sim, 1994 : 101).

While resistance may emerge from a conscious choice of alternative practices of the self, it may also be generated at the unconscious level. Here, a number of writers have drawn upon psychoanalytic theory in an attempt to describe the interface between the individual's psyche and the ways in which subjectivity is constructed via discursive formations and social relations (see, for example, Henriques *et al.*, 1984; Donald, 1991; Lash, 1991). In so doing, they seek to explain how subjects participate in their own domination as well as resisting it. In brief, they argue that certain drives and desires and their repression due to social norms construct the unconscious, which is expressed through those thoughts and behaviours individuals have least control over : 'dreams, memories, fantasies, slips of the tongue, neuroses and anxieties, erotic excitement and other sensual embodied experiences' (Lupton, 1995 : 135).

Resistance at the level of the unconscious does not emerge from reflective processes, but rather from the inherent contradiction between desire and censure. Pressures placed on individuals, through social context or convention, to conform to patterns of behaviour which feel 'unnatural' lead to resistance to established norms :

> [T]hough the rational, logical self may consciously conform to social norms and external imperatives, the unconscious wills the self to explore new ways of being, to disrupt convention and coherence. This individual level of resistance may be translated to collective and organised acts of resistance if these desires and frustrations are recognised as shared rather than being confined to the individual's personal experience or psychic makeup (Lupton, 1995 : 136).

Lupton (1995) exemplifies this argument in relation to sexuality. The sexual body is constructed, she argues, in certain ways by dominant discourses that seek to constrain some forms of sexual expression deemed 'unnatural' and to promote and legitimise others as 'natural'. However, the multiplicity of

discourses on the sexual body have now established sources of articulating sexual identities and have facilitated the formation of social groups amongst those who have been categorised as 'deviant', resent this categorisation and demand certain rights and social change. Thus, as McNay (1992 : 39) argues, the 'sexed body is to be understood not only as the primary target of the techniques of disciplinary power, but also as the point where these techniques are resisted and thwarted'.

At a conscious level, individuals frequently engage in thoughts and/or activities they know to be socially censured and, at either the conscious or unconscious levels, people may derive pleasure from 'deviant' acts simply because of their very status as 'deviant'. As I shall argue in more detail later, the interaction of censure and pleasure, of constraint and desire plays an important role in determining whether individuals adopt or challenge the dictates of external governmentality.

Further to this argument, certain practices of the self may be considered neither conscious nor unconscious, but simply 'non-subjective' (Hunter, 1993 : 128): habits perpetuated neither by external requirements nor conscious impetuses but by an individual's unthinking routines. Here, the notion of 'habitus', as developed by Bourdieu (1984, 1990), is useful in understanding the ways in which choices and bodily presentations are both shaped and constrained by an individual's social positioning. Bourdieu developed the notion of habitus to deal with the paradox that people may act in certain ways, directed towards certain ends, without being conscious of these ends, but also without being necessarily determined by them. The habitus is formed within the structural conditions in which people are located. It is *reproduced* in both the private and public domains and it is *expressed* in the ways in which people conduct themselves.

Thus, while the importance of conscious self-control needs to be recognised in order to understand the ways in which people conduct and regulate their bodies, construct forms of subjectivity and challenge or reinforce external

governmentality, the unconscious and non-subjective dimensions of behaviour also require consideration. There might, then, be said to be a continuum along which resistance, or the construction of alternatives, ranges from the highly conscious radical oppositional struggles, at both the group level and the individual level, to the unconscious, at which resistance takes place through emotional impulses and desires which may not necessarily be recognised or articulated by the individual as resistance. However, the non-subjective practices of the self, where behaviours are internalised through the habitus and are performed 'automatically' also requires some recognition.

Clarke *et al.* (1976 : 45) argue that social relations can be seen as a 'theatre of struggle' to which subordinate groups bring a 'repertoire' of strategies and responses. Women, for example, in contrast to their stereotypical image as passive, submissive, compliant, accepting and non-resistant (that is, powerless), have always resisted, sought new ways to take something for themselves, constructed new ways of doing things (see, for example, Pitch, 1985; Heidensohn, 1992). Pitch (1985) argues that women have long been involved, individually and collectively, in seeking changes to their social world, which she relates to women's resistance to the conventional burdens of domestic care and control. Consider, for example, the many groups of women who have sought increased state intervention in a range of areas - domestic violence, rape, abortion and childcare, for example - and who have drawn attention to instances of discrimination, inequality and poor treatment[11]. Women have increasingly created roles for themselves and sought and won economic and political power.

Not *all* women, of course, and not all in the same way. There are many differences between women in terms of social class, age, ethnicity, marital status and education and it is not possible to discuss women's resistance in terms of some unitary notion of womanhood. Moreover, women have

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[11] The contradictions inherent in demanding increased state intervention while challenging external governmentality have not, as yet, been fully addressed by such groups.

themselves long been involved in social control (as doctors, psychiatrists, police officers, magistrates, prison officers and so forth), the effects of which have often been felt by other women.

Patients also clearly resist medical power and the passive patient role. That the medical literature is so obsessed with non-compliance clearly indicates that patients' decisions *not* to follow 'doctor's orders' occur reasonably often. While the power relations within the doctor-patient relationshipareweighted towards the doctor it is *usually* the patient's decision whether or not to consult, whether or not to continue seeking advice and whether or not to comply with a prescribed treatment regimen. Patients also form consumer groups to oppose professional medicine and challenge medical authority through various means. Not *all* patients, of course, and not all in the same way. Silverman (1987) argues that resistance emerges from a number of sites : patients who are paying for a service, for example, or those who 'know the ropes', or those who are medically trained are all more likely to directly challenge medical authority.

Prisoners, similarly, do not necessarily respond compliantly either to the fact or to the conditions of their confinement, evidenced most clearly in the prison disturbances which have occurred periodically since the inception of the penitentiary (Adams, 1992). Prisoners have always sought new ways of coping, of adapting as well as of resisting. Not *all* prisoners, of course, and not all in the same way and a central focus for both penal policy and research has arisen from the ways in which prisoners *do* respond to imprisonment. In the following pages, I present a brief review of some of the strategies of prisoner response identified in previous research so as to provide the context in which women's responses to imprisonment - as *women*, as *prisoners* and as prisoner-*patients* - may be understood.

On 'doing time'

In general, prisoners are faced with many potential sources of anxiety and threats to their self-identity : the offence, the public stigma, the sentence, the

actual deprivations, the affronts and the loss of control which imprisonment necessarily entails. Different issues are likely to be salient for different prisoners at different stages of their sentence.

The issue of how prisoners 'do time' has been extensively examined.[12] In much of the prison literature links are made between what Sykes (1958) terms the 'pains of imprisonment' and the nature of inmate culture. Here, strategies of prisoner response tend be discussed in terms of a range of tactics : from total psychological withdrawal to all out rebellion.

Goffman's study of the interaction order, as discussed above, has exerted a considerable influence on our understanding of the relationship between self-identity and social identity and of the ways in which individuals 'present' themselves in *everyday* life. In *Asylums*, Goffman (1961) extends this analysis to life in 'total institutions' : places of 'residence and work where a large number of like-spirited individuals, cut off from wider society for an appreciable period of time, together lead an enclosed, formally administered round of life' (Goffman, 1961 : xiii). Goffman analysed the experiences of inmates in a Washington mental institution and, by extension, in any 'total institution' : 'jails', 'penitentiaries', 'army barracks', 'work camps', 'boarding schools', 'monasteries', 'homes for the blind, the aged, the orphaned and the indigent' and so forth (Goffman, 1961 : 4-5). He was particularly concerned with the impact of the total institution on inmates' identities and self images : what the institution made of individuals and what individuals made of life inside.

Goffman describes the predictable pattern of day-to-day life experienced by those in 'closed worlds' as having four distinctive elements :

1) 'all aspects of life are conducted in the same place and under the same single authority';

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12 See, for example, Clemmer (1940); Sykes (1958); Goffman (1961, 1975); Morris and Morris (1961); Morris *et al.* (1963); Irwin (1970); Cohen and Taylor (1972); King and Elliott (1977); Sapsford (1981); Mandaraka-Sheppard (1986); Eaton (1993).

2) 'daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike';

3) 'activities are tightly scheduled';

4) 'activities are ... designed to fulfil the official aims of the institution (Goffman, 1961 : 6).

Upon entry, individuals experience 'civil death' (Goffman, 1961 : 16) through a series of mortifying processes : they often lose their civilian clothes and rights, they have very limited privacy and they are forced to endure 'batch' living. Their personal territories are invaded, they are 'disinfected of identifications' and they lose their 'identity kit' (1961 :19-21). The loss of 'identity equipment' prevents the individual from presenting the usual image of him- or herself to others (Goffman, 1975 : 239). Each individual is removed, often abruptly from the day-to-day environment - the 'home world' - that confirmed a certain 'conception' of him- or herself (Goffman, 1961 : 14) and placed in an institution that crushes any sense of self-worth. The individual undergoes 'mortification of the self' (1961 : 21).

In total institutions, presentations of the self are precarious : clothes, for example, are often provided by the institution. The result is that institutional life fails to corroborate one's prior conception of self. Moreover, one cannot escape 'mortifying' situations or defend oneself in the usual manner, a problem which Goffman refers to as 'looping' (1961 : 35). In outside society, an embarrassed individual can, for example, remove him- or herself from the embarrassing situation, but in a total institution there is nowhere to escape, and it is impossible to distance oneself from the mortifying situation.

Once this initiation is complete, total institutions attempt to 'rebuild' their captives' identities through the selective allocation of 'punishments and privileges' (1961 : 51). Things that are easy to obtain on the outside are fought over inside. Cigarettes, coffee, access to facilities, and so on are given as rewards for good behaviour. Punishments are given as a consequence of breaking the rules and consist of the temporary or permanent withdrawal of

privileges. Goffman (1961 : 50) states that, in general, 'the punishments meted out in total institutions are more severe than anything encountered by the inmate in his home world'. He argues that the pettiness of the privilege system is as much a threat to a person's identity as the mortification of the self. It is, according to this argument, difficult for a person to sustain self-respect when he or she has to act obediently in order to be able to receive, for example, a letter. In an effort to circumvent institutional rules, people constantly look for 'angles', 'gimmicks', 'deals', or 'ins' that will enable them to 'obtain forbidden satisfactions or to obtain permitted ones by forbidden means' without directly challenging the authorities (1961 : 54).

In the face of the humiliating circumstances of privilege and the mortifying processes, individuals try to protect a sense of self by 'playing it cool' : they adopt certain 'tacks' in the hope of 'eventually getting out physically and psychologically undamaged' (Goffman, 1961 : 64-65). Playing it cool in mental hospitals involves a combination of secondary adjustments which Goffman (1961 : 61-64) classifies as, 'situational withdrawal', 'intransigence', 'colonisation', and 'conversion'. These 'line[s] of adaptation' are essentially tension-reducing techniques :

> Each tack represents a way of managing the tension between the home world and the institutional world (Goffman, 1961 : 65).

In brief, situational withdrawal is a way of removing oneself from past and future, and from all social ties and relationships. Individuals lose interest in their immediate surroundings and withdraw from all but immediate bodily functioning. Establishing an intransigent line involves setting a lower limit to attacks on one's self-identity, below which individuals will resort to retaliation or non-compliance. Here, 'the inmate intentionally challenges the institution by flagrantly refusing to cooperate with staff' (Goffman, 1961 : 62). Intransigence, however, is 'typically a temporary and initial phase of reaction, with the inmate shifting to situational withdrawal or some other line of adaptation' (1961 : 62). Colonisation occurs when there is a rejection of outside life and a reorientation

of oneself to the total institution, 'a stable relatively contented existence is built up out of the maximum satisfaction procurable within the institution' (1961 : 62). Finally, in the fourth adaptive strategy, conversion, there is the adoption, in appearance at least, of the institutional definition of reality : 'the inmate appears to take over the official or staff view of himself and tries to act out the role of the perfect inmate' (1961 : 63).

The importance of Goffman's work for the current analysis lies in his contribution to our understanding of the ways in which individuals construct a life of their own that becomes meaningful, reasonable, and normal given certain circumstances : the contextual *rationality* of seemingly *irrational* action. Goffman's 'inmates', however, tend to be conceptualised as relatively *passive* members of their 'total institution' (which, given that theirs was a mental hospital, is hardly surprising). Their 'fight' is primarily about the nature of the identity that the institution is trying to impose on them. Goffman is thus concerned with the ways in which individuals *adapt* to the institutional conditions of mortifying processes. Implicit in his writings, however, is an assumption that mortification succeeds : that former identities are 'spoiled' and/or stripped away and that the various forms of adaptation - the 'secondary adjustments' - merely provide some mitigation of the damage done.

Other writers, however, explore the strategies which individuals bring with them into prison which enable them to cope with prison life and which are not stripped away by mortification processes (see, for example, Irwin and Cressey, 1962; Irwin, 1970; Cohen and Taylor, 1972; King and Elliott, 1977). For them, 'playing it cool' (that is, prisoner behaviour) can not be understood merely as a response to imprisonment *per se*, but as an adaptation to the larger world of which the prison is merely one facet. In this respect, prisoners may well respond to imprisonment in similar ways as they respond to stress in their outside lives. Strategies of prisoner response should not, therefore, be seen in terms of 'idealised types', but rather as descriptions of what people actually *do* which may be analogous to what they actually do in 'ordinary' life.

Irwin (1970), for example, argues that the focus of studies of prisoner behaviour should not be on how prisoners adapt to prison, but, rather, on how prisoners approach the question of how to *do* their time. For Irwin those who cope with imprisonment (that is, who do not commit suicide or sink into the depths of psychosis) may be divided into prisoners who 'identify with and therefore adapt to the broader world than that of the prison' and those who 'orient themselves primarily to the prison world' (Irwin, 1970 : 67). He further divides those whose basic orientation is to the outside world into prisoners who 'wish to maintain their life patterns and identities' and those who see imprisonment as an opportunity to 'make significant changes in life patterns and identities' (1970 : 68). In effect, Irwin identifies three main prison-adaptive modes, which he terms 'jailing', 'doing time' and 'gleaning' (1970 : 68).

'Jailing' represents the mode of adaptation of those prisoners who orient themselves to the prison and its culture, who cut themselves off from the outside world in an attempt to 'construct a life within prison' (1970 : 68). This response, according to Irwin, is characteristic of the 'state-raised youth', whose institutional career has prepared him (or her) for the role of prisoner : 'the prison world is the only world with which he is familiar' (1970 : 74). In prison, they become involved in the social system of wheeling and dealing, and the battle for power and prestige.

For those prisoners who retain a commitment to the outside world and who wish to retain their life patterns and identities (criminal and otherwise), 'doing time' involves trying to maximise comforts and luxuries and minimise hassles. They 'avoid trouble', engage in activities which 'occupy their time', secure 'a few luxuries', form 'friendships' with other prisoners, and do whatever is necessary to 'get out as soon as possible' (1970 : 69).

Some prisoners, however, make attempts to change their life patterns and identities and take up a mode of adaptation called 'gleaning'. Here, prisoners seek out opportunities to 'better themselves', 'improve their mind' or 'find themselves' and take advantage of the resources that exist in prison :

educational opportunities, vocational training schemes, treatment programmes and so forth (1970 : 76-77).

Some evidence of the universality of Irwin's categories - developed in prisons in the United States - is to be found in the work of King and Elliott (1977) who found them to apply with more or less equal force in Albany prison on the Isle of Wight.

Most studies of prisoner behaviour identify certain *personal* prison-responsive modes such as those discussed above. In these studies it is postulated that individual prisoners, in an effort to find a solution to the pains of imprisonment, engage in a range of behaviours : from psychological withdrawal through acquiescence to innovation and change. While conceding that inmate organisation has sometimes been strong, most of these researches argue that *collective*, concerted action is relatively rare in prison :

> The inmates lack an ideological commitment transcending their individual differences and the few riots which do occur are as likely to collapse from dissension among prisoners as from repression by the custodial force (Sykes, 1958 : 81).
>
> The prison rebel is no inspired revolutionary but an individual who is prepared to pit himself actively against the system (Morris and Morris, cited Mandaraka-Sheppard, 1986 : 118).

Indeed, the starting point for many studies of prisoner behaviour is a concern about the *lack* of organised resistance within prison, about the maintenance of 'good order', and about the infrequency of disturbances and protests which may be understood in terms of the questions of power and legitimacy discussed above.

However, there is evidence that for some groups of prisoners, strategies of response are more collective and 'political' in nature, and, while not necessarily resulting in all out rebellion, there are clearly occasions where disciplinary power is actively contested and resisted through organised attempts. Cohen

and Taylor (1972), for example, found a high level of resistance (both individual and collective) amongst the men at Durham's maximum security block - E-wing. Cohen and Taylor distinguish five types of resistance : 'self-protecting' (including attempts to make life more bearable, active or passive refusal to cooperate and deliberate challenging of staff rules); 'campaigning' (including organising petitions, writing letters to M.P.s and penal reform groups[13] and leaking stories to the press); 'escaping' (literally); 'striking' (including the 'most accepted weapon of non-violent resistance' : the hunger strike) (1972 : 144), and finally 'confronting' (defined as the most appropriate mode of fighting back for those groups 'who can unite under an anti-authoritarian ideological banner, and who can manifest sufficient solidarity to counteract the inevitably harsh retaliation by the authorities') (1972 : 145).[14]

Strategies of prisoner response, whether collective or individual, may be seen as lines of defence against the anxieties and stresses of being socially and physically confined. However, as most writers point out, the various defence mechanisms are unlikely to coalesce into any unitary 'style'. Prisoners have to cope with their day-to-day anxieties as they can and it is likely that different people adopt different tactics in different circumstances. Social class, age and ethnicity, as well as gender are also all likely to influence the range of strategies at one's disposal. Moreover, notions of the 'good' prisoner (like the 'good' patient) may also be influential. The 'good' prisoner does not question institutional authority. If they attempt to do so they may be further penalised. Attempts by prisoners to negotiate and/or change the nature of their confinement can, for example, be interpreted as a challenge to authority. Frustration, expressed either externally or against the self, can be interpreted as rebellion. As Scraton *et al.* (1991) point out :

> [T]he organisation of 'resistance' against the absolute power of the regime also guarantees the labelling and victimisation of

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13 Challenges mounted from inside have often been supported by directed collective action from outwith the prison walls (see Sim, 1990; Carlen and Tchaikovsky, 1996)

14 The late 1980s and early 1990s saw an increasing incidence of collective disorder in British prisons culminating in the month-long protest at Strangeways prison in Manchester (see Scraton *et al.*, 1991; Sparks, 1996).

> prisoners. To them is ascribed the status of 'awkward', 'difficult' or 'violent' ... By stripping prisoners' actions of meaning and by criminalising their acts the authorities depoliticise and pathologise their resistance. Punishment is extended and intensified, thus emphasising the absolute authority of the regime and protecting its established order and practices (1991 : 63).

Patterns of response can be conceptualised, therefore, on the one hand, as attempts by individuals to preserve some sense of self, a sense of their own self-worth, while, on the other hand, they are acts which the institution is likely to interpret as symptomatic of 'deviancy'. Thus, the environmental attack on the self by the institution may have the consequence of *creating* the symptoms it is designed to 'treat'. Strategies for adaptation and resistance are thus likely to produce the situational improprieties that re-define an individual's behaviour and re-affirm the power of the institution.

CHAPTER 2

In 'the system' : *Becoming* a prisoner

> Justice has got to change for women. We're not men dressed in skirts, as a previous governor said (Angie).
>
> I've learned more [about the law] since this case, well since I've been in prison, than I've learned in my life. I didn't know the system was so bad, the system is so mean and cruel (Sharon).
>
> When you look at the whole system, I just don't see any logic or fairness or common sense (Brenda).

In the United Kingdom, as in most Western societies, the majority of convicted offenders are *not* sent to prison. Becoming a prisoner is quite a complex process : an individual has to have some interaction with that larger entity known as the criminal justice system which, at the very least, usually involves contact with the police, prosecution authorities and the courts. The probation service may also become part of the process as may medical and psychiatric services. Those who end up in prison are those who unsuccessfully negotiate 'the system', or who have nothing with which to negotiate.

There is little agreement on how women offenders are, or should be, dealt with in the criminal justice system. The official statistics tell us that women are grossly under-represented amongst offenders. The statistics also reveal that women are more likely to be cautioned than men. At the sentencing stage, they are more likely to receive an absolute or conditional discharge, a probation order or a supervision order than are men, and less likely to receive a custodial sentence or a community service order. However, the statistics also show that a higher proportion of women prisoners are first offenders compared to male prisoners (NACRO, 1995a; Penal Affairs Consortium, 1996).

Such statistics provide little detailed information about sentencing patterns and yet they have prompted much debate about whether women are treated more *leniently* or more *harshly* by the system. A common assumption in the conventional criminological literature is that women are treated more leniently by the system than are men simply because they *are* women (Mannheim, 1965; Walker, 1968). This is often referred to as the 'chivalry hypothesis'.

This view has been challenged by a growing number of feminist writers, who describe the process in a very different way, viewing the system's treatment of women as discriminatory and sexist[1]. They argue that the system, designed as it was by and for the male majority, treats women as something of an anomaly. As a result, the system fails to acknowledge either the special needs of women or the *rationality* of much of women's offending. They argue that women are punished not only for breaching the criminal law but also for breaching sex role expectations.

This chapter explores some of these claims by looking at the mechanisms through which 'justice' is delivered. The aim of the chapter is twofold : first, to analyse **the law, the police** and **the courts** as they were experienced by the women in this study. Secondly, to examine some of the key issues which arise out of the operation of criminal justice. These issues will be explored on two levels :

- The ideological : whether gender *assumptions* operate in the criminal justice and related welfare systems;
- The practice : what actually happens to women offenders within the system.

In doing this, the broad aim of the chapter is to look at the process through which *some* women, like *some* men, become prisoners.

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1 See, for example, Smart (1976); Heidensohn (1985); Edwards (1984); Eaton (1986); Carlen (1988); Morris (1988, 1990); Worrall (1995).

The Law

> I've learned a lot about the law, a lot. It's very male-dominated. Especially more so with women, it comes down harder on women because we've stepped out of our role that society has made for us. Because we've stepped out of that role then therefore we must be deviant (Olga).

The law, as an abstract notion, means different things to different people, and in discussing the law, the women in this study often conflated *the* law with law *enforcement* and *administration.* The following discussion, therefore, looks first, at the law in a statutory sense, and secondly, at the various sites in which the law gets defined and interpreted.

With some notable exceptions[2], the criminal law does not *formally* distinguish between men and women to any great extent, although several writers have suggested that there may well be *more* laws relating to men's behaviour than to women's, hence the over-representation of men in criminal statistics (see, for example, McIntosh, 1978). Women's behaviour, it is argued, tends to be 'policed' in other contexts, notably the domestic sphere, and by other, non-criminalising agencies, including the medical and 'psy' professions (that is, psychiatry, psychology and psychoanalysis) (see Donzelot, 1980; Smart, 1989, and chapter one).

Other writers, however, argue that (patriarchal) values embedded in the laws, policies and practices of our legal system establish and reaffirm a particular view of women : 'women's value rests on their fulfilling their expected roles as wives and mothers' (Feinman, 1992 : 1). Feinman (1992) argues that such a view not only limits women's rights under *due process* (because the law's considerations go beyond that of the crime committed), it formally and/or

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2 In law, only men can be convicted of rape. Only male homosexuality has ever been 'criminalised'. Only women can be charged with infanticide and only women can be cautioned under the 1959 Street Offences Act and be charged with soliciting (Heidensohn, 1985)

informally regulates the behaviour of women and the control of their bodies, especially their reproductive capabilities.

An increasing number of studies have explored the relationship between the law and women's bodies (see, for example, Walkowitz, 1980; Edwards, 1981; Smith, 1981; Smart, 1989, 1995). Their focus has tended to be on current and historical attempts to regulate and control women's lives *through* their bodies. In particular, they have explored the ways in which the bodies of women have been *constituted* in legal discourse, and how, in turn, women's bodies have featured in the *construction* and *practice* of law (Smart, 1989).

Walkowitz (1980), for example, in her study of prostitution in the second half of the nineteenth century, describes how laws on Contagious Diseases effectively constructed *the* prostitute. The Contagious Diseases Acts of the 1860s were introduced to control the spread of venereal disease amongst the armed forces. Under the Acts, the police were empowered to arrest women *suspected* of prostitution and the courts had wide powers to imprison such women and to enforce medical examination and treatment upon them (Heidensohn, 1985). These legislative measures, according to Walkowitz (1980), constructed women's bodies - particularly those of working-class women - as sites of dangerous sexuality. What is interesting to note is that their danger was conceptualised not only in *moral* terms but also in *medical* terms : they were seen as 'carriers of disease' (Smart, 1989 : 94).[3]

While Walkowitz's study reveals not only a double standard in the law, where women but not men are penalised for the *same* behaviour, it provides some understanding of how medico-legal discourses have historically sought to regulate women's behaviour. Women's bodies are constructed as *the* site for unlawful practices and deemed in need of social, legal and medical regulation.

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[3] Recent debates about the spread of HIV/AIDS have similarly constituted the female prostitute as a vehicle of disease, despite research indicating that it is more likely to be their male clients who indulge in 'high risk' behaviour than the women themselves and that the risk of infection from male to female during sexual intercourse is much higher than vice versa (Bury, 1994)

Smith (1981), proffers a similar approach to an understanding of the legal construction of culpability in cases of infanticide, an offence with which only women can be charged. The Infanticide Act of 1938 created a special category of offence under Section 1 (1) where a woman causes the death of her child of under twelve months while her mind is 'disturbed by reason of not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation consequent upon the birth of the child'. The Act enables the court to avoid the mandatory life sentence for murder and to impose whatever penalty it considers fit.

Smith (1981) argues that the legal discourse in relation to women's responsibility and culpability at law has been historically constructed in and around masculinist notions of women's bodies. Women, because of their reproductive abilities, have been conceptualised as closer to nature, less rational and less responsible for their behaviour (see chapter one). As a consequence, infanticide became differentiated from murder in legal discourse and constituted as a medical 'condition' : puerperal insanity. Smith argues that while *all* women were seen as unstable, this was particularly so during pregnancy and childbirth. A medical discourse was thus seen as more appropriate to women's lives. Cases of infanticide reveal how the law has discounted judicial practices for determining guilt in preference for a medical discourse on insanity (see Allen, 1987; Smith and Hogan, 1988; Hoggett, 1990).

In criminal law, therefore, women constitute a problem not only because of illegal acts performed *on* their bodies, but also because of their supposed inherent instability. Smart (1995) argues that a similar construction can be seen in relation to family law :

> Legal concepts of marriage, inheritance, legitimacy and illegitimacy all hinge on the female body and its constraints. A marriage is only lawful once it has been consummated; inheritance and the legal status of children all depend upon the lawfulness of the act of intercourse performed upon the

> woman's body. The status of her hymen has been crucial to her social status; laws of marriage, illegitimacy and inheritance have all been directed to one sole purpose - namely to ensure that a (good) woman's body is penetrated only under correct legal and social conditions (Smart, 1995 : 225).

Laws on abortion and surrogacy can also be understood in terms of the medico-legal control of women's bodies : the denial of the woman's right to final authority in reproductive decisions (Petchesky, 1984). Moreover, current attempts to regulate and control the pregnancies of women who use illegal drugs ('crack pregnancies'), HIV-positive women, and the mentally 'subnormal' not only engender a sense of *déjà vu*, recalling the eugenics movement in Britain at the turn of the century (Maher, 1992)[4], but they must also be viewed as the product of a process whereby law has extended its terrain to incorporate new medical knowledges. As Smart (1989) has described it :

> Through the appropriation of medical categorisations and welfare oriented practices rather than judicial practices, law itself becomes part of a method of regulation and surveillance. Law therefore has recourse to both methods, namely control through the allocation of rights and penalties, and regulation through the incorporation of medicine, psychiatry, social work and other professional discourses of the modern episteme. (Smart, 1989 : 96).

The collusion between medical and legal discourse in relation to new reproductive technologies provides the potential for increased intervention in women's lives.

Thus, we can see that in law women, in crucial respects, *are* their bodies : reduced to their reproductive and/or sexual capacities. What is interesting to note is that men's bodies are not so constructed. A man may be violent, for example, or may *use* his body instrumentally, but it is his *actions* which tend to be problematised and criminalised rather than his body, despite equally

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[4] Garland (1985 : 142) has defined eugenics as 'the study and deployment of agencies under social control for the purpose of improving the "racial qualities" of future generations, either physically or mentally'. See Sim (1990) for a discussion of the influence of the eugenic movement in Britain.

deterministic explanations for such behaviour (testosterone overload, for example, or an extra Y chromosome).

This is not to suggest, of course, that women themselves do not see their bodies (and bodily changes) as significant. Rather, as Smart (1989) points out :

> [L]egal and medical discourses have tended to make women *no more than* their bodily functions and processes, or bits of bodies (Smart, 1989 : 96, emphasis in the original).

While women's position under law is theoretically equal to men's, there are, therefore, examples of prejudice against women embodied in laws such as those on prostitution (see Edwards, 1987). However, there are also examples of prejudice against men, evidenced in laws such as those on homosexuality which effectively render lesbianism innocuous and hence invisible.

In practice, it may not be possible to divorce the law and law-making from the society in which they operate. Here, different assumptions about the roles of men and women seem to underlie the law : stereotypical notions about women and men, the nature of women's and men's lives and about appropriate femininity and masculinity.

However women are actually defined in law, for the women in this study the law was seen as largely 'man-made for men' :

> Women don't stand a chance. I never stood a chance. It's a man's law that's why. I mean it was all his side. I mean the guy's not here any more, I killed the guy, but I was beaten up and snapped. I had a breakdown in 1988 and they went into everything. They went way back. I had a child adopted at 17 and that was thrown around in the court and it had nothing to do with the court case. I was married for 19 years, the marriage was all right, but they tried to mess that up. Now do you see them doing that to a man? (Claire).

> It's almost as though it is more accepted for a man to be a bit of a scallywag, a bit of a boy. For women and for mothers it is taboo. Society today is very complex. You know for men it's

> 'He's a bit of a scallywag', with a tap on the back, 'Good old chap'. But when a woman does it it's 'Oh no, she must be a bad mother, a bad person' ... I think they are a lot more lenient with men (Carolyn).

The majority of legislators *are* men, as are the majority of ministers and Permanent Secretaries (Kavanagh, 1990). In 1992, ninety-six per cent of High Court judges were men and ninety-five per cent of circuit judges. Not one of the ten Law Lords was a woman. Eighty-one per cent of practising barristers were men and ninety-five per cent of the queen's counsel (NACRO, 1992a).

What these figures reveal is that it *is* men who largely set the 'agenda of law-making' and its administration (Heidensohn, 1985 : 34). What is less clear, however, is how this influences that agenda. That is, would the agenda be different if it were set by women, or women and men equally?

The Police

> I was in the police station from Friday to Monday. I didn't get a shower or anything there. I'd hate to live with them because they acted more like animals (Wendy).

Section 95 (1b) of the Criminal Justice Act, 1991, places a statutory duty upon the agencies of criminal justice to avoid discrimination against any persons 'on grounds of race or sex or any other improper grounds'. This requirement applies to all forms of decision making, at all stages of the criminal process.

The police occupy a crucial role in determining *who* enters the criminal justice process. It is widely recognised that the police act, not only as *enforcers* of the law, but also as *interpreters*, and that 'extra-legal' factors frequently affect police decision-making (Manning, 1971; Jefferson, 1990). Relatively little work, however, has focused on police decision-making with respect to sex, or on the beliefs held by the police about women offenders. Carey (1979), in an unpublished study of police cautions, interviewed a sample of police officers

who all mentioned that the sex of the accused had no bearing on the decision whether or not to prosecute. Cautions were given for routine rather than idiosyncratic, chivalrous or discriminatory reasons (cited, Morris, 1990).

Laycock and Tarling (1985), in their examination of variations in police cautioning, similarly found a general presumption in favour of prosecuting all adults, irrespective of sex. However, in practice, they found differences in some forces between the treatment of men and women, with the latter being more likely to be cautioned.

Cautioning *is* the main disposal used for women offenders (Hough, 1995) and a far greater proportion of women than men are cautioned by the police, rather than prosecuted (NACRO, 1995). However, this does not demonstrate preferential treatment of women by the police. Rather, it may be that women tend to commit less serious offences than men.

Several writers have discussed how socialisation into a police 'culture' influences the way officers go about their work and relate to those with whom they come into contact (see Jefferson, 1990; Reiner, 1992; Fielding, 1994). A pivotal characteristic of British police culture is an 'ethos of masculinity', evidenced, according to Smith and Gray (1985), by :

> the emphasis on remaining dominant in any encounter and not losing face, the emphasis placed on masculine solidarity and on backing up other men in the group especially when they are in the wrong, the stress on drinking as a test of manliness and a basis for good fellowship, the importance given to physical courage and the glamour attached to violence (Smith and Gray, 1985 : 372).

Jefferson (1990), in his study of the Metropolitan Police Special Patrol Group (SPG), describes unit life as resembling a 'male club' where 'the pressures of socialisation are not easily evaded' and where :

> Masculinity is central ... The absence of women, the male camaraderie ... the premium of decisiveness, firm interventions

> and toughness, the sense of being the cavalry to whom beleaguered divisions turn to for help, all help make SPG work the epitome of a certain traditional notion of 'manliness' (Jefferson, 1990 : 127).

As in other areas of the criminal justice system, police forces are numerically dominated by men. In 1991, only twelve per cent of police officers were women (NACRO, 1992)[5]. Moreover, the police deal primarily with men as suspects and offenders. This, then, raises key questions about the relationship between *culture* and *behaviour*, and the ways in which the relatively few women who the police process as offenders are dealt with.

Research suggests that police officers routinely employ stereotypes to make sense of the world they police (Young, 1991). If we consider cases of rape, for example, police perceptions of women as victims, of their morals, roles and behaviour have been clearly evidenced. Chambers and Millar (1983; 1987), for example, describe how the police approach sexual complaints from women with a 'high degree of scepticism arising in part ... from the widely held belief, common also outside police circles, that women were likely to fabricate complaints' (1987 : 61). Such scepticism, according to Chambers and Millar, which could determine whether or not a case was passed on to the prosecution services, appeared to be learned in training and was part of the general police culture.

It is, of course, difficult to gauge the extent to which such perceptions inform police behaviour towards women offenders, but it seems likely that they symbolise a specific and particular world-view.

Hunt (1984 : 294), in an account of her experience as researcher-cum-observer among police, states that the 'policeman's world constitutes a symbolic universe permeated with gender meanings and this symbolic structure is preponderate

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5 Research suggests that the values of women police officers tend to converge with those of the dominant masculine culture (Fielding and Fielding, 1992), although this is an issue which has been given little systematic attention in the literature (see Heidensohn, 1992).

over other factors which explain the behaviour of the police'. She argues that police officers have created polar categories of 'clean' and 'dirty' or 'moral' and 'non-moral'. Male police officers tend to see 'real cops' as inhabiting 'dirty' territory : the 'outside realm of the street' (1984 : 283), where non-morality is a necessity. Women, in contrast, are generally seen to be 'moral', associated with 'inside work' and the 'clean' domestic domain. Moral women (that is, wives, mothers and daughters) are, according to Hunt, 'trusting and emotional ... persons whose actions are embedded in love and kindness' (1984 : 288). She goes on to suggest that those women who enter the policeman's world, either as offenders or as police women, cannot be considered 'moral women'. They have rejected the 'feminine attributes' associated with 'inside work' and, as such, they are masculinised in their behaviour[6]. Prostitutes, for example, are seen as covertly masculine (unlike lesbians who are overtly man-like). They are 'toms' who sell themselves for profit on the market place, and, in contrast to moral women, their success is 'measured by the number of sexual conquests as well as the amount of money [they] earn' (1984 : 288).

A distinction between prostitutes and 'real' women was made clear in the Yorkshire Ripper inquiry. Following the brutal murders of ten women alleged to be prostitutes, the killing of an apparently 'respectable' woman prompted the following statement from West Yorkshire's Acting Assistant Chief Constable :

> He has made it clear that he hates prostitutes. Many people do. We, as a police force will continue to arrest prostitutes. But the ripper is now killing innocent girls (cited, Edwards, 1987 : 49).

Prostitutes themselves, while often complaining of police harassment and entrapment, appear resigned to such negative imagery (Heidensohn, 1985). As *the* group of women with most regular contact with the police, it may be that they develop, through experience, a sense of personal identity which protects

[6] This viewpoint gained expression in Adler's (1975) 'liberation thesis', which contended that, as women are accorded male opportunities, then they are increasingly likely to become masculinised in their behaviour. Campbell (1995 : 9) notes, however, that women offenders are likely to come from 'that segment of society most obviously excluded from any form of liberation'.

them from attacks against their self-images launched by the police[7]. Women less used to the police in their policing role, however, can feel very frightened and intimidated :

> I was in a real state, a mess, before I even got to the police station. I can't remember much about the police station. I was in shock ... It was like a dream. I was walking in a nightmare of a dream. I tried explaining that I was on Valium, that I was dyslexic but they didn't care. They didn't want to know.... I was isolated and humiliated. I was made to feel very dirty. I remember being so scared and frightened and wanting them to go away. I can still feel it and nothing will ever take that fear away from me (Kym).
>
> I'd never been in a police station in my life before. I was taken to a police station because they had orders. I was just an absolute jelly for days. I did everything they told me to do because I thought they would let me go. I was trying to help them but they just switched everything around. It was awful ... I was in the police station for 4 days (I still panic when I hear raised voices). It was like a bad nightmare. I thought I was going to wake up and everything would be all right and that this wasn't really happening to me (Olga).
>
> The police, I went through it blindfolded. I just went through it blindfolded. I just did everything they said. When they said you can go, you go. Really you just go through the motions. You just do as they say all the time (Chris).
>
> I didn't realise what a state my mind was in. I was in real shock. I had to write statements and everything and when I look at them now I think what a load of rubbish (Claire).

Horn (1995), in her study of police perceptions of women offenders, argues that police officers tend to categorise women offenders as 'good' or 'bad' women. She suggests that this is most clearly evidenced in beliefs about violent women. While women offenders are perceived more negatively than women who do not offend, most are thought to be essentially 'good women' (that is, non-violent), who have temporarily offended due to circumstances. Some women, however, especially those who are physically violent, are thought to be

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[7] Cohen and Taylor (1972), in their study of maximum security prisoners, suggest that certain offenders develop, through their criminal careers, strategies to protect themselves from attacks against their self-images.

'bad' and actually 'worse' than male offenders[8]. They are thought to be more manipulative, often using their femininity to manipulate men, including policemen (Horn, 1995 : 17). Horn (1995) illustrates the distinction between 'good' and 'bad' women offenders :

> 'decent' women who cry, or bring their children to the police station with them, are perceived as 'genuine', and deserving of sympathy. Those who are labelled 'rough', however, and who cry, or bring children to the police station, are perceived as 'manipulative' (Horn, 1995 : 17).

Horn (1995) suggests that police officers do not tend to see women who offend as 'natural' criminals in the way that they do men. This is not to suggest that they regard such women as 'typical' women. Rather, they are reluctant to allow women to step out of their traditional 'feminine' roles and so efforts are made to render women offenders harmless (that is, unthreatening to their own sense of masculinity). This is similar to the central tenets of the biological determinist model discussed in chapter one, which proposes that women are *naturally* law abiding, and, while women may commit offences, they are not 'real' criminals and hence alternative explanations are sought for their behaviour.

Many of the women in the current study recognised that certain stereotypes about women and about women offenders, together with their own behaviour when questioned or arrested, had an impact on the way in which the police reacted to and treated them :

> It's almost as if [they think that] women can't possibly get to the top by legitimate means. It would have to be either by sleeping with someone or by criminal activities, or both ... They kept asking me what it was like to be a man, saying things like, 'Well if you behave like a man, you've got to expect to be treated like one'... It seems to me that my problem was that I'd stepped out of my role completely in their eyes. First, I was a woman

[8] This popular viewpoint is regularly depicted in the media. In October, 1994, *The Guardian*, for example, ran a story about girl gangs entitled 'Deadlier than the Male'.

> making it in a man's world, so already I must be a little odd [laughs] and secondly, yes, I broke the rules which govern us and women don't do that sort of thing. So, I think I was seen as *more* aggressive, *more* criminal (in inverted commas). You wouldn't think that people would think like that but they do and the implications are very very frightening (Brenda, emphasis added).

> I think it's how much hassle you've given the police ... If you go along with the police and give them all the answers that they want and this that and the other, then it'd probably work better for you. If you give them hassle, you refuse to answer this that and the other, or whatever they want to know, then they just make it the most difficult. I just can't believe what went on, I can't believe the lies (Jane).

The women in this study were asked whether they thought that they had received different treatment from the police than they would have done had they been men. While many thought that they had received worse treatment : 'being a woman, I think they came down harder on me' (Beth), some thought that they had been treated better : 'I think they go a little easier on women' (Meg), and several described almost paternalistic encounters with certain (individual) police officers :

> The police were fine, strange as it might seem. The policeman who arrived at the flat was the one who had dealt with the burglary. He knew I was in shock (Pam).

> I remember one particular policeman being very concerned and taking me to one side and saying, 'Now what's all this about?' and, 'Let's see if we can sort all this out' ... He reminded me of my Dad [laughs] (Ann).

Tchaikovsky (1985) describes a similar encounter with the police, in which she recognises that aspects of her own biography offered her 'protection' against harsh treatment :

> I got the 'fatherly' concerned detective and the hard and nasty one ... The police were not violent, although I had expected that too. I was far too naive to realise that my 'respectable' background was my protection. Indeed, my respectable father

> was on his way to the station with the best brief he could find (Tchaikovsky, 1985 : 25).

The majority of women in this study, however, expressed a dislike and suspicion of the police engendered in many cases by their experiences of harsh and/or unsympathetic treatment :

> I know what the police are like ... they're putting the questions to [you] and at the end of the day they are writing down what they want (Gwen).

> Well I thought the police didn't work like that and they do. It's just such a shock because I have never been in any trouble in my life and if the police say something then the police are right. Well I don't believe in it any more (Emma).

> Especially when it's your husband... and they're questioning you about a murder case, they shouldn't question someone straight away. Not after saying 'Your husband's dead' (Kym).

Fielding (1994 : 63) argues that, while policing is 'imbued with the values of masculinity', other factors (situational and structural) are also likely to interact to influence police decision-making. Throughout the criminal justice process there are opportunities for the operation of assumptions, value-judgements, stereotypes and prejudices, not only to do with gender, but also to do with class, race, sexual orientation and so forth. The women interviewed in this study variously put their attitudes to the police down to police harassment of, and/or discrimination against : women in general, lesbians, the working-class, people 'who've been in care', and other groups. As Fielding (1994 : 63) points out 'cop culture' is also a 'white' culture and police harassment of black people was frequently cited in the accounts of black women, who referred to unprovoked incidents in which they had either been verbally abused or even assaulted by police :

> I was battered in the police station to be quite honest with you. When I went to Risley they were supposed to take me to an outside hospital my face was so badly swollen. I was bleeding from the mouth and things like that. The police came in to

> interview me because I was going to press charges but at the same time it's like complaining to the police who investigate the police and I know I won't get anywhere so ... it doesn't make sense (Sylvia).
>
> The police came round to my flat at about six in the morning. They ransacked the whole place and arrested me and my boyfriend ... they took us to the police station and kept us there for hours and I remember one particular policeman kept making little remarks, kind of jokes to the others about black women. Not loud enough for me to hear everything, but loud enough for me to know what he was getting at. Do you know what I mean? (Julie).

Chiqwada (1989) argues that black women are more likely to suffer social factors which contribute to their *image* as suspects, criminalise them and influence their subsequent processing through 'the system', and it is likely that black women suffer the double disadvantage of being stereotyped according to race and gender.

This then provides some foundation for the view that only certain women end up in court, let alone in prison (Reddish, 1995). Such women, by virtue of their law-breaking, their sex and/or other personal characteristics, are *all* likely to be those who the police have regarded as being 'gender deviant' (Carlen, 1988a) : they are 'unnatural' women. Their resistance to 'the law' - their rule-breaking - in a legal sense and in terms of sex-role expectations, is likely to reinforce police and popular stereotypes of appropriate femininity and about the nature of women's offending.

The Courts

Courts tend to present a 'dramatisation of deviance', a tendency heightened under the English adversarial system (Heidensohn, 1985 : 40). For many of the women interviewed in this study, the drama was all too recognisable :

> I'd never been to a police station or handcuffed or fingerprinted or photographed or anything. I look back now and realise that I never really saw the court thing and the trial as real. It was like being on the set of a play (Brenda).

> I'd never been in a court before. I didn't even know where to go or anything and standing there with people talking about you as though you don't exist, which is what they do. I'd love to find out but I'm sure they know before you even get in that box what they're going to do with you. All that standing there and the prosecution having a bit of a go and then the defence having a bit of a go and I'm sure it's all a complete play act (Ann).

From studies of court procedures, of the ways in which cases are conducted and defendants are convicted and sentenced, we can learn a lot, not least about the ways in which women experience criminal justice in them.

While evidence for the lenient treatment of women by the police simply because they *are* women is, as we have seen, weak, research findings with respect to sentencing have produced contradictory findings and there is little clear and reliable evidence to show that women offenders are *consistently* treated either more harshly or more leniently than men by the courts. Hough (1995 : 22), in a review of the evidence, suggests that overall, men and women are probably treated 'similarly under similar circumstances'. However, men and women rarely do commit *similar* crimes in strictly *similar* circumstances.

Some writers suggest that the (male) majority of decision-makers respond to women offenders in much the same way as they respond to their mothers, wives and daughters. This theory has some support, not least by certain members of the judiciary themselves. Heidensohn (1985), for example, cites Lord Denning's view that the law should both differentiate between men and women and treat women 'protectively' :

> It would be very wrong in my mind, if the statute were thought to obliterate the differences between men and women or to do away with chivalry and courtesy which we expect mankind to give to womankind (cited Heidensohn, 1985 : 38).

Sentencing statistics from both magistrates' and crown courts certainly seem to suggest discrimination in favour of women and girls, and have been used to support the argument that women are treated leniently (see Moxon, 1988; Wilczynski and Morris, 1993). Research on sex and sentencing decisions, however, has increasingly questioned this assumption (Farrington and Morris, 1983; Morris, 1988; Eaton, 1987, Smith, 1988). Farrington and Morris (1983), for instance, in their study of court files on almost 300 hundred men and just over 100 women convicted of theft offences, found that women, at first, appeared to be more leniently dealt with than men : fifteen per cent of men in the sample were given suspended or immediate sentences of imprisonment compared to three per cent of women. Eleven per cent of women were given probation compared to five per cent of men. However, when both the nature of the offence and the offender's previous convictions were taken into account, the apparent differences disappeared - sex was not related to sentencing severity independently of other factors (Morris, 1988). While women appeared to receive more lenient sentences this was *only* because they had committed less serious crimes and were less likely to have previous convictions.

Research on sentencing also indicates important differences in the 'extra-legal' factors which may influence the treatment of men and women. Here, it might be that we need to consider the importance of *gender* rather than sex to explain sentencing disparities. A number of writers have suggested, for instance, that while chivalry may well extend to some women - whose behaviour conforms to approved stereotypes - leniency will not be shown to women who 'deviate' from notions of appropriate sex-role behaviour.

Helena Kennedy (1991), for example, argues that :

> [I]f a woman conforms to a judge's idea of what is appropriate for a woman he will have trouble convicting her ... 'Chivalry' exists but it is very much limited to those women who are seen to conform (Kennedy, 1991).

Lloyd (1995), similarly, describes conversations with lawyers who agree that chivalry is limited to women who 'conform'. She argues that judges and magistrates, like the police, tend to make decisions on a division of 'good' and 'bad' women, and she points to the significance for the court of a woman defendant occupying a traditional role : mother, wife, housewife.

As we have seen, women entering the criminal process are so numerically rare as to be 'out of place' and so explanations are sought for their presence. Women's behaviour is typically explained within a discourse of 'abnormality' and 'irrationality', despite seemingly rational explanations from the women themselves :

> Christmas was coming up and I was skint ... so I went shoplifting for Christmas [laughs], most women go Christmas shopping, but I went Christmas shoplifting. I think they thought I was mad when I told them that in court (Jez).

Pearson (1976), in a study of a Cardiff magistrates' court, found that the sentencing of women was highly individualised and that women were treated in court as if not fully responsible for their actions. She suggests that responsibility is lessened in two main ways : first, women are seen as social casualties, and/or, secondly, they are seen as mentally ill. Minimising women's responsibility for their 'non-feminine' actions, however, deflects attention away from the alternative explanation that women might resort to crime for the very same reasons as men.

In their study of magistrates' sentencing decisions, Farrington and Morris (1983), identified a number of factors which seemingly influence the courts' treatment of men and women, including the involvement of others in the offence, marital status, family background and the sexual composition of the bench. Thus, women convicted with one or more other offenders were more likely to receive severe sentences than those convicted alone. Divorced and separated women also received relatively severe sentences, as did women coming from 'deviant' family backgrounds. Women dealt with by a bench

containing two women were dealt with more severely than those dealt with by a bench containing two men. The researchers speculate that women who step out of the traditional feminine role may well receive harsher sentences because they may be those who other women particularly 'disapprove of'.

Wilczynski (1991) explored the types of distinctions made between women who have committed the same offence. She examined twenty-two cases of infanticide, in which the majority of women (14) were clearly identified as essentially 'good' women who had temporarily and tragically lapsed. As a consequence, they were given probation or hospital orders. The remaining eight women, however, were given custodial sentences. These women were conceptualised as having acted in ways inconsistent with stereotypical notions of appropriate femininity. That is, they were viewed as 'bad' women : cold, uncaring, selfish and neglectful.

Kruttschnitt (1982), similarly, in an analysis of more than a thousand cases involving women offenders, found that the more 'respectable' a woman was, the more lenient her sentence. Here, 'respectability' referred to a good employment record, no alcohol or drug use and no psychiatric history. Irrespective of the offence, the less 'respectable' a woman was, the more likely she was to get a severe sentence.

Eaton (1987 : 100), in a case study conducted in a London magistrates' court, argues that the 'language of the courtroom' both *reflects* and *reinforces* the prevailing picture of the social order : 'it contains and communicates the attitudes and assumptions of those involved in the social construction of justice'. She points out that those women whose lives conform to a certain pattern of family life - 'breadwinner husband and dependant wife responsible for child-care and domestic labour' - are more readily 'protected' from the label of 'criminal' because membership of a family, she argues, is recognised to involve a degree of social control. Thus, if a woman in court 'acts her part' - modest,

humble, remorseful - and reference can be made to her competence in the domestic sphere, she is not seen as 'criminal'. She is a 'good' woman.

The rhetoric of the courtroom was not lost on the women interviewed in this study :

> I had an abortion when I was eighteen and that was brought up in court. The fact that I wasn't married, that I had made the decision to have a career rather than a family, all of that was brought up in court. There were even suggestions about my sexuality, which were completely irrelevant to the case (and completely untrue as a matter of fact) ... Throughout the trial the person that they talked about was not me.... It was like a double standard of language. A man would have been seen as assertive, I was aggressive. A man would be seen as a risk-taker, I was seen as making stupid decisions. It was interpreted that I didn't care about the people and I didn't care about the decisions (Brenda).

> I was working as a stripper when what happened happened, working for an agency ... I enjoyed it, I enjoyed the power over men. But they had a field day with me in court. They really went to town ... The judge, I'll never forget it, the judge looked down his nose at me and kind of spat out the word 'stripper', as if just by saying it he might catch something [laughs] (Kym).

> The judge, the first day I laid eyes on him I knew I wasn't going to get out with this guy. He was old, he'd just been made a recorder, and he says, 'has she got somewhere to stay?' as if I was a piece of meat sitting there. He thought I showed no remorse. But I'd had three breakdowns. My mind was in a hell of a state (Claire).

Women who are seen as *using* their femininity, their bodies and reproductive abilities, to manipulate also seem to receive harsher treatment (Horn, 1995). To provide an example : In 1990 Judge Pickles sentenced a nineteen-year-old woman to six months imprisonment for the theft of £4,000 worth of goods. The case prompted public and media attention not only because it was the woman's first offence, but because she had a ten-week-old baby and that Judge Pickles, when sentencing, had commented that he wished to deter young women from becoming pregnant in the period between being charged and

appearing in court in the hope that this would save them from a prison sentence (McNeill, 1990).

In the current study one woman recounted a similar experience :

> [The baby] was only eleven weeks at the time ... and the judge said, 'I know it'll devastate your family and I know you'll never re-offend and it won't do you any good going to prison, but you've got to deter others'. He said, 'I can't be seen to be condoning women who get pregnant just in the hope that they will receive leniency'. I just kept thinking I'm going in here to stop other people rather than being here to make me understand what I'd done. I already understood what I'd done.... And the thing is I hadn't planned the pregnancy like that ... I mean you're like dangling on a string. I mean it was twelve months without going to court (Ann).

The theme of punishment for breaching sex role expectations has been identified in much of the feminist criminological literature. Pat Carlen (1983), for instance, in her seminal work on women's imprisonment, interviewed sheriffs in Scotland and found that, on the one hand, sheriffs claimed that when sentencing women, they took into consideration the same factors as when sentencing men. On the other hand, it gradually emerged that they were not prepared to send women to prison at the expense of the women's children. The women who were sent to prison were those who, in the eyes of the sheriffs, had failed *as mothers* (Carlen, 1983). Thus sheriffs not only wanted to know whether a woman was a mother, but whether she was a *good* mother.

To illustrate how notions of 'good' and 'bad' mothering influence the way a woman is treated in court, Helena Kennedy (1991) cites a case which she was involved in :

> It concerned a series of armed robberies in which there was a 'Bonnie and Clyde' relationship ... The judge asked about the woman, who, twelve years earlier, when she was in her teens, had had an illegitimate child. The child had been fostered and there had been no mention of it in the inquiry report. But the judge was at great pains to ascertain whether this woman had

> ever visited her child, whether she had shown any care for this child, whether she had maintained any contact with this child; he wanted to know what kind of mother she was.... None of this bore any relation to the offences she was in the dock for. And ... those sorts of questions are never, but never, asked about men (Kennedy, 1991).

Similarly, a woman in this study reflected on the notion of 'good' mothering :

> When a man goes up to court they don't ask him how good a husband he's been and how good he's looked after his family. When a woman goes up in front of the judge he judges her on her character. OK she might be a prostitute but she might be a good mother. She's probably had to prostitute herself to get money for her family, to look after her family. Most of the women in here have had to steal money for their family. Why doesn't the judge take that into consideration? He's splitting up families, never to be joined again. Children are being put into homes. When a woman stands in the dock she has to justify herself and what he says is that 'women shouldn't offend and if you offend and you come in front of me, you take the consequences of a man. I'm going to put you in prison' (Mair).

Women who have shown violence or aggression are at particular risk of being treated more harshly than women who are perceived to conform to notions of appropriate femininity and womanhood. Aggression and violence are seen as much more *essentially* masculine than other forms of law-breaking, and so violent women are viewed as particularly 'unnatural' and worse than their male counterparts (Stanko, 1994, 1995; Lloyd, 1995). They are more likely than men to be 'psychiatrised' : labelled psychotic and to end up in a special hospital Ann Lloyd (1995), in her study of violent women, cites a consultant psychiatrist at St George's Hospital and Medical School :

> For example, if somebody has committed a stabbing in the pub ... and a man has done it, then you look at it and think, 'Oh God there's an argument involved, it's a drunken brawl' - most of the time these people don't get psychiatric disposals made. If a woman has done it ... people immediately sit up and take notice ... she gets referred to a psychiatrist... The impact of what she's done may well be translated from a sort of statistical abnormality, because so few women do it, into a psychological abnormality. She is unrepresentative of the majority of women

> and therefore something must be wrong with her (cited Lloyd, 1995 : 57).

Many see the psychiatric system compared to the penal system as a 'soft option' and, it may be so, if it means going to a local psychiatric hospital, but it is not necessarily the case if it means being sent to one of the 'specials'. As Stephenson (1994) points out :

> The maximum security that entails, the indeterminate sentence, the stigma, the inevitable institutionalisation have severe and lasting consequences for those who are sent to these hospitals (Stephenson, 1994 : 11).

While women make up approximately four per cent of the prison population, this rises to twenty per cent within the special hospitals and research indicates that women are twice as likely to be sent for psychiatric assessment and treatment by the courts than men and seven times more likely to be diagnosed as in need of treatment in conditions of maximum security (Allen, 1987; Stephenson, 1994; Lloyd, 1995).

Sentencing decisions provide only a partial picture of court decision-making procedures and practices. Other processes shape sentencing outcomes such as the preparation of medical and psychiatric reports, social enquiry and pre-sentence reports and pleas in mitigation. Here, it seems that it is not only the police and judiciary who operate with stereotypical notions of femininity.

Allen (1987), looked at the depiction of women offenders and their offences in pre-sentence medical and psychiatric reports. She found that within these reports the portrayal of female offenders follows a distinct, sexually-specific pattern which tends to 'neutralise' the women's responsibility and dangerousness. She suggests that women are treated very differently from their male counterparts and that a different set of standards and attitudes are brought into play. While the viewing of women as mentally and emotionally unstable, may well be advantageous to certain individual women, exonerating their

offending behaviour, Allen argues that it is a high price for *all* women to pay insofar as it is premised on a belief in women's inherent instability.

The women in this study were particularly aware of the potential for their behaviour to be conceptualised in psychiatric terms. Some described pre-sentence assessment procedures in which they recognised the importance of self-presentation :

> Before sentencing I was sent to a psychiatric doctor, a psychologist, to do puzzles and things which I didn't find funny at all because I was still in shock. I was asked to start doing puzzles to test whatever and I felt it was the wrong thing to do. I remember asking the psychologist 'Why must I be doing this? Why don't you ask me about my well-being rather than asking me to do puzzles?' ... Dealing with the psychologist made me feel like dealing with the police because at the end of the day they're dealing, representing the Crown. I don't like the idea of women who are weak being pushed to a psychiatric place and psychologist for tests while they are still in shock. I asked them 'How do you expect me to perform in an examination when I'm under shock?' (Darelle).
>
> In my case they tried to say I was insane and so I had to fight with myself to try to act like someone who wasn't insane (Claire).
>
> I don't know, you just feel as if you're being set up. I strongly believe that a medical report done on me by the prosecution was the wrong diagnosis ... but it seems to me that the more you try to get your point across the more they tend to write you off (Sharon).

Stephenson (1994) cites a former registrar at Broadmoor, who posits the following explanation for the tendency of judges and psychiatrists to 'psychiatrise' much of women's crime:

> If a woman commits an offence which is regarded as incompatible with her female status she has committed a double transgression. She has transgressed against a code of what it is to be feminine - docile, passive, gentle - and she has transgressed against the criminal law. She may either be regarded as doubly bad, doubly evil ... or if she is not bad,

> therefore she must be very, very mad (cited Stephenson, 1994 : 11).

Several writers have looked at the representation of women in reports prepared by the Probation Service (see, for example, Worrall 1989; Minogue, 1994). Minogue (1994) argues that the Social Enquiry Report (SER) and the new Pre-Sentence Report (PSR) (that is, post Criminal Justice Act, 1991) represent critical elements affecting the treatment of women offenders. Requests for such reports are more commonly asked for on women (Mair and Brockington, 1988), providing some support for the suggestion that women's presence in court somehow needs explaining.

In his study of 197 court reports - both SERs and PSRs - on both men and women, Minogue (1994) found that explanations of women's crime differ from explanations of why men commit crime :

> These differences concerned gender images and stereotypes which characterise women offenders as sick, depressed, of loose morals and ... poor mothers (Minogue, 1994 : 4).

Both Minogue (1994) and Worrall (1989) point out that women tend to be defined in these reports in terms of their domestic roles with particular emphasis on their housekeeping abilities and their social and sexual behaviour.

While family circumstances are central to SERs and PSRs (and to pleas of mitigation) prepared on behalf of *both* sexes (Eaton, 1986), domestic responsibilities, particularly childcare, are more likely to arise in cases involving women and, as a consequence, women and men tend to be presented differently : 'dependent and domestic' and 'breadwinner' respectively (Gelsthorpe, 1996). Relationships and the frequency of their breakdown are often emphasised in the reports on women with the implication that this represents instability on the part of women offenders. What is interesting to note is that the breakdown of male relationships seem to be accepted as 'normal'.

As in medical and psychiatric reports, so in SERs and PSRs attempts are made to *minimise* the responsibility of women for their crimes by *emphasising* their vulnerability. Worrall (1989) argues that this has implications for *all* women offenders and particularly for those women who are negatively assessed *as women* :

> On the one hand, it renders the majority of female offenders invisible by interpreting their offences as petty, harmless and 'one-off' matters. On the other, it renders a minority of female offenders highly visible [and] demonstrates either their dangerousness or their incorrigibility, rather than demonstrating the inadequacy of the process by which they came to be defined (Worrall, 1989 : 79).

She concludes that large numbers of women offenders are trapped by an inappropriate need to fit them into stereotyped categories, a point which the women prisoners in this study themselves recognised :

> Women suffer a lot more than men and usually the woman lands up with a longer sentence and that's through male judges, archaic judges stuck in their ways. You're in 2 categories in the eyes of male judges, the Madonna type like their mothers were or, if you've gone out of the mould, you're just a whore. Women are convicted before they even step inside the court (Angie).

> The judge knew I was not guilty. There was no evidence. I'm sorry to say it but it seems that some of these judges don't like women, especially professional women. They don't like them. The judge came to that court room and he'd made up his mind, 'Mrs Brown has to go' (Darelle).

Carlen (1976) argues that court proceedings are designed to humiliate and degrade defendants, male or female. However, a greater proportion of women entering the criminal process are first offenders than men, and, as such, they are likely to be less 'experienced' in court affairs. Many of the women in this study recounted feelings of isolation and exclusion from the whole process, finding the court experience alien, bewildering, humiliating and unfair :

> I didn't have a clue. I didn't have a clue, I just stood there and I thought, 'Well I'll let them get on with what they have to do'. I was a nervous wreck. I was shaking and I just didn't have a clue (Diane).

> When they are talking about you they are talking about somebody totally different. They literally turn every situation round, they swap things round and you are sat there thinking 'Are they talking about me?' And they are not. It just doesn't work out that they are talking about you and you just go through it willy-nilly. You just let it happen because there is nothing you can do to stop it (Emma).

> I was mentally crushed by the court case and then I lost my dignity by collapsing. The judge was horrible. I didn't want to give him the satisfaction of thinking 'Stupid woman. Weak person'. Collapsing in court added insult to injury. I lost my dignity as well as my freedom and my self-respect (Kirstie).

Several of the women argued that they had not fully understood what was happening during the proceedings, not least because of the language used, that they were unclear on who the key actors were, and some had not understood the court's decision. Some of the women mentioned, for example, not knowing when or whether they could speak or who they should address their remarks to. Here, it seems that little is done to help make the experience less alienating, a point illustrated by Dell (1971), in her study of women committed to Holloway:

> [O]ne girl put it, 'I kept being told to get up and sit down'. It is not easy in such circumstances to do justice to one's own defence ... Frequently the women said that they had not been able to catch what was being said. One woman described her feelings when she was invited to speak in court and failed to respond, much as she wished to : 'I was too overawed and frightened ... I didn't want to make a fool of myself - I would only have cried' (Dell, 1971 : 17-19).

Having to defend oneself verbally can make even the most articulate falter. Many women recounted their nervousness and inarticulacy and recognised that this may have had some impact on how they were subsequently treated :

> I didn't really explain myself at the court. I just wanted to get them all to say guilty and get us away. I just wanted to be away from it all. I didn't want to go through all this court carry on ... at the time I didn't want to be bothered. I was just embarrassed about the situation I was in more than anything else. I just wanted to tell everyone to hurry up and let us get away because I knew I was going to go to jail for a long time (Barbara).
>
> I loved the guy but he was very jealous and possessive and it just came to a head that one night ... I killed him, but I didn't mean to. I just wanted to hit out, I wanted to hurt him. But, I should never have said that in the court. I should never have said that I wanted to hurt him (Claire).

Several writers have shown that men and women not only experience court in different ways, but that there are also differences in their legal representation and advice (see, for example, Parker *et al.*, 1981). Some of the women in this study, for example, had been encouraged to plead guilty against their own inclinations :

> I was told, 'We don't want to be seen as persecutors'. They said that if I pleaded guilty to certain charges 'nothing bad will happen to you'. I refused, I'd already been persecuted for 18 months before the trial (Brenda).
>
> Looking at these things critically, and say well does it mean that you have to plead guilty to a crime that you know nothing about in order to get a shorter sentence? At the end of the day it's nonsense (Darelle).

Here, of course, it is impossible to predict the nature of the advice men might have received. However, Parker and colleagues (1981), in their study comparing male and female juvenile offenders before the courts, suggest that women are more likely to be advised to plead guilty, to more trivial offences, than men. Moreover :

> [P]assivity may be expected from girl defendants, viewed as appropriate behaviour and even encouraged by some court workers ... Girls may find it doubly difficult to break through this ascribed passivity and speak out (Parker *et al.*, 1981 : 106).

Many women in this study felt that their legal representation had been poorly prepared and some felt particularly excluded from vital decisions affecting their lives :

> I found the whole experience really daunting ... I hadn't even met my barrister before the day. And he took me into the restaurant because there was nowhere else to go and asked me what I'd done basically. I was thinking, God, this man's representing me and he didn't even know what my name was. (Ann)

> I think that my solicitor was a total waste of time. I think he sold me down the road.... I think they did a deal, the prosecution and the defence. That if they accepted a manslaughter charge, plea, that they would give me life anyway. And that's what was done. (Diane)

Finally, there is then some evidence to suggest that *some* women are dealt with harshly and may well be sentenced for *who* they are rather than *what* they have done. Here, it is argued that those women who fit stereotypical expectations of 'lady-like' behaviour seem to receive different sentences from those who do not. This issue is, however, further complicated, since gender interacts with other factors such as social class and ethnicity and, as I have already suggested, it may be inappropriate to present women's experiences as unitary. Moreover, it would be wrong to assume that men are dealt with in non-discriminatory ways. The male defendant is similarly constituted (although in different ways) and *some* men are punished more severely than others. McDermott and King (1992), for example, describe the processes through which *some* men *become* prisoners and the impact of these processes on both the men and their families. The writers also illustrate how distinctions are made between 'good' and 'bad' men in decisions about security categorisation following the imposition of a custodial sentence (King and McDermott, 1995).

Distinctions are drawn *between* women and *between* men from their initial contact with the police through to sentence being passed. In the process, women are confronted by a series of stereotypical notions about women and

about the nature of women's lives. Such notions, as we have seen, are often contradictory and confused. However, they serve to construct a specific perspective on the nature of women's offending and on the needs of women offenders and those women who step *outside* the conventional model of appropriate femininity (by dint of their offending and their personal characteristics) run the risk of finding themselves incarcerated *inside* our prisons.

Postscript : From court to prison

On the pronouncement of a custodial sentence so begins a process in which a woman is 'literally and metaphorically "taken down"' (Eaton, 1993 : 21). It is a process characterised by restrictions, regulations, isolation and exclusion, aimed at controlling, constraining and constructing her behaviour. She has *become* a prisoner, excluded from society and all that previously constituted her sense of self-identity :

> My husband ... I wanted to see him before I went and I expected to be able to sit with him like this and I couldn't. He was shut in behind the glass and that was terrible. I wanted to give him my wedding ring because I didn't want to bring it with me and I was in tears and he was in tears and this prison officer was just sort of staring at us (Ann).

> It was a huge shock. When they first took me down to the cells I burst out crying. I remember distinctly, and I'll remember it for the rest of my life, a sign on the wall saying 'We treat prisoners with humanity and care' etc., and this officer came in and said 'Have you got the body book, I've got to put Smith in'. And then on the wall there was a chalk board headed up 'DISPOSALS' and on it was 'Smith, 12 months, disposal to Risley'. And I thought, how can this be care and humanity? I mean a body book and I'm going to be disposed of. That was horrendous (Brenda).

> The biggest first shock apart from the initial being charged and then sentenced is the shock when someone can actually tell you that you've *got* to go somewhere, put you in a police car, lock you up and send you somewhere. You can't believe that someone can do this to you. It's awful (Chris).

Such *formal* control is used on those who have eluded *informal* control mechanisms. That is, the ideologically dominant models of femininity and domesticity that regulate women's behaviour within the context of their everyday lives. Women who accept a gender role as constructed within such a model are not only subject to informal control, they are seen as 'normal' women. Their (conforming) behaviour is conceptualised as inherently 'natural', as biologically determined. Women who do not conform, however, who do not accept the prescribed gender role, are thus more likely to be viewed as 'unnatural' and subjected to the rigours of formal control mechanisms : state intervention in their lives.

The women prisoners in this study had taken a variety of non-conforming paths, either through choice or through a lack of choice. Of the fifty women interviewed only fourteen were, at the time of their arrest, living within the 'conventional' family model : that is, married or cohabiting with a long-term male partner[9]. While thirty-nine of the fifty women had children (eighty-three children between them), the 'family' lives of the majority were characterised by divorce, separation, lone parenthood and frequent relationships. Ten of the women had been brought up in institutions from an early age and most had experienced poverty for much of their lives. Moreover, many of the women, by dint of their sexual preferences, skin colour, careers (criminal and otherwise) or involvement within drug cultures, for example, were further removed from the model of conventional (middle-class) womanhood.

Whatever the circumstances that brought these women to prison, perspectives which ascribe status to them in terms of how closely they conform to conventional womanhood - that is, 'non-violent, non-criminal, attentive to personal appearance and with their identity rooted within monogamous relationships and the nuclear family' (Genders and Player, 1987 : 167) - ensure that these women are accorded a disparaged position : defined and treated in negative terms.

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[9] A further nine were in prison convicted of the murder or the manslaughter of their husband or male partner.

CHAPTER 3

The imprisoned body : Regulation, control and self-identity

> They traumatise you in prison. They rape your soul (Pam).
>
> Because they've got your body then they think they should have your mind and spirit as well (Brenda).
>
> Prison tries to destroy any dignity you've got or pride you've got or anything like that (Jane).

In the previous chapter I considered the processes through which some women, like some men, become prisoners. In prison, both men and women are subject to intense social control, directed not only towards the *regulation* of bodily practices but also towards the *construction* of certain types of subjects.

Women prisoners are stereotypically perceived to be a highly disturbed population - either 'mad' or 'bad' but certainly not normal (Barker, 1993) - and the prison system has evolved with the containment of such women in mind (Edwards, 1994). In prison, women are subject to specific forms of intervention and control which seem more invasive than those experienced by men, relying on the *ownership* of a woman's identity as well as her behaviour.

In this chapter I aim to do three things : first, to look briefly at some of the 'facts and figures' of women's imprisonment. Secondly, to examine the nature and scope of contemporary regimes for women prisoners. Thirdly, to explore the main deprivations and sources of suffering identified in the accounts of women prisoners themselves. In so doing, I hope to consider the ways in which social control in women's prisons is constituted not only by institutional demands but also through specific discourses around femininity.

Women's imprisonment : Some facts and figures

There are currently fourteen prisons for women in England and Wales, five of which are units within men's prisons (Low Newton, Durham, Risley, Brockhill and Winchester). Of the nine women-only prisons, five are closed (Holloway in London, Styal in Cheshire, Cookham Wood in Kent, New Hall in Yorkshire, Bullwood Hall in Essex); three are open prisons (Drake Hall in Staffordshire, Askham Grange in Yorkshire and East Sutton Park in Kent), and one is a remand centre (Eastwood Park in Bristol, which has recently been opened to replace Pucklechurch). Five of the prisons include young offender institutions (Styal, Bullwood Hall, New Hall, East Sutton Park and Drake Hall) and four have facilities for mothers with babies (Styal, Askham Grange, Holloway and New Hall).

In recent years, as the courts have responded to a growing spirit of toughness in penal policy, the number of women in prison has increased sharply, with the rate of increase nearly twice that of male prisoners : between 1992 and 1995 the number of women prisoners rose by fifty-seven per cent (from 1,353 to 2,125), whereas the number of male prisoners rose by twenty-nine per cent (from 39,253 to 50,606) (Penal Affairs Consortium, 1996).

Women prisoners currently constitute approximately four per cent of the total prison population : on the 23 February, 1996, there were 2,073 women in prison, of which approximately twenty-seven per cent were remand prisoners (HM Prison Service, 1996), many of whom will not ultimately re-enter prison as sentenced prisoners (NACRO, 1995a). Of those women under sentence on 30 June, 1994, forty-two per cent (540) were serving short sentences (that is, up to eighteen months), twenty-three percent (294) were serving medium-term sentences (over eighteen months and up to three years), and thirty-five per cent (458) were serving long sentences (over three years including life). One hundred and eleven women were serving life sentences (NACRO, 1995a).

Why do women go to prison? The Criminal Justice Act, 1991, provides statutory criteria for the use of custody formulated on two counts : public protection and the seriousness of the offence. This being the case, one would expect that the women in prison must be those considered the most dangerous, from whom society must be protected. However, most women sentenced to imprisonment are neither violent nor dangerous. Many have committed minor offences and the majority have no or few previous convictions. Of the 4,406 sentenced women prisoners received into prison in 1994, for example, thirty-three per cent (1,454) were imprisoned for fine default, twenty-six per cent had been convicted of theft or handling stolen goods; twelve per cent (514) had been convicted of violent or sexual offences or robbery; seven per cent (287) had been convicted of drugs offences; six per cent (265) of fraud and forgery; three per cent (137) of burglary, and the remaining women had committed other offences or the offence was not recorded (Penal Affairs Consortium, 1996).

The Penal Affairs Consortium (PAC, 1996 : 4) argues that the rapidly increasing use of imprisonment for women cannot be understood in terms of a rising tide of violent female offending. Rather, it is 'primarily due to a greater readiness to lock up non-violent women offenders'.

The women who end up in prison, as has been suggested, are often those who are marginalised, poor and from ethnic minority backgrounds (Edwards, 1994). On 30 June 1994, twenty-five per cent of women prisoners were known to be of minority ethnic origin (that is, Black, South Asian, Chinese or other Asian origin). Twelve per cent were British nationals and thirteen per cent foreign nationals (PAC, 1996). Most women prisoners have experienced poverty prior to imprisonment, often facing multiple debts (Carlen, 1988a; Carlen and Tchaikovsky, 1996; PAC, 1996). For such women, the process of imprisonment serves not only to exacerbate existing problems, but may also create new ones.

Regimes for women

> Throughout, the focus must be on the needs of *the individual.* Some women prisoners are young, out of touch with their families, seemingly without ties of any sort. Others, in contrast, will have clear family responsibilities. For mothers, a custodial sentence will, with the exception of those women admitted to Mother and Baby units, mean separation from children with all the stress that involves. Other women may have been caring for elderly relatives. Many women may be concerned about their partners' ability to cope without them. In other cases husbands or boyfriends may also be in custody.... Staff need to be aware of, and sympathetic to the very natural worries to which many women will be subject (HM Prison Service, 1992, emphasis added).

Women's imprisonment has largely been ignored by politicians and policy makers (see Liebling, 1991; Hayman, 1996). Dixon (1994 : 4) has argued that because women form a minority of the total prison population, their administration can be seen as an 'adjunct to the Prison Service ... women and female offenders appear an appendage to policies linked with the male system.' Lord Justice Woolf, for instance, decided at the outset of his enquiry into the 1990 prison disturbances not to 'investigate or make findings about problems which solely relate to women, none of whom was involved in the disturbances' (Woolf, 1991 : para. 2,18). Women's prisons were thus effectively excluded from the inquiry despite a series of disturbances at one women's remand centre that same year (Carlen and Tchaikovsky, 1996).

While it may be difficult to identify problems which, by definition, relate *solely* to women prisoners, other than menstrual disorders, pregnancy and childbirth, many aspects of imprisonment which, in principle, apply equally may have different meanings and implications for women and men. The relative neglect of women prisoners, however, has meant that most of what happens in women's prisons is based on a comparison with men's prisons. As a consequence, men and men's prisons remain the norm from which women and women's prisons deviate. In a system where women emerge as deviations, their needs and experiences are often misunderstood (Morris *et al.*, 1995).

In regimes for women prisoners we can see the influence of conventional explanations for women's crime and prison routine and practices continue to be based on gender-specific *assumptions* about women's role in society and about the 'needs' of women prisoners. These assumptions are based on a model of family life in which, according to Eaton (1993 : 21) 'women are defined as domestic in their concerns and subservient to men at home and at work'. This conception of the role of women, together with explanations for their offending behaviour, therefore, characterise not only the fact, but also the nature, of women's imprisonment.

Since the segregation of men and women prisoners in the early nineteenth century, regimes for women have, according to Genders and Player (1987 : 162), been 'dominated by forms of patriarchal control'. Here, two of the notions about women offenders previously discussed are apparent : first, domesticity - 'real' women do not offend, and, secondly, psychiatric morbidity - women who commit crime must be 'sick'. These imperatives have historically underpinned interventions in the lives of women prisoners designed, according to Sim (1990: 130), to 'reshape the very spirit of the criminal woman back to the role for which she was seen to be biologically and sociologically suited - that of wife and mother.'

In the late nineteenth century women prisoners were largely employed in cooking, baking, knitting, needlework and laundry-work for men's prisons and for private families. The main purpose of education and training was disciplinary and was limited to communicating basic skills. Florence Maybrick, writing in 1905 of her fifteen years in prison, describes a regime the purpose of which was to enforce 'tidiness' or 'cleanliness' in a prisoner (Maybrick, 1905). She also discusses the severity of the regime and the constant supervision :

> [T]he rule of supervision is never relaxed. Try and realise what it means always to feel that you are watched. After all, these prisoners are women, some may be mothers, and it is surely the height of wickedness and folly to crush whatever remnant of humanity and self-respect even a convict woman may still have

> left her. These poor creatures who wear the brand of prison shame are guarded and controlled by women, but men make the rules which regulate every moment of their forlorn lives (Maybrick, 1905 : 121-122).

These orientations have continued throughout the twentieth century and are still evident today in regimes for women prisoners. Ann Smith (1962), in her account of the development of women's prisons in Britain, describes the changes which took place in Aylesbury prison in the early part of the twentieth century :

> Discipline at Aylesbury was necessarily strict but ... From 1900 'well-behaved convicts' were allowed to retain in their cells photographs of 'their respectable friends and relations', and, in 1901 a system of 'recreative industry' was started. With material provided by the Lady Visitors ... the convict women were allowed to 'dress dolls, make children's garments, petticoats and fancy articles' in their spare time (Smith, 1962 : 142).

The development of Holloway prison in the 1960s provides a clear example of the ways in which notions of domesticity and psychiatric morbidity have had an impact on the evolution of regimes for women prisoners. In 1962 Ann Smith, envisaged that by the following year Styal prison in Cheshire would have become the largest women's prison in the country and that the closing of Holloway, which she describes as a 'sepulchre', would 'mark the beginning of a new era for women prisoners' (Smith, 1962 : 324). In 1968, however, the new era dawned with the then Home Secretary James Callaghan's announcement that Holloway was to be rebuilt as a medically and psychiatrically-orientated institution. Women prisoners were to be subject to individualised psychiatric treatment rather than punishment *per se*. They were to be offered 'therapeutic regimes', including psychotropic drug therapy, analysis and counselling (Heidenshon, 1985). It was thought that women would come to prison in need of 'rehabilitative treatment' and would subsequently be returned to society *made* well. The prison was built without a traditional hospital wing (the whole prison was effectively a hospital) and a former Medical Officer was appointed

Governor. The idea that a woman's prison should be a hospital clearly illustrates the different conceptions of why women and men offend.

Holloway prison was also, however, to maintain an emphasis on domesticity. The design of the prison was such that there was to be a series of self-contained units each with a 'family centre'. The emphasis was to be on establishing patterns of 'home life'. Training, for example, was to focus on the development of personal relationships, family life, home management, cooking and childcare.

In a detailed discussion of the Holloway redevelopment project, Rock (1996) reveals how things went drastically wrong : the developments created serious problems within the prison which led to it being identified as a public and political scandal. The prison became well known for high rates of self-harm, violence and the plight of a *small proportion* of mentally disturbed women (also see Moorehead, 1985; O'Dwyer *et al.*, 1987).

The experiment at Holloway is emblematic of the contradictory attitudes towards women criminals and of the relations between medicine, penal ideology, social control and behaviour in women's prisons (Rock, 1996). While the experiment failed notoriously, the medicalised perspective, explicit in Holloway's philosophy and practices in the 1970's remains (albeit implicitly) and a principal aim of women's imprisonment today is to provide for the needs of *individual* women.

While there have been some important changes in the development of educational and work-related training in women's prisons since the 1960s, for example the introduction of computer training, office and business management courses[1], a key emphasis remains on the teaching of traditional 'women's subjects' such as cookery, dress-making, beauty therapy and childcare. The range of classes offered by Styal prison's education department in 1994/95, for

[1] See Carlen, (1990), for a detailed discussion of education and pre-release schemes in women's prisons.

example, includes : 'a one day hair dressing course; Open University work; flexible learning; computer and office skills; a catering course; a child care course; a soft furnishings class; a young offenders' course; and two Vocational Training courses in home economics' (Inspectorate Report, Home Office, 1995: 14).

Aesthetically, women's prisons tend to reinforce notions of domesticity and femininity. Women prisoners have 'rooms' (as opposed to cells) which are often 'feminised' with floral curtains and duvet covers. Women are often called by their first names and live 'on' 'houses'. Attempts have been made to make conditions 'homely' rather than institutional. Women prisoners are allowed to wear their.own clothes (although this is due, in part, to a belief that women are less of a security risk) and make-up.

As Allison Morris (1990 : 4) points out 'facades can be deceptive', however, and 'in many ways, female prisoners are worse off than their male counterparts.' While apparently more relaxed than men's prisons, women's prisons may be considered more oppressive because women are effectively denied self-determinination.

Since the 1960s, as the movement from a mood of social responsibility and liberation has been towards one of greater authoritarianism, there have been increasing demands for tighter security and control within women's prisons (as in men's). A series of disruptions in the 1960s initiated the development of a number of secure units - 'the block' or 'Bleak House' at Styal and a closed wing at Holloway - and legitimised increased surveillance and intervention in the lives of women in custody. The rationale for these developments lay in the disruptive behaviour of the women themselves which was interpreted as further evidence of individual psychological imbalance (Sim, 1990). Since then, security and control, on the one hand, and assumptions of psychiatric morbidity (with the concomitant notions of inadequacy, irrationality and irresponsibility), on the other hand, have characterised regimes for women prisoners, aimed,

according to Edwards (1994 : 9), at achieving 'submission through controlling ... mind and ... behaviour.'

The main ways of controlling a woman's mind and behaviour outside prison have thus been incorporated into prison regimes : namely, domestication (evidenced by there being little work for women prisoners other than domestic work and by education classes emphasising childcare and domestic skills) and psychiatrisation.

In prison, as in the community, women are more likely to be prescribed 'mind controlling' drugs per head of the population than men (Owen and Sim, 1984; Shaw, 1985; Genders and Player, 1987; Edwards, 1994), providing further evidence of the ways in which prison regimes have been *adapted* on the basis of women's supposed inherent instability. There is, however, little detailed information (available) on prescription practices in prison[2], although anecdotal accounts from both prisoners and prison staff suggest that the use of psychotropic drugs in women's prisons is high[3]. Genders and Player (1987) argue that the practice further reinforces women's dependent status by denying them any chances for self-determination and that such drugs are prescribed for women *not* diagnosed as mentally ill as well as for those considered to be suffering from a pathological condition.

In general, women's prisons operate under the same rules as those for men (see Loucks, 1993). However, there is evidence to suggest that women experience a harsher disciplinary regime than men and that rules are more rigorously enforced. The average number of disciplinary charges brought against women prisoners is consistently higher than those brought against men. In 1992, for instance, the number of punished offences per head of the average prison population was 3.1 for women and 2.0 for men (HMSO, 1992a). In a system

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2 Official statistics from 1985 reveal that between January, 1984 and March, 1985, proportionately five times as many doses of psychotropic medications were dispensed to women prisoners as to men (Home Office, 1985).

3 The (over-)prescription of psychotropic drugs in women's prisons remains a complex and controversial issue and the subject is discussed in more detail in chapter five.

determined not only *by* organisational demands but also *through* firmly ingrained discourses around masculinity and femininity (see Sim, 1994), women are more likely than men to be punished for offences involving a breach of good order and discipline. Edwards (1994) suggests that :

> This is not because female prisoners are more recalcitrant than males but because the unwritten rules of conduct and the role expectations are drawn more narrowly (Edwards, 1994 : 9).

Here, it may not be that *higher* standards of behaviour are required of women prisoners than of men prisoners but, rather, that dominant gender norms within disciplinary power practices ensure that too much masculine expression in women is censured as deviant and hence punishable, even though the masculinity expressed may not transgress the acceptable limits of masculinity (see Sumner, 1990). Thus, women prisoners but not men may be penalised for the *same* behaviour.

The experience of imprisonment : deprivations and sources of suffering

> The worst thing about being in prison is the sheer sense of isolation and the lack of control over your life. It's bad enough losing your liberty but prison tries very hard to strip you of your dignity, your sense of who you are (Carolyn).

In prison, women are subject to a regime not just directed at behavioural practices, but, overtly and covertly, at the very *constitution* of the self. Here, personalities, subjectivities and relationships with others are governed so that even aspects of the self deemed intimate are severely challenged. Experiencing imprisonment thus poses questions about, as well as an assault upon, the self.

In an attempt to understand the experience of imprisonment for women and to synthesise the accounts of women prisoners themselves, I have classified those deprivations and potential sources of suffering emerging from : (a) their dispossessions (in terms of bodily practices, social roles and personal property);

(b) their experience of discipline and the maintenance of order; (c) their isolation, and (d) their social discreditation. These are not, of course, experientially exclusive categories. Social discreditation, for example, can augment one's sense of isolation. Moreover, each leads to a loss of control and action. In the pages that follow, I describe these sources of suffering and discuss the impact on women's identities and self-images.

Dispossessions

> Once a prisoner has crossed the threshold of a convict prison, not only is she dead to the world, but she is expected in word and deed to lose or forget every vestige of her personality (Maybrick, 1905 : 75).

For the period of their physical confinement, a prisoner's body effectively belongs to the state. On arrival at prison, the convicted person is taken to the reception area, the place where their status as prisoners (that is, the property) of the state becomes firmly established. This process, described by Goffman (1975 : 237) as 'programming', is one which removes them from all which formerly made up their identities, constructing instead a new 'prisoner' identity. Personal possessions are taken and itemised. Prisoners are allowed to keep with them only those items specifically listed. They are coded, searched, stripped, bathed, and examined. From these initial moments of socialisation, a woman is subject to restrictions and regulatory practices which may be understood as constructing a particular role for her. Eaton (1993 : 21) states, she *is* a prisoner - 'depersonalised, degraded, denied any control over her day-to-day existence ... totally subject to the authority of others'.

Reception procedures in women's prisons appear to have changed little in the past 40 years. In 1957 Mary Size described the reception of 'new arrivals' :

> The woman is then placed in a cubicle and later taken to an office where her record is compiled. She then undresses behind a screen and hands each garment to the officer, who examines it. She is provided with a dressing-gown and slippers and passes

> through a door to an adjoining bathroom ... she dresses in the bathroom and returns to the office. In the meantime the officer has entered all the property she brought with her in the property register, the list is called over to her and if she is satisfied that it is correct, she signs the register. She returns to the cubicle to await medical examination (Size, 1957 : 18).

What this description fails to capture, however, is the sense of confusion and disorientation which the reception process engenders. For the women interviewed in this study, the initial experiences of imprisonment were described as 'the worst'. They described feeling numb, distanced and unable to comprehend what was happening. First offenders in their first prison particularly described not knowing what to expect and how the process was further complicated by prison staff with insider knowledge the women do not possess[4]. Their situation, however, is soon made all too real to them. One woman recounted her arrival at Risley Prison :

> I was frightened to death. The only thing I knew of prisons was what I saw in films and on T.V. All I could think of was Prisoner Cell Block H ... The way I was treated ... I was stripped. I felt degraded. I felt dehumanised. I was a number, a sack of potatoes. I was certainly not a human being. And they look at you as though you're mad if you say 'I've got to do what?' It was incredibly frightening (Jen).

During reception the prisoner usually sees a doctor and nurse and there is a medical examination. The examination - ironically, a test of 'fitness' (see chapter 5) - is brief and superficial. The prisoner's appearance is checked and she is strip-searched. For the women interviewed, the strip-search was a symbolic and emotionally distressing experience :

> It was frightening. I mean I was in shock. You're so overwhelmed with the culture of the place, the sights and sounds and everything. You can't believe that someone can say something like 'Take all your clothes off'. I thought how dare she. And you're standing there all shy ... They give you this

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[4] Women have also described this sense of confusion at being transferred from one prison to another : 'When you're moving from prison to prison they don't give you a detailed list or whatever of what the next prison is all about. You're just thrown from one prison to another and it's fend for yourself' (Olga).

> grotty blue towelling dressing gown and you don't know how many have worn it before you. And they used to look through your hair for nits and I'm thinking don't touch me. And they say 'Do a twirl'. It's just so degrading.
>
> She continues :
>
> I was given an internal examination. I didn't know I could refuse. You don't know what your rights are and when you've had 'Yes you do take your clothes off, you've got no choice'. It's like when they took my jewellery off, I'm saying, but you can't, you can't' and they're saying 'We can and you've got a choice of doing it the easy way or the hard way'. And this starts to wear you down and so when someone says 'You've got to have an internal examination'. By that point ... I was furious when I found out years later that I didn't have to be submitted to that. But I thought I had no rights. They had just stripped everything away (Emma).
>
> When you first get in it's 'strip and take all your clothes off'. Having to take my clothes off alone and put this horrible dressing gown on, I was devastated. Then having someone look at my body. It's devastating (Sue).

The attack on one's sense of self comes not only from the invasiveness and intrusiveness of the procedure, but also from the knowledge of one's relative powerlessness vis-à-vis the prison authorities. The woman cannot distance herself from her own body and yet she *is* dispossessed from it. At any time in the future she may be forced to expose her naked body to the 'gaze' of others on demand. She is stripped, physically and metaphorically, of all that she was.

While women prisoners are not totally stripped of their 'identity kits', in that they are allowed to wear their own clothes, procedures concerning clothes, particularly access to clean clothes, add to this initial confusion :

> I haven't had any clean clothes yet [after four days]. I've only got one pair of knickers so I'm washing then of a night time and putting them on the radiator to dry. My pad mate hasn't had any clean clothes for five days. I haven't had a bath, just strip washes and going to the loo ... you're worried when you're sitting on the loo that the door's going to open or the little flap's going to go. It makes you feel so dirty (Beth).

A woman's prisoner status is continually reinforced during this period - she is a prisoner, what can she expect? :

> I set foot out of my cell door for my meal and then I didn't eat it and that was the only time I came out of my cell for the three days. Not one person, not one officer came to see why I hadn't been out and if I was all right even. I was frightened. I was in shock because of being there. I had been separated from [my daughter] who was only 11 weeks at the time ... They could look at your situation and say 'Well she's never been before, she's upset'. But basically you're a prisoner, that's the place you've got to be (Anwen).

Goffman (1975 : 237) suggests that these initial experiences involve a test of wills which may be conceptualised as a form of initiation :

> An inmate who shows defiance receives immediate visible punishment, which increases until he openly 'cries uncle' and humbles himself.

The confusion engendered is a foretaste of the prison regime. Within prison, a woman's life becomes controlled by others. With that control comes intense scrutiny, constant surveillance and a loss of privacy :

> The only things that are private in jails are hopes and dreams. Everything else is under scrutiny. The showers are in twos. The toilets are in the room. There is nowhere where you are not under scrutiny except in sleep, and even in sleep you are checked (Beth).

In prison, women lose the authority to act without the permission of others. They are denied choice over the simplest of every day actions. From what time they get out of bed to when they can read, write letters, watch television or take a bath, all activities are controlled and regulated by others. Here, values of independence intensify the pains of imprisonment. Prisoners become aware that they cannot do things previously taken for granted and the tangible restrictions become daily reminders :

> It is very stressful because having your freedom one minute and than it's taken away from you and having people telling you what to do. People telling you when you've got to go to bed, when you've got to wake up in the morning, when you eat and things like that. You feel as if everything's been taken away from you. You are just breathing. You don't control your life any more (Sylvia).

In an environment where a person's time is regulated by others, time takes on a meaningless quality :

> Prison life is almost frozen in time. You hear outside life going on. You hear children, you hear dogs barking and it's almost like you're encapsulated in a frozen aspect because time here has a timeless quality because each day here is the same as the next. You don't recognise the passing of each day. I can't remember if today's Wednesday. I can't differentiate between what I did on Tuesday or Saturday or last week. It's like that film 'Groundhog Day'. Prison life is Groundhog Day (Carolyn).

Becoming a prisoner typically demeans identity because women have little control over their situation and the quality of their existence. For many women prisoners, their freedom of moment outside prison is often also curtailed through financial restrictions and childcare commitments and it is in terms of their reduced contact with those left behind - their role dispossessions - that most women seem to suffer.

In prison, women's relationships with the outside world are inevitably upset, a process which Goffman (1975 : 236) has described as the 'first curtailment of the self'. The barrier imposed by the institution between an individual and the wider world disrupts the 'scheduling of the individual's roles' : mother, partner, daughter, friend and so forth. Genders and Player (1987 : 168), in their study of 254 women prisoners and Youth Custody Trainees (YCTs), found that even those YCTs with few domestic responsibilities felt their loss of liberty most keenly in terms of their lack of contact with their 'social and emotional environments.... [they] spoke of missing their parents, their friends and their round of social activities'.

For women with children, loss of contact often leads to the very real fear that their family might disintegrate; that they might lose their children, either into the care of the local authority or to estranged family members. This fear is particularly real for women serving long sentences and for foreign national women whose children are often in their country of origin. For such women, fear is often heightened by a lack of information about their children and by concerns that their children might forget them, fail to recognise them or that they might reject them.

Not only do mothers have to cope with their own pain on separation, many were also aware of the impact of their imprisonment on their children :

> That's the big problem and that's the saddest part about the whole sentence. [The children] have gone to live with my ex-husband. He still suffers from his problems - he drinks quite a lot. When I phone sometimes they're in tears so I'm then destroyed by it. I want to take their pain as well (Kirstie).

The suffering of their children was a consistent theme in women's accounts of imprisonment. For many, it constituted an additional emotional burden :

> They're psychologically damaged, my children ... There should be more notice taken of what it's doing to the family women leave behind them because if you're taking a woman out of a family, you're having much more impact on that family than if you take a man. I feel strongly about what they're doing to my children and what they're doing to the children of women in prison (Chris).

Paradoxically, while much of the treatment and training of women in prison concentrates on childcare and domestic skills, imprisonment, even short term imprisonment, can disrupt, if not destroy women's relationships with those outside. In prison, most women are not allowed to be mothers and one of the most devastating consequences of their loss of liberty may well be the restrictions placed on their contact with their children. This paradox was

summed up by a Nigerian woman who had neither seen nor received news of her children in three years :

> It's funny really, they preach family values but at the end of the day the way women are being sentenced, especially long sentences ... and children are separated from families, you may lose your children completely and it doesn't help. Woman is the family. They say that man is the head, but woman is the neck. When you cut off the neck, the head is just rolling. When you cut the head off, the neck is still there, which is the woman (Darelle).

Women sent to prison may not only have dependent children, but may also be carers for other family members. This can be an additional worry for some women prisoners, as the following quote illustrates :

> The worst thing is being away from my family. I have a terminally ill father and I can't do anything to help and that makes me feel helpless. Being away from my children is another hard aspect. The day-to-day living [in prison] I can deal with, I can handle, but being away from my family when there's problems, I can't cope with (Kym).

Of course, for some women imprisonment provides a welcome escape from certain personal relationships outside. Twenty-one of the fifty women interviewed discussed their experiences of physical and/or sexual violence (often relating it to the nature of their offence), and it is known that many women prisoners have been subject to such abuse, often at the hands of male partners (Posen, 1988). For such women, imprisonment offers an opportunity to reflect upon their lives and relationships :

> I haven't been beaten up, whereas on the out ... four and a half months, that's my biggest break ever in twenty-five years, that I haven't been assaulted. I haven't had that to put up with (Gwen).

The women recognised, however, that imprisonment provided little real opportunity to 'break away' : 'I'll probably go back [to him] from here. Where else can I go?' (Gwen).

While the restrictions on women's lives were felt most keenly in terms of their relationships with those outside, women also suffered from a loss of possessions, described by Sykes (1958) as one of the major pains of imprisonment for men. For women, this loss did not relate so much to the lack of personal belongings inside prison, but, rather, it was felt in terms of losses outside. In physical terms, few women escaped incurring any loss of possessions on imprisonment. Homes had, for instance, been burgled or vandalised and housing tenancies had often been forfeited or houses repossessed. The women were concerned about such losses and the very real likelihood of difficulties post-release :

> When you come to prison you've lost everything. Everything has been taken away from you. Relationship, it's gone down the drain. House, it's gone down the drain. You go back out, they let you go out into a world where you've nothing to turn to. All your possessions and everything are gone (Sylvia).

Some women also experience more profound losses in terms of the death of a partner, relative or friend :

> I haven't grieved properly. You're not allowed to, you're in prison. You're an inmate, you're convicted, you're charged, you're a remand. You're not allowed to grieve ... You've not got any time to sort yourself out. I ended up having a nervous breakdown and trying to commit suicide after four weeks (Kym).

> I've lost my husband, I've since lost both my parents ... and it's coming to terms with all that, you know. It takes a long time and you still don't get over it. It's with you for the rest of your life (Olga).

The concerns of women prisoners, therefore, often relate to emotional and practical problems *outside* prison, as responses to the questionnaire survey confirm (see Table 3.1 below and Appendix III). These concerns *cause* women to suffer as they experience imprisonment : 'most of my stress is to do with things that are going on outside' (Chris). They are sources of suffering,

however, often augmented by the enforcement of institutional rules and regulations.

Table 3.1. Percentages of respondents currently experiencing concerns relating to problems outside prison

Concerns about :	***n***	***Percentage***
Family members (other than children)	123	58
Children	117	55[1]
A relationship	107	50
Money	77	36
Housing	67	31
The death of somebody close	30	14
[1] 85% of women with children reported having concerns about them		

Discipline, punishment and the maintenance of order

Prison life is rule-governed and Rule 7 (1) states that 'every prisoner [should] be provided, as soon as possible after his reception into prison ... with information in writing about those provisions of these rules and other matters which it is necessary that he should know' (Loucks, 1993 : 40). Despite this rule, obscurity surrounds the availability of information for prisoners and copies of the official rules are difficult to obtain. None of the women interviewed had seen a copy of the rules and many were aware of their relative powerlessness because of their lack of 'insider' knowledge :

> It's not knowing ... You feel stupid. You feel like an outsider. You feel that everybody is looking at you. I think they think that if they treat you like a mushroom - cover you in shit and keep you in the dark - then they have control and they have power (Tricia).

New prisoners find out what the rules are from other prisoners. Ironically, often the only way of finding out what one cannot do is by doing it and getting into trouble :

> In the first few weeks you get told off for all the things you don't know and there's no way you could know. I've found out that there's about 160 things you need to know just to survive in this place. From what you can bring in to what time you can have a bath. Coming in you haven't a clue and they're so rigid and you get into trouble for not knowing what you can do (Brenda).
>
> You find out how you go along when you get told 'Right you're not supposed to do that, you're supposed to do this'. You normally only find out when you've done something wrong (Debbie).

The rules, which are loosely phrased, are also interpreted in such a way as continually to reinforce a woman's prisoner status, that is, lacking free will and subject to the whimsical decisions of others. Because the rules themselves are not clear, they are experienced by women prisoners not as a means of clarifying a situation, but as a way of perpetuating the confusion.

Rule 47 (21), for instance, which deals with conduct which 'in any way offends against good order and discipline' and which has variously been described as a 'catch-all' or 'anything goes' rule, is so generally worded that it leaves both prisoners and staff unsure of what behaviour constitutes a disciplinary offence. Under this rule, any behaviour can effectively be regarded as a breach of discipline. From the experiences of the women interviewed in this study, offences include : lending a phone card to another prisoner, sleeping in bed too late, whistling in the corridor, having fruit in a locker, walking on the grass, having a bath without permission, bringing a dress or a pair of shoes back from home leave and so forth.

In 1991 the most frequent category of offence against discipline in women's prisons was 'disobedience or disrespect', which includes abusive language

(NACRO, 1992b). Mandaraka-Sheppard (1986) argues that swearing and quarrelling can have a positive function in that they provide an outlet for accumulated tension (see chapter four). However, in a system which ascribes status to women in terms of how closely they conform to conventionality, bad language and arguing are often not tolerated.

The women in this study experienced prison rules as petty, vague and inconsistent in their application :

> The petty rules get to you. They have petty rules. Some officers are petty and some aren't. And you think.... I mean there's girls who are out of their heads on smack and they throw fights. And they're giving you a petty rule and you think why don't they go and see them. I mean there's so many things to remember. One officer said to me 'Right I'm putting you on report. You haven't made your bed'. And I said 'What? There's people having fights on smack and you're worried about my bed?' So it's down the block (Diane).

> Well I think there should be rules and regulations but if there's going to be they should all stick to the same but they don't. Some let you get away with things but others don't. So them that don't let you are the baddy baddies but they're just doing their job really (Iris).

Rule enforcement was experienced as focusing primarily on women who did not, or would not, conform to appropriate behaviour patterns. The woman in prison is expected to be amenable, dependent. Women, recounted the overzealous policing of rules by certain officers and the use of discipline to subdue any expression of independence :

> I've been picked on a lot by the officers which shocked me a lot because I suppose I expected it to be the inmates. Some of the officers said that I threaten them and I threaten the system. So they've come down harder on me ... If you've got spirit then I think they come down harder, they try to break it (Carole).

Women are expected to play a subordinate role in relation to institutional authority and the rules are used against those who do not. The punishment of

women who do not conform is clearly evidenced in the treatment of lesbian women in prison. Lesbianism poses a major threat as it conceptualises women without reference to men, thus challenging traditional gender roles (Eaton, 1993). The women in this study described how any demonstration of affection between prisoners was often interpreted by prison authorities as 'lesbian activity', a taboo :

> There's just been seven shipped out for lesbian activities ... they get into trouble not of their own making (Mair).

> Being gay in prison can be problematic. People assume that relationships will develop. But often you're only trying to comfort another prisoner. You get to the stage where you daren't help someone out for fear that they'll misinterpret it as something else. I'm surrounded by women in here but it's not as if I fancy all or any of them. But they don't see it like that and I've been discriminated against on the basis of my sexuality (Kym).

> The screws are frightened to death of lesbians in prison. I think they think it puts them out of control (Sharon).

By constructing a specific category - lesbian activity - where heterosexuality is the norm from which woman-centred sexuality deviates, prison authorities not only attempt to subvert homosexuality but also to suppress expressions of solidarity between the women. Relationships between women are therefore constrained because women get split up or moved to other prisons as a punishment.

The ways in which rules are enforced further exemplifies a discipline designed to engender passivity and conformity. One woman described her experience of an adjudication following a relatively trivial, albeit typical, episode :

> They gave me a form when I came in which said that you can have a bath once a week, no mention of times, unless you're a worker and then you can have one every day. Also, if you're going to court the next day, you can have a bath. So one evening - I was going to court the next day - it was after association, about 7.45pm - we get the rooms locked at 8pm - I

> went and had a quick bath. While in the bath one of the officers came in and screamed at me, 'You're not supposed to be in the bath. Get out. You're on report'. The next thing I had to go before a board. They said, 'You're on report for having a bath at 7.45pm. What have you got to say, guilty or not guilty?' So I said 'guilty', but I did have something to say ... Anyway, I was found guilty. Guilty for having a bath (Glen).

From the institutional perspective, the offence, while trivial, is evidence of a woman creating space for herself and acting independently in an environment where her actions are defined by others. For the woman, this episode not only characterises the inconsistent nature of 'the rules', it further reinforces her relative powerlessness.

The stress generated by the enforcement of rules and regulations was compounded for some women (particularly those sentenced for drugs-related offences) by the use of strip and cell searches. Rule 39 allows for the search of every prisoner on reception and subsequently as the authorities think necessary, although *no* prisoner *should* be stripped and searched in the sight or presence of an officer not of the same sex (Loucks, 1993). However :

> I had a strip [search] in my room and there were two officers and the SO and he was really nasty. I mean, I didn't mind the strip as such - for drugs it was - and they searched my room, but he was really nasty. I put a complaint in about his attitude. Then when I had my leave I knew I was going to get stripped when I came back and when I went into reception and there were five officers and my PO said 'We're going to have to strip you'. So I stripped off - there's only supposed to be two officers but there were five - and I got into the cubicle and I told them I had my period and so they sent for the nurse. The nurse glanced and said 'that's all right' but one officer told me to take the tampon out. I was flabbergasted. I should have refused but I took it out...
> ... I spoke to the Governor the next day who said I had no cause for complaint. He said that while there had been five officers present, only three had been looking [laughs]. So it was hushed up and there was nothing more I could do (Mair).

For this woman, strip searches were routine and were formally justified by concerns over security and the prevalence of drugs in prison. They were experienced, however, as humiliating and oppressive. Her punishment for 'kicking back' (complaining) at the system was the ultimate denial of dignity. Such a procedure not only reinforces a woman's prisoner status, it also potentially impairs the image of herself : 'It's squatting which is most degrading' (Tracy).

With every minute detail of the prisoner's life open to such surveillance and inspection at any time, women have little space in which to hold on to some sense of personal identity. The restrictive prison regime and the complex rules regulating behaviour intensify women's emotional and physical isolation, deepening the pain of imprisonment.

Isolation

> It's strange really. In here you are surrounded by people, you are never alone but, at the same time, it's very very lonely (Meg).

Isolation is a major consequence of a restricted life. The experience of imprisonment alone sets the imprisoned person apart from others. A person's self-identity is normally situated within their networks of social relationships. Prisons physically remove people from those relationships and when women speak of the prison experience they chronicle their isolation - from their family and friends and from all that normally contributes to their sense of self.

Women are often accommodated in prisons some distance from their homes and families which makes visiting both problematic and expensive. Most of the women interviewed complained, not only about the separation from their families, but also about the difficulties maintaining contact. All three prisons within which the research was conducted are situated on the outskirts of towns and are difficult to reach using public transport. Women described the problems their visitors encountered, especially those bringing children. Often a half hour

visit for the prisoner, for instance, entailed a whole day of travelling and waiting for the visitor. Reflecting upon their isolation, women variously noted that relationships were difficult to maintain, that some had waned, that former friends had drifted away, and that, for some, contact had been completely lost with people outside :

> It's too far and too expensive for my family to visit. I used to have a lot of contact with them when I was on remand ... Then I went to Durham and it was cut down to once every three weeks. But then I went to Cookham Wood and I hadn't seen them for six month and things started to go down hill after that. My mother was drunk on the first visit. So after that ... Most of my friends have died of alcohol poisoning or I've just lost contact with them. I've made a few friends in here but they don't keep in contact when they get out (Barbara).

> You really find out who your friends are, or should I say aren't, when you come to prison (Carolyn).

Lesbian women also discussed how the problems of maintaining relationships with those outside were further complicated by an 'official disapproval of lesbians' (Suzanne) :

> There is a visiting scheme which pays for certain visits by close family and partners, but partners are defined as 'someone of the opposite sex'. So, either I lie and say that [partner] is close family, which they know isn't true because we met in here. But at the end of the day it's wrong. Why should we lie to protect their prejudices? (Kym).

The physical and social isolation of women prisoners is often magnified by their inability to deal with problems outside prison :

> What I find hard to deal with is the lack of control you have over your life in here and the lack of control over things outside. Coming in here, I still have to worry about all that - the kids, I worry if they're OK., the house, if it's OK. All these things. To someone who has always been in control, to have that completely taken away from you. I feel so powerless to do anything about anything (Beth).

> I'm out of control ... at home you can control things but you're just out of control here and it plays havoc with your head. You ring home every night and there's always something and it does your head because what can you do? You can do nothing (Mair).

Carlen (1988b) argues that isolation is one of the main ways in which women are controlled outside prison. The women interviewed in this study also reflected on the isolation they experienced in their outside lives often because male partners had not liked them mixing with other people :

> He never trusted me. If I went to the shop and said I'd be two minutes and it would be thirty seconds to five minutes longer it would be who was I talking to and all this stupid rubbish. And I mean I'd never done nowt because I was very shy then and I never did speak to anyone (Karen).

Eaton (1987 : 107) suggests that women's isolation is not merely the consequence of the social organisation of housework. It is also the result of the 'traditions of privacy which surround the family' and which render those relegated to the domestic domain vulnerable to the abuse of power in that domain.

For the women interviewed in this study, their lives outside prison were also often characterised by loneliness, brought on by social isolation, and exclusion from decision-making processes. Their lives, for example, were routinely governed by the intervention of state agencies which made decisions on their behalf over housing, benefits, childcare and so forth. However, their dependency on others to help solve their problems whilst *inside* prison far exceeded their experiences in their outside lives. Women's frustration at having to rely on institutional bureaucratic mechanisms to receive information or to seek advice, for example, was consistently voiced in their accounts. Their frustration was often heightened by the lack of continuity, co-ordination and internal communication characteristic of large organisations :

> You're waiting and you just have to sit there. Little things that are so easy to do and you just have to go round in a big circle ... I put in an app [application] to see the social for two things. I wanted to talk about the kids and I also wanted to know about the house ... and it came back that they've scribbled out about the house so now I'm going to have to go and find someone to find someone to find out what that means (Sarah).

Most women have to leave their children outside prison (I discuss mothers and babies in prison below). They are removed from being active agents not only in their own lives but also in the lives of their children. In many cases, they also have to cope with the frustration of learning, second-hand, that events are taking place over which they have no control :

> The other day I got a message from my social worker that [my ex-husband's] got custody of the kids. So now I've lost everything. I've literally lost everything. I've got no personal possessions, nothing. He's kept the lot. And now I've lost my kids on top so ... I've got two [children] and he's just had an injunction taken out on me where I can't even write to them or anything and there's nothing I can do about it because somebody somewhere has decided that I'm not fit to be a mother (Wendy).

Women with partners in other prisons described the constant 'waiting game' for receiving and sending messages. One woman, whose partner had been moved to three different prisons in a 12 month period, described the difficulties of making contact :

> There's been a couple of times when I needed to get in touch with him. I needed to know that he was all right. It was just something that he said in his letter. Another time something actually happened and I was here and I needed to get in touch with him and I got hold of the PO and I asked if he could arrange for me to ring him at his prison. Just for two minutes, just to make sure he was all right. And as always it happened on a weekend. And the officer rung up and his prison said yes all right and just before I was about to make the phone call they phoned back to say no way. I mean, that could have made the difference between him topping himself or not (Meg)

While social isolation is itself a consequence of the loss of liberty, there are some groups of prisoners for whom the sense of isolation is likely to be intensified : for instance, vulnerable prisoners, those on the isolation block, those on the hospital wing, foreign national prisoners and those prisoners serving long sentences.

Foreign national women in prison, for example, suffer the same deprivations as British nationals. However, their isolation is likely to be more entrenched. Such women face isolation through language and cultural differences as well as through geographical distance. For these women concern about families back home augments the prison experience. Many have dependent children, most of whom remain in their country of origin. Some are denounced by their families and lose contact with their children altogether.

The pain of separation from, and the fear of rejection by, their families were consistent themes in the accounts of foreign national women. Their pain was often compounded by a prison regime insensitive to their needs :

> I have been refused winter clothes and I don't know why. I'm really depressed about it. I'm from a warm country and I can't stand the cold weather. I have had no news of my children or my husband and have not been able to contact them to let them know that I'm OK. I feel so alone at times and find it difficult to understand what's going on (Helen).

Social isolation, not surprisingly, seems to increase with sentence length as prolonged confinement takes its toll on involved others. The involvement of others outside helps to maintain a woman's sense of self : it is evidence that the challenge to the self (through role dispossession) is not complete. For women serving long sentences (as for those with no involved others), the drift into social isolation often intensifies as they see family, friends and relationships slip away. For such women, isolation from normal social interaction over a long period of time can lead to feelings of not being able to handle even limited

social encounters. One woman serving an eight year sentence described visits from her children :

> When my kids come up on a visit, I can't be doing with them. I can't do with the kids. And before that's all I lived for, my husband, my house and my kids. And now it frightens me because I don't know if I can cope any more (Molly).

In prison, woman are largely isolated from 'normal' interaction with men and yet prison life pervades male authority. Sim (1990) has demonstrated how men have traditionally overseen the treatment and control of women in prison - as governors and as doctors, for example. Since the late 1980s, women have also been subject to more direct control by male prison officers. Moreover, the dominant gender norm within penal policies and practices is one of masculinity (Sumner, 1990; Sim, 1994). The deployment of male officers may thus only serve to reinforce women's gender role vis-à-vis legitimated authority. Eaton (1993) sums this up :

> The addition of gender as a factor in dominance reinforces a lesson that has implications beyond the concern for good order within the institution. It reveals and reinforces patterns of authority ... It is not their maleness [which is the issue]. It is maleness within a hierarchy, functioning so that both are endorsed - the prevalence of hierarchy and the relative subservience of women [prisoners] (Eaton, 1993 : 35).

The question of whether male officers should be employed in women-only prisons, however, elicited strong and often conflicting reactions from the women prisoners interviewed in this study. Some women described paternalistic encounters with male officers which they either accepted or found offensive. Other women found their interaction with male officers preferable to that with female officers. Others still found the presence of men threatening irrespective of their experiences with individual male officers. Many women prisoners have experienced oppressive and violent relationships with men in their lives outside prison. For such women the presence of men in a woman's prison may reinforce the forms of control with which they are all too familiar.

Some women, however, felt deprived of normal, everyday, interaction with men. This was most apparent in the accounts of women serving long sentences. As Genders and Player (1988) also found in their study of women serving life imprisonment, the women's concerns related to their ability to socialise with men and to losing their sexual attractiveness :

> I'm forty-eight now which means that I'm going to be in my fifties when I get out. My body's going down hill, I know that. No man in his right mind will give me a second look and I don't know if I'd be able to cope if he did. The thought of going out somewhere with a man seems incredible to me at the moment (Sue).

While the loss of heterosexual relations did not seem as paramount for the women interviewed in this study as it was for the men in Sykes' 1958 study of a maximum-security prison, many women simply missed male company :

> That's the hardest thing ... it's not so much the sex, I think it's the company (Diane).

> I like men. I like male company and that's one of the hardest things about being in here for me (Chris)

The structural location of one of the prisons (Low Newton) within a male remand centre meant that the women there were not totally isolated from contact with men, although there were no combined activities. Rather, some communication was possible by prisoners of both sexes shouting to one another across the main courtyard. Despite this, the nature of relationships which can be built up between men and women is clearly limited and the absence of male company is often held responsible for much of the 'lesbian activity' which occurs in women's prisons (Genders and Player, 1988).

Imprisonment, while affording women little personal privacy or scope to isolate themselves from others, can be further isolating in that it focuses an individual's attention on the self. As a consequence, imprisoned women often experience

loneliness, which is itself a form of suffering : 'You trust no one. You just feel very very alone and I think that's the worst thing about it all' (Dawn).

Here, the sense of isolation and loneliness brought on by imprisonment is heightened by the knowledge that one's behaviour is under constant surveillance. This inhibits the display of emotions :

> You haven't got anywhere you could go to air your views or to get your head together. The other day I came in here and all I wanted to do was sob my heart out. There isn't anyone there that you can turn to, just to chat with or cry your eyes out to. So you go and sit in your room and it gets all out of proportion and everything gets really blown up (Ann).

> There is nowhere where you can go to be alone. Everywhere you go there's someone watching you. You go to your room and there's someone there, you go to the chapel and there's someone there. There's nowhere ... I've never felt quite so alone and yet I'm never alone, do you know what I mean? (Jane).

When a person is isolated from the outside world through imprisonment, the relationship with those on the *inside* can take on great importance. Here, the images of self reflected by prison staff and other prisoners may become the basis for self-appraisal. When imprisoned women receive positive reflections of themselves in interaction and take them as credible, they are more likely to see themselves positively. But when discredited by those on whom they depend or to whom they attach significance, then maintaining a positive self-image can be problematic.

Experiences of being discredited, embarrassed, trivialised, ignored and otherwise devalued can therefore intensify the emotional isolation of women in prison. When people feel negatively identified, they often begin to feel emotionally isolated while remaining in the presence of those who devalue them :

> They say that loneliness is a room full of people and that's certainly the case in here (Pippa).

Social discreditation

> These people are frightening because they take this seriously. They go out of their way to put you down and to keep you down and it's all OK because at the end of the day you are a prisoner. I think that's the worst thing, the sense of powerless to do anything about it (Anna).

Prison life entails the constant exposure of the self to others. Attacks to the self identity of women in prison can therefore result from discrediting definitions of the self arising from their interaction with others, particularly prison staff.

Much of treatment and control in women's prisons is premised upon the individualisation of the women's problems. Here, women are generally characterised as having in some way 'failed' in their adult responsibilities (Genders and Player, 1987; Eaton, 1993). From reception, women are routinely reminded of their status as prisoners and therefore as inadequate women.

O'Dwyer and Carlen (1985) describe a process of 'winding-up' which begins as soon as a woman arrives in prison. While the system itself can wind-up many women, they argue that others are also specifically wound-up by the prison officers themselves :

> If they don't like the look of either the prisoner or what she's been charged with, then it's a wind-up job.... they'll start making comments about your clothes - your socks smell, didn't you get a wash in the police cell, things like that, well below the belt (O'Dwyer and Carlen, 1985 : 151).

Such 'comments', examples of what Goffman has termed 'verbal profanations' (1975 : 239), are continual reminders of a woman's status in the prison hierarchy. The women interviewed in this study described various ways in which prison officers can 'wind-up' prisoners : providing commentaries on the women in terms of their bodily deportment, hygiene, clothes or looks, for example. Calling the individual by 'pet' names, pointing out their negative

characteristics, teasing them, laughing at them, talking about them or discussing their personal affairs with other officers are all potential 'wind-ups' and women often 'gear up' for potentially discrediting encounters :

> The screws laugh at you. They think it's funny because they laugh and that but ... I don't know if they do it on purpose but they're the ones who wind you up in the first place. And then they just laugh at you. You get thick-skinned to it after a while but it can still affect you (Lyn).

Throughout the course of the fieldwork, I witnessed many discrediting encounters between officers and prisoners. Many start out as a joke which can be misinterpreted. At other times, the profanations are more deliberate as the following extract from my fieldnotes reveals :

> I was in the office [interviewing a female officer] when another [male] officer came in. My interviewee introduced me and we talked for a while about the research (usual questions : 'What about the staff?', When is someone going to take an interest in our health?', etc., etc.). The conversation moved on to a discussion between the two officers about one particular prisoner. During this discussion, the male officer turned to me and said, 'Do you know there's a correlation between female criminality and ugliness? Let me prove it to you'. He then left the office coming back a few minutes later with one of the women in tow. He pointed to her and said, 'See I told you so'. He then turned to the woman and said 'Never mind, you can't help it can you love' (extract from fieldnotes).

Dramatic discrediting occurs during the course of encounters when women experience public humiliation and embarrassment. One woman recounted how officers used to 'take the piss because of my accent' (Sharon). Another described an occasion where a valuable piece of her jewellery was found after having been lost in 'the system' (she had been moved around the prison system on several occasions). Before giving the ring to the woman an officer had slipped it on to her own finger and said, 'See it suits me better, I think I'll keep it' (Angie). For the women, these incidents represent the constant reinforcement of their second-class status.

The significance of the discrediting encounter depends on it's perceived magnitude, the situation in which it takes place and the amount of repetition of discrediting events. One woman described the constant jibes about her weight from some officers and her attempts at withdrawal from potential scenes of devaluation:

> From the officers and the discipline staff it was always little things like they'd make little nasty comments about my weight when I walked past - 'Here comes slim', that sort of thing - or hum little songs. There's no acknowledgement of how you're feeling. It's very very difficult for some people and so you end up with some women who just don't put themselves into that. I mean I've found myself, I don't go down the main corridor so that I don't have to bump into an officer.
>
> She continues :
>
> The way the system has knocked me about I'm angry at myself for letting it get to me like that but it just upsets you ... There's lots of women who simply aren't prepared to put themselves up to get knocked down (Brenda).

Discreditation by reference to their children was a consistent theme in the women's accounts. One woman, for example, described how a particular officer read aloud excerpts from her children's letters :

> She used to read chunks of their letters out for all to hear before I'd even had a chance to read them. If I started saying anything she used to turn to me and say 'You love your children don't you?' And when I used to answer she'd say things like 'Well it says here that they don't love you any more, they don't give a damn' (Chris).

The pain of separation from children and other family members was often exacerbated by the behaviour of officers. Women with children were often made to feel guilty about their children :

> It gets to you after a while. I feel bad enough about the kids as it is but they make you feel worse, always going on about what a mother who cared would have done. You worry about

> whether you've been a good mother ... but what could I do? He was beating them and me up (Karen).
>
> They say things like, 'At least I know where my kids are going to be tonight, you don't', things like that. But I know I've been a good mother (Liz).

The women's ability as mothers was frequently brought into question, perhaps most clearly exemplified in the case of mothers with babies in prison.

The state decides who can and who cannot have their babies with them in prison :

> The Secretary of State may, subject to any conditions he thinks fit, permit a woman prisoner to have her baby with her in prison and everything necessary for the baby's maintenance and care may be provided there (Prison Rule 9).

Both Styal and Askham Grange have facilities for mothers to have their babies with them up to a certain age. On the mother and baby units women are subject to the full rigours of prison discipline and, while there have been significant changes on the units in recent years including the introduction of nursery nurses to replace nursing staff, women described the constant surveillance of them and their mothering skills[5] :

> When I got back from hospital I felt like all eyes were on me to see if I could cope. To see if I could cope with the baby and with being a mother. Every little thing I did - from feeding to changing him - I was conscious of being watched and of being judged. Some officers used to come over to the cot and just pick him up without asking and then it was 'have you done this, don't do that, remember to do the other'. It got to the stage that I was terrified to pick him up in case I dropped him and he'd be taken away from me (Glen).

Donzelot (1980) has described the way in which agents of the state work *with* women whose patterns of childcare conform to the most appropriate maternal role - usually middle-class women - and work *on* those women whose practices

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[5] See Catan (1988) for a discussion of the regime on prison mother and baby units.

deviate - usually working-class women, black women and 'deviant' women. For women prisoners, the state becomes directly involved in their maternal role, not only in determining *where* the women's children will be nurtured but also *how* they will be nurtured. Critical attitudes towards doctors, health visitors, nursery nurses, nursing staff, midwives and social workers as well as officers were evident in the accounts of women on the mother and baby units, who generally felt that such people 'took over'. The women were also concerned that their babies might be snatched away from them if they did not conform to certain childcare practices, or if they transgressed the prison rules.

Ironically, while medico-legal discourse constructs women as mothers, penal practices remove their control over mothering as the following extract from one of the group discussions illustrates :

> Respondent 1 : The other day I was just putting him down for his nap and [nurse] comes along and says, 'Don't do it like that, do it like this. Hold his head like this', or something. I thought, I know that but you're telling me anyway.
>
> Respondent 2 : I was breast feeding and one time I remember I had to go over to see the probation or something, and so I left [the baby] with one of the nursery nurses. By the time I got back she had her on a bottle. I thought that wasn't on.
>
> Respondent 3 : They always seem to catch you when you're doing something wrong [laughs]. If you lose your temper a bit because they won't stop crying, or if you don't follow the instructions on the feed or whatever ... they never see you when you're the perfect mother.
>
> (Discussion Group 6)

While discrediting definitions of women prisoners may be overt, much discrediting occurs in more subtle ways such as when a person is tacitly devalued or discounted. This occurs in those situations when others simply *assume* that the woman prisoner in not to be given 'normal' adult woman status. Sim (1990 : 155) states that regimes for women prisoners have been legitimised by 'the conceptualisation of the women as "girls" whose mental capacity and

behaviour [has] to be lifted to the standard of "normal" adult women'. He argues the relationship between prison staff, particularly officers, and women prisoners has long been characterised by processes of infantilisation.

Prison life denies women choice over the most trivial of matters. From dawn to dusk their lives are timetabled. They are told when to sleep, eat and, as one woman told me, 'they'd even tell you when to breath if they could' (Jo). Women prisoners are often referred to as 'girls', irrespective of their age, and are treated accordingly. Many sleep in dormitories and the atmosphere in some women's prisons is distinctly St.Trinians-esque. Styal is a former children's home, Askham Grange is a former country mansion. In such establishments women are often relegated to the position of naughty schoolchild, denied adult status and the accompanying responsibilities :

> It's like being in St.Trinians rather than in prison ... it's like one big rambling house for girls ... and we're the mischievous little buggers (Molly).
>
> You feel like naughty little school girls. It makes you feel angry and if you let it out you just get taken down the block (Suzanne).
>
> We're treated like kids - naughty, thick, kids. And I've got grown up children of my own (Anwen).
>
> You are treated here like kids to be honest with you. It's like if you are good you can watch the television you know (Sylvia).
>
> They imply that you're not right in the head, that you're brainless and after a while in here you begin to feel like that (Sylvia).

Rather than feeling comforted by their 'puppy-dog' status, women often feel alienated and annoyed. The women interviewed described how they often felt ignored by officers or trivialised and that their concerns were not taken seriously :

> On the outside there's times when you don't know what you should do or you don't have the information but on the outside people say they don't know and that they'll have to find out. But

> here they just ignore it. You find yourself in a conversation with someone and it just stops and the next thing you find is a door slammed in your face and it's 'Go away'. It's incredibly upsetting. You come back from situations like that crying your eyes out and you've probably only gone to ask for something trivial (Kirstie).

This situation is augmented by what Goffman has termed 'forced deference' (1975 : 239). As part of the subjugation process, prisoners are required to use verbal acts of deference in their interactions with staff, such as saying 'miss'. They are also required to ask for permission to go to their rooms, use the bathroom, the telephone and so forth :

> It's ridiculous. We have to put in an app[lication] to put in an app[lication]. If you want one thing you have to ask for it on a certain day, if you want another thing it's another day. And if you forget which day it is (which is easy to do in here because every day is the same) you miss out on a visit, home leave or whatever (Jen).

Explicit and implicit devaluation can also occur in the encounters between prisoners (see chapter 4) and between prisoners and prison health care staff (see chapter 5). Moreover, each of the women interviewed was aware that their prisoner status gave them an identity which went beyond the prison walls and over which they had little control. Women were concerned, for example, about people's reactions to them post-release (potential employers, family, friends, neighbours and so forth). Three women had also recently been the subject of negative reporting in the popular press. Here, the women were conscious of the ways in which their lives were understood in terms of dominant discourses around femininity and around female criminality. They recognised that their status as prisoners had the potential to become their major source of social identity :

> Before I came to prison I used to think about women in prison as people with horns and tails, a bunch of criminals, not real women. I couldn't imagine someone from prison coming to my home. And it's not like that because anybody can come to

> prison. But the way I used to look at people who'd been in prison is the way that people will look at us (Darelle).

Finally, self-discreditation can occur when an individual can no longer take for granted some valued attribute or function which they view as fundamental for a positive self-image.

From what has been described so far, it is perhaps not surprising that low self-image and self-esteem was evident amongst women prisoners interviewed in this study. Not only did women lack confidence in themselves, but they also felt devalued and discredited by the system. They felt humiliated by the invasions of their personal privacy, concerned about the maintenance of relationships, and dispossessed of valued self-images and personal property, the impact of which can bear a deep psychological distress. When woman speak of the prison experience, they chronicle a number of things - the restrictions, regulations and control; their isolation from family, friends and all that is familiar; the constant 'putting down' processes - which are all sources of tension. Within prison, excluded from decisions about their lives, women are defined as different from and less than 'normal' women and this can be seen as part of a process of keeping them down :

> The stress in this place, just the negative energy, is very difficult. To see people broken and battered over simple things, that should be easy to ask for, you get into conflict and that's what keeps you down (Kirstie).

How then do women respond to these experiences? How do they cope with the stress and anxiety induced by such a disruption to their daily lives? Do women prisoners accept a discredited self and watch their self-images crumble away without the development of equally valued new ones? Alternatively, do they actively intervene and hold on to their sense of self, their individuality? The next chapter addresses these questions by looking at the ways in which women prisoners *do* respond to those deprivations and sources of suffering and to prison life in general.

CHAPTER 4

Reacting and adapting : Women's responses to imprisonment

> The only thing you have control over is how you respond to it, what happens to you then (Pam).
>
> I eat ... I push all my anger, all my upset down. Because when you're just within one place, you can't go out, you can't do anything. You can't sort the problem out yourself. The power is not in your hands. So you're stuck there and you've just got to cope with the stress and it's like a big game, a big test to see how far till you're going to blow (Diane).
>
> I know I've changed a lot since coming into prison but what I didn't want to change was my values and they haven't. In many ways they've improved. You make a conscious effort not to let yourself slip. I was slipping very much at one point years and years ago. Now it's just me living, albeit in prison (Chris).

In the preceding chapter I explored the ways in which current policies and practices within women's prisons are directed, both explicitly and implicitly, towards the construction of a certain type of subject : a subject who is regulated, and controlled. The processes of normalisation associated with disciplinary power practices do not, however, necessarily render all individuals similar or produce passive conformity or the regularity of identities. Rather, the governmental strategies of women's imprisonment may go unheeded, or may be adapted or actively resisted.

This chapter moves beyond describing the network of strategies directed towards regulation and control, by examining the *responses* of individual women to such attempts in the context of their day-to-day prison lives (the institutional responses to women's responses are discussed in chapters five and six). For the women in this study, responses to imprisonment ranged from

forms of escapism to attempts to intervene actively against the forces acting upon the self. In a system designed to change them, many women recognised that they had indeed changed, but often through a heightened consciousness of the world, themselves or human nature as well as through heightened self-concern.

In discussing their own responses and those they had witnessed in others, the women described different ways of handling and defusing the contradictory pressures structuring their prison lives. From these descriptions I have identified five main strategies of response : **cutting-off**; **making good**; **kicking-off**; **substance use**, and **self-harm**.

These are not rigid or mutually exclusive responses, however, and different women use different (and, at times, seemingly contradictory) strategies at different times and in different situations. As they go through their sentence they make a number of adaptations, develop new ways of reacting, new ways of coping, new patterns of thought. This may be an unconscious process or it may be more deliberate and purposeful.

Moreover, these strategies of response are not necessarily unique to this particular group of women prisoners - variants of each have been identified in previous prison literature (see chapter 1) - nor are they necessarily unique to women in prison, and the broader aim of this chapter is to locate women's responses to imprisonment within the context of a wider analysis of the ways in which women respond to stress in the everyday world. In such responses we can recognise attempts by women to make a space for themselves and to hold on to a sense of self.

Cutting off : 'heads down, no nonsense'

> I think I was cutting-off to cope, and I think I still cut-off to cope. I just switch everything off (Jen).

In an environment which rewards passive, co-operative, dependent behaviour, some women respond stoically, conforming to the prison regime, not because they necessarily recognise and respect its 'legitimacy', but because they hope to avoid the harsher forms of disciplinary control. Such women, who might be considered 'converts' in Goffman's (1961) analysis or 'time-doers' in Irwin's (1970) (see chapter 1), present themselves as already sufficiently disciplined : the perfect prisoner. While many of the women interviewed in this study accepted that they had 'done wrong' (in terms of breaking the law), others felt unjustly criminalised and few felt that they should be in prison. However, they were prepared to conform to prison rules because, on the one hand, they felt that they had 'little choice', and, on the other hand, because they wanted to get through their sentences as quickly as possible and as unharmed as possible :

> In here I'm the perfect prisoner. I do what I'm told, when I'm told. I don't cause any hassle. I just keep my head down and get on with it. God, if only they knew what I was really like! (Anna).

> Basically, you've just got to get on with it. I don't agree with the way we're treated, the petty rules and all that, but at the end of the day I just want to get through this experience and hopefully in one piece (Sarah).

> My attitude towards here is like if you keep your head down you don't give them any problem then it's easier for you. It just makes life that bit easier and you've really got no other choice anyway unless you don't mind being put on report, losing days and that (Meg).

> For what I've done, I think I deserve to be punished but I don't think I deserve to be in prison and not for five years, not when you hear of other people getting five years for manslaughter and things like that. But the important thing for me now is to get back to my family as soon as possible. That's the carrot dangled in front of me (Fiona).

None of the women interviewed were indifferent to what was happening to them in prison (even those who had been inside before). However, they followed the prison regime, projecting an image of themselves (consciously and sub-consciously) as submissive and accommodating. In order to 'fit in' with prison life, while also holding on to a sense of self, the women recognised, however, that they often cut themselves off from the prison world, coping with their feelings by repressing them. :

> I don't show ... I don't give them the satisfaction of showing them that I'm upset so you don't see me cry but you don't see me happy either. I've just stayed on this one level and it's the only way that I've been able to cope with it. I'll probably cry when I get home. I might be happy when I go home (Jane).
>
> Basically, I just grin and bear it. I keep out of trouble and try not to get involved, you know. I make a conscious effort to distance myself (Carole).

In this way, women attempt to remove themselves from involvement in their own and their fellow prisoners' lives. Such a response, which may be described as 'keeping your head down', 'biding one's time' or 'not getting involved', was regarded as a specific coping strategy, one way of creating space between themselves and 'the system'. However, some women recognised that, in doing this, they were embracing the rule denying them responsibility, that they were complying with a regime which sets up specific definitions of appropriate behaviour (in this case passivity). This was evident when women reflected on their responses to instances of injustice :

> On my first morning I was in the queue for medications. There's a lot of people in the queue and a lot of aggressive young women ... and on my first morning in that queue four of them came up the corridor from the bottom gate and pushed into the queue and a girl was unfortunate enough to say something and they kicked her around the head, the chest, stomach. They were kicking hell out of her and the officer, by the time the officer turned up they had gone and the girl was getting up and mouthing off and she got put on report. I realised then that to survive in here you have to go through some hairy situations

> and I learned not to say a word, and that's not like me but that's what's expected in here (Kirstie).
>
> You've got to keep your mouth shut when you see fights and arguments, even when you know who started them. You can't get involved or you'd be on report with them (Gwen).

While some women may feel disempowered by the regime, other people or events, others make specific choices to distance themselves so as to protect themselves and to maintain a sense of self :

> I just tell myself, 'Keep your head down, get it done and get out'. I make myself not think about it. I switch off. That's the only way I can cope (Anwen).
>
> There's a lot of goings on in this prison - drugs, drink - but I just keep myself to myself. It's the best way (Molly).

Such a stratagem, a variant of Goffman's (1961) 'situational withdrawal', can be observed in women outside as well as inside prison (particularly among isolated women and those with a heavy burden of childcare and domestic responsibilities). Sapsford (1981) argues that such a response is part of the symptomology of depression which is observable both inside and outwith institutions.

The principal way in which women attempt to cut themselves off from the prison world is by concentrating their thoughts on their outside lives : their 'home worlds' (Goffman, 1961). On imprisonment, the majority of women are not completely dispossessed of their social roles although their ability to perform them is seriously curtailed and, as we have seen, this is a major cause of concern. The women interviewed described how their basic orientations to the outside world were maintained through letters, telephone calls, visits and home leave, although this is not to suggest that the woman necessarily considered the facilities for such satisfactory. Rather, what seems to be important is an *ideology* of life outside which helps women (even those with no involved others) to cope with life inside :

> There isn't a minute I don't think about my kids. That's what keeps me going (Sylvia).
>
> You only need to look at my record to see what means most to me and that's my children. It's only the thought of them that has kept me going. I nearly committed suicide once and the only reason I didn't do it was the children. It would have been the easiest way out but I couldn't do it to them (Karen).
>
> I always always think about being outside. I think that's one of my coping strategies. I keep a grasp on the outside world (Olga).

Some women, in contrast, described conscious attempts to dissociate themselves from their outside lives so as to protect either themselves or those left behind :

> I have not seen my mother or my son for ages, but that's the way I cope. I would rather not see them but they need to see me. I would rather not have phone calls but they need to hear me (Pam).
>
> I haven't had any contact with them [family] since being in here. But that's down to me. I think it's better for them and it's better for me. I don't want them seeing me here. I'd rather just get on with it and pick things up with them later (Jan).
>
> I deliberately try not to think about what's going on out there, my friends off to a pub or some club somewhere. What they're up to, what's going on. If I stopped to think about it too much I'd only end up upsetting myself and I'm upset enough as it is (Tricia).
>
> I don't think about home. I make myself think about other things. It's the only way I can get through the day. If I thought about home I'd only end up getting upset and trying to escape or something (Helen).

Such responses do not, however, seem to indicate a *rejection* of the outside world in favour of the prison world. Rather, they seem to represent a means of coping with the pain of enforced separation. None of the women interviewed in this study cut themselves off from the outside world to the extent of Goffman's (1961) 'colonised inmates' or Irwin's (1970) 'convict jailers' (although it may be

that women who choose to take part in research of this nature are those whose basic commitments *are* to the outside world). Even those women with long institutional careers and those with seemingly little going for them 'on the out' maintained an orientation, in principle at least, to the outside world. They did not reject the outside world although many felt rejected *by* it. For the women in this study, cutting-off from the outside world usually involved conscious efforts not to think about those outside (because this intensified the pains of imprisonment) or to plan for their own future lives outside prison :

> I don't think about release. I don't think about anything except surviving that day. It's such a surreal existence in here, the ground keeps shifting under your feet. You are dealing with people who are not necessarily honest in their dealings with you and your whole concept of day-to-day living doesn't include anything that's normal. So I can't think of life beyond this because that would imply something normal (Darrelle).

> At the moment I can't think that far ahead ... It's just get today over with and then ... I try to take it day by day, hour by hour (Sharon).

For women serving long sentences, distancing themselves from either the outside world or the prison world whilst holding on to a valued sense of self seems particularly problematic :

> It's OK for the bed-and-breakfast girls. They can come in, keep their heads down and their noses clean and then slot right back into the outside world, until the next time ... I have to fight it. I fight institutionalisation, really fight it. But the number of women who everyday do the same thing, at the same time, in a set routine. They have nothing to get them emotional. I don't want to leave here after 15 years, or whatever, I don't want to leave as an institutional zombie, only capable of doing what I'm told (Sue).

> Over the years you become very dependent on the system, you can see it happening and you try very hard to prevent it, to prevent yourself becoming too dependent. But it gets increasingly difficult ... At the beginning of your sentence you think about nothing but life outside and it eats away at you until you reach a point where you say to yourself this isn't doing any good. So then you try not to think about what's going on

> outside because it seems so far away and you just get on with day-to-day living. But by then you've got yourself caught up in a vicious circle of dependency. It's incredibly frustrating (Angie).

Genders and Player (1988) have discussed how a major anxiety for women serving long sentences is that they might lose all motivation to survive, all sense of self-identity. The women lifers they interviewed at Durham H-wing feared 'that they would lose every vestige of independence and assume habituation and extreme passivity' (1988 : 154). The women serving long sentences interviewed in this study were similarly fearful of mental and physical deterioration and the threat of institutionalisation, a process which they often recognised in others. Some also reflected upon times during their own sentences when they had been 'close to the edge' :

> I kept myself clean but I stopped putting on make-up. I only had the clothes I went in so they found me some out of DPA - the Oxfam of the Prison Service - so I just looked a total state, but I didn't care. And I got to the point of being frightened if someone came into the room, not of being beaten up, I was just so withdrawn, I was forgetting how to speak to people (Chris).

For this woman, withdrawal represented an initial and temporary phase of reaction and while many women cut-off in order to conform to, and cope with, the prison regime this can all change. The act of a fellow prisoner or a member of staff, for example, or news from outside, or changes in penal politics, policies and practices can all put women in a situation where they have to reconsider, change or adapt, their strategies for coping :

> I had loads of grief off the officers because I put in a complaint ... I lost loads of stuff, visits and that. That put me in bad stead because I was prepared to do a good sentence, get my head down, but I couldn't after that (Mair).

> I realise now that I was just going through the motions. I was just existing really. I tried to shut everything out because that was the only way I could cope with it at that time. Then something happened ... I realised that I needed to get on a do something with my time, make something of myself, and that's when I started with the O.U. (Olga).

> Nothing is certain in this place. Like I was supposed to be going shopping soon and I was really looking forward to it. Just a day out but it's the knowledge that you're going outside and nobody's going to know. You're just like everybody else that are outside going into a shop ... but the press got hold of a story about a lifer going shopping and there's recently been a clamp down on days out and that so that's that. No day out for me. I kicked-off about that (Diane).

Making good

> I've got a wacky sense of humour and I try and keep it, even at the lowest point. Morale is the main thing. If you can see the funny side of life, no matter what it is, then you can keep on going (Kym).

While time for women in prison may have a meaningless quality, it is nevertheless something that they 'do'. King and Elliott (1977 : 226), in their study of Albany prison, point out that 'nobody likes doing time' and, certainly, none of the women prisoners interviewed in this study talked about enjoying the experience. This is not to suggest, however, that attempts are not made to construct a meaningful life whist in prison (either by legitimate or illegitimate means) and the women described a range of strategies for helping them 'get through' their sentences as quickly as possible and with the least hassle. Here, attempts were made to make prison life more bearable and included 'prison friendships', 'swaps, switches and trades' and 'time and mind occupations'.

In an environment which engenders a suspicion of authority figures and in which women scrutinise their encounters with others for hints of discreditation and negative reflections of the self, some women, as has been suggested, 'keep themselves to themselves' and do not open up either to prison staff or to their fellow prisoners. In the questionnaire survey, for example, twenty-four per cent of women prisoners (n=51) reported that if they had a serious problem in prison they would 'keep it to themselves' (see Appendix III). All of the women interviewed described the difficulties of establishing trusting relationships in

prison, although, for some, prison friendships (usually with their 'pad-', 'room-' or 'house-mates') become an important means of providing mutual support as well as for passing time. The women interviewed described how they discussed problems amongst themselves relating to concerns outside prison (particularly their children and relationships) and to concerns inside prison (how to overcome the 'red tape', the 'goodies and baddies' of the system and so forth).

In addition to problem sharing, the women also described the prison barter system discussed in previous prison research (see, for example, Irwin, 1970; King and Elliot, 1977; Genders and Player, 1987). Here, women exchange material goods (such as food, tobacco, drugs and telephone cards), services (such as letter writing and form filling-in) and knowledge and experiences (criminal and otherwise).

While it seems that few women do not take part in the prison economy in one way or another, and some women prisoners could certainly be described as 'duckers and weavers' (who become expert at prison 'fiddles'), I found less evidence of the kinds of established 'racketeering' engaged in by some (jailing) male prisoners (see Irwin, 1970; King and Elliot, 1975; Sapsford, 1981). While this might simply reflect a lack of opportunity in women's prisons, it might be due to women being less experienced in what Sapsford (1981 : 73) has described as 'the use of property and favours' in their lives outside prison. What the women prisoners' exchange network does seem to provide, however, and with which many women may be unfamiliar in their outside lives, is an aggregation of resources (materially, experientially and emotionally), a source of entertainment and banter and, importantly, some mitigation of the main sources of suffering, particularly the sense of isolation :

> We have quite a good laugh to tell you the truth. There's a few of us who get together and tell stories, jokes and that. It makes you feel better knowing there's others in the same boat as you and, to be honest with you, there's a hell of a lot of women in here worse off than me so that makes you grateful for what you've got (Beth).

> Don't laugh, but we're like a criminal women's guild. We don't swap cooking tips though. Well, I suppose some might (Anna).

From their initial reception into the prison world women are certainly not lost for advice from other prisoners and staff about how best to 'do their time' and some of the women interviewed spoke of actually sitting down and working out how to make 'the best of a bad situation'. For many such women, imprisonment offers an opportunity for reflection, re-evaluation and change. Some women, for example, described how the process, oppressive as it might be, had heightened their consciousness of themselves, who they were and who they wished to become. For these women, imprisonment may be seen as a source of self-discovery and self-development :

> This experience for me, apart from how much it has destroyed my family, this experience has been one that I wouldn't want to reverse, strangely enough. I've had a good think about my own sexuality, which is important because I've never had the guts to think about it before. I've met a lot of people who I can talk about these things openly to without fear of recrimination. You can't do that outside (Kirstie).

> It's given me time to think, to re-asses my life and my beliefs. Some girls get through on drugs, others have alcohol binges when they go out. I'm getting through with the help of the spiritual side, not in a religious sense, but more in a philosophical sense ... I'm learning meditation - I think that should be mandatory for everyone coming into prison. It's the only way you can get any privacy (Brenda).

> This has changed everything that I can think of. It's changed how people view me ... I'm doing my time and when I go out there I'm going to try for once to live a life that will mean something to me and not other people (Pippa).

Here, we can see a variant of what Irwin (1970 : 27) terms 'gleaning' : where prisoners make efforts to 'better themselves' or 'find themselves' while in prison.

An important strategy of prisoner response (which has elements of 'gleaning' and 'time-doing') is to concentrate one's efforts on an educational programme, a

fitness programme, a hobby or prison job : tactics which Cohen and Taylor (1972 : 138) have described as 'body-' and 'mind-building' :

> I say I haven't learnt anything but I have. I thought I could cook before but now I'm a good cook. I couldn't sew and now I can sew. I've done loads of stuff - art, poems, drawings - I would never have done at home. No one could have got more out of their sentence (Mair).

Such activities provide certain landmarks through which prisoners can see themselves progressing : promotion to a position of responsibility such as librarian, mastery of a skill such as dressmaking, completion of a soft-furnishings course, completion of a course of academic study, the nurturing of animals were all examples of aspects of women's prison lives to which they attached importance :

Cohen and Taylor (1972 : 138-139) point out that, for male prisoners, 'a favourite occupation in prisons is body-building'. Similarly, some women saw imprisonment as an opportunity to work on their bodies, in the sense of becoming physically 'fit and strong'. For others, as we shall see, the body becomes a channel for expressing their dissatisfaction and frustration. Here, there is a sense that the body becomes a *project*, to be worked at and on, as part of maintaining self-identity (Shilling, 1993). Shilling (1993) describes this as a process in which people make strong public and personal statements about who and what they are. One woman in this study commented :

> It makes me feel good when I look in the mirror and see myself looking as good as I can ... it's two fingers up at the establishment. It means that they haven't brought me down (Carolyn).

In this sense, investing in the body provides a means of self-expression and a way of increasing the control women have over their bodies. In a situation where one is unable to exert control, at least one can have some effect on the size, shape and appearance of one's body. Treating the body as a project does

not necessarily entail a full-time preoccupation with its wholesale transformation but, as we shall see, there is the potentiality to do so.

For 'mind-building' prisoners - those 'on' education - prison education departments are highly valued (see Flynn and Price, 1995). Education seems to be one aspect of the prison regime that few people find coercive, although the women interviewed in this study recognised the limited (limiting) range of courses available to them. In the questionnaire survey sixty-three per cent of women prisoners (n=151) rated the education facilities as good or very good and, in the accounts of the women interviewed, education departments, unlike any other part of the prison, were depicted as safe havens : 'it's my sanctuary'. Here, it seems, women can escape the domestic domain (albeit temporarily) and education can be seen as a way of (re-)capturing positive self-images, as a means for self-development as well as an opportunity to obtain skills and qualifications appropriate to the outside world. For some, often those serving long sentences, it was regarded as a lifeline :

> It is my survival strategy. It keeps my mind occupied (Olga).

> Not only does it help to pass the time but it keeps my head in one piece. When I was at Durham ... I used to say 'What's the point?' But when I came here I thought 'You stupid bitch, you've wasted all that time'. But in another way I don't think it was wasted because it gave me a chance to sort my head out and to come to terms with things. That's all behind me now. I can concentrate on studying (Sue).

Education is a privilege, however, and the women were aware that it could easily be taken away from them :

> I used the initial trauma to design a guide for inmates (my skills are in marketing) ... coming in you haven't got a clue and they're so rigid and you get into trouble for not knowing what you can do. So I made a guide, I wanted to use the time productively. But I was picked on for trying to get things done ... I was removed from education under the premise that I was a threat using the computer. I was punished for wanting to help. I was

> taken off education and put onto house cleaning which was designed to bring me down (Brenda).
>
> I know that if I put a foot out of place, all of this [computer, books, etc.] will be taken away. It can be taken away at a whim. Because someone somewhere feels that women in prison have too easy a time, or, if I'm not seen to be conforming, my access to books, the PhD, everything can be taken away. That's one problem you don't have to contend with (Chris).

A prisoner's removal from education can be experienced as a severe loss, a further source of suffering, and the recognition of one's precarious position vis-à-vis education serves an important control function.

Women's access to education is often also disrupted by the prison regime. It is secondary to the requirements of good order and control and can be easily withdrawn due to staff shortages, industrial action and so forth. It is also subject to discontinuity between prisons. Moreover, there are a number of disincentives to learning which can prevent women from exploring their own potential :

> I'm lucky, I get £15 a week, which isn't bad (X gets about £5.50 on education). I have to work very hard to get that but it does allow me to buy fruit and cigarettes. I had to make a decision between education and cigarettes and there wasn't really any contest (Iris).
>
> I have to make the choice whether I go to class, have a bath or exercise (Discussion Group 1).

The women interviewed also cited the attitudes of certain prison officers as being a disincentive to learning : 'they take the piss, saying things like "trying to better yourself are you, I wouldn't bother if I was you"' (Tracy). Throughout the fieldwork I encountered an attitude towards education (and to health care, see chapter five) from some prison staff (discipline officers, nursing staff and clerical staff) which can be understood in terms of principles of 'less eligibility'. That is, there was a tendency to view education as a luxury, which women prisoners 'don't deserve' :

> There's women in here doing degrees and there's people outside who can't even read and write (comment from a member of clerical staff, recorded in my fieldnotes).

> I'd love to do a degree course, I'd love to sit around all day painting, making cakes, writing poems, all of that. They come in and they have everything given to them on a plate and the rest of us ... if you ask me, they get too much (Prison Officer).

Education in women's prisons can thus be seen as one aspect of prison life through which it is possible to mitigate and/or reverse the general trend of women's experiences (inside and outside prison) : a 'chance to make good' (Jan). Women 'on' education saw it as an important way of gaining some control over their present and future lives. However, the potential for prison education, as a means of empowerment, is frustrated by the very environment within which it operates. Moreover, the emphasis upon education in women's prisons (but not men's) being an 'aid to living' rather than a 'tool for a job' (HM Prison Service, cited Flynn and Price, 1995 : 24), and the continuing stress upon the inculcation of domestic skills, reinforce women's position in relation to legitimated authority thereby increasing the likelihood of their practical dependency upon welfare agencies and/or men post-release.

Kicking-off

> The system is incredibly destructive. A lot of the girls will kick-off against it in a vicious way or mouth off at the officers or whatever because they can't articulate what it is that is happening to them (Jen).

> These two set fire to the jail ... They lit a fire in their cell and ... they've got no fire alarms, no fire alarms went off... We could have all been killed (Discussion Group 2).

In a system which infantilises, trivialises and denies women authority, some women actively retaliate, or 'kick-off' against that system. Strategies for kicking-off include complaining, campaigning, minor infringements of the prison rules and more extreme, violent reactions.

At an informal level, women prisoners routinely 'sound-off' amongst themselves (and to other sympathetic listeners). Complaints and moans about conditions (particularly the food), facilities (particularly those for visiting) and 'the system' generally are common place and provide an outlet for accumulated frustration, a method of 'letting off steam'.

At a formal level, there are several avenues open to prisoners wishing to make a complaint, including : complaints to the prison authorities, the Board of Visitors (BOV), the Prison Ombudsman; petitioning the Home Secretary, and legal action. The internal complaints system has changed in recent years (partly in response to the recommendations of the Woolf Report, 1991, and the questions raised about 'justice' in prisons)[1]. Time limits have been set within which reasoned responses should be received and BOVs have lost their disciplinary functions (increasing, in principle, their independence and impartiality).

From the prisoner's perspective, however, the system is particularly confusing and access to the various channels of complaint are tightly controlled and regulated, making complaining 'just not worth it':

> What's the point. It's like making a complaint about the police which is then investigated by the police. The system is not there to help us or to protect us. It's there to protect the system and ensure the status quo (Sharon).

> Say you've got a complaint or something, then it's just a non starter. If you put in an app. [application] to see a governor, it's your right to see a governor, but very often it doesn't get any further than the centre office. So if they don't want you to see the governor, you've got no chance (Jane).
> I put in a complaint to the Board of Visitors [following a strip search] and they were going to come and see me ... They were then told that I wanted to drop it but I was told to drop it (Mair).

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1 See Cavadino and Dignan (1992); Sparks and Bottoms (1995); Sparks (1996) for fuller accounts of the relationship between the grievance system, order and legitimacy in prisons and the implications of the Woolf Report (1991).

While the system itself may deter prisoners from making complaints, they are also deterred by an awareness of the ways in which voicing grievances has implications for their subsequent treatment, particularly if it involves complaining about the behaviour of a prison officer :

> Personally, I'd find it quite difficult to complain. I'm not the type of person who's scared to say anything but I don't want to cause any trouble because I don't want any extra days. I don't want to be here a day longer than I've got to. So I would just get on with it (Ann).

> I put in a complaint about this one particular officer and I got loads of hassle after that. Things went missing, I lost a lot of stuff (Wendy).

> There is no justice in prison ... People are scared to complain (Pam).

For some prisoners, however, complaining becomes an 'art form', and there are those who use every opportunity to make complaints - the 'habitual grumblers'. Many of the women (and staff) were aware that repetitive complaining effectively discredited *all* complaints :

> Genuine complaints are not dealt with because of the behaviour of a small minority, the ones who complain about everything (Beth).

Cohen and Taylor (1972 : 140) state that 'in all prisons there is a mode of fighting back which involves formalising such responses as moaning, niggling, complaining and making a nuisance of oneself' : campaigning. Several of the women interviewed in this study were actively involved in campaign tactics, including : organising petitions and writing to MPs, solicitors, penal reform groups, 'watch-dogs' and the media[2]. The women were variously involved in publicising their own particular cases (in the hope of quashing a conviction or a sentence) and their own personal deprivations (in the hope of maintaining contact with a child, for example); in raising questions about the nature and

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[2] Such tactics have been described by Mathiesen (1965) as 'censoriousness' : ways of seeking change by *using* the system rather than directly fighting it.

philosophy of women's imprisonment and in campaigning for better conditions generally :

> I appealed against my sentence. I had a very quick appeal within seven months. But that was thrown out because the judges thought I knew. Thought I knew my husband was going to get hurt, so they threw my appeal out. I've had to take another course of action now. Liberty are involved, Justice are involved and Helena Kennedy has taken my case on ... Now I've got that little light at the end of the tunnel, because it's so easy to go down and once you're down it's very hard to get back up (Olga).
>
> We fought for extra milk for lifers which we now have. Big deal isn't it, but things like that are important (Sue).
>
> Yes I am doing this for me. I shouldn't be here and it's as simple as that. I didn't do what they said I did. But there's also a lot more at stake here. Women are being sent to prison without any thought of what it's doing to them or their families. So, in many respects I'm doing this for all women in prison (Discussion Group 5).
>
> The judge knew I was not guilty. There was no evidence and it is that knowledge that sustains me, keeps me fighting (Darelle).

Challenges mounted by the women prisoners themselves were often supported by groups outwith the prison walls[3], although none of the women in this study were supported by campaigning 'men-folk' in the way that the men in King and McDermott's (1995) study were supported by campaigning 'women-folk'.

For many prisoners, campaigning can be seen as a temporary (albeit morale-boosting) phase of reaction and, once the campaign is over (whether the outcome be successful or not), they shift to another strategy of response, 'until the next time' (Sue). For others, however, campaigning becomes more of a way of life: their *raison d'être*. For five of the women interviewed, campaigning had, in many respects, become their lives (present and future) :

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[3] Penal politics have, in recent years, slowly but surely been influenced by the 'radical campaigning' of such groups as Women in Prison. See Carlen and Tchaikovsky (1996) for description of the Women in Prison Campaign and an analysis of the relationship between some of the recent developments in penal politics and the difficulties confronting prison 'reformers', 'reductionists' and 'abolitionists'. Also, see Eaton (1993) for a list of women-centred penal reform groups.

> It's given me a sense of purpose, one which won't just stop when I pass through those gates. I'm going to keep on picking away until someone sits up and takes notice of what the system's doing to women in prison (Kym).

The women recognised, however, that their continued activities made them unpopular with both officers and other prisoners :

> I know I'm not flavour of the month. Some of the officers have told me that I threaten the system. But that's what makes me more determined. I'd like to be known as [name], the woman who took on the system and won.... There's not much chance of that, but ... watch this space! (Discussion Group 5).

Women not involved in campaigning expressed some reservations about those who received such publicity and there was a general feeling that they might 'ruin things for all the rest of us' :

> I think all the publicity ... it's like a double-edged sword. It's only the cases that are high profile that can really get something out of it. The sensational ones. A normal case like mine, they don't want to know and so we're penalised that way ... and there's no other way for us to fight our cases unless T.V. or [outside] campaigners get interested. But my case is not sensational enough, it won't bring in the viewers. They say they're there to bring justice, but if it's not sensational enough, if it won't bring in the public, they don't want to know. A lot of women are languishing away because they're not sensational enough to bring in the public viewing or the public outcry (Angie).

What struck me about the women campaigners (both the committed and more transient) was what I shall describe as their 'strength of will', evidenced by statements such as : 'I'm a fighter', 'I never give in', 'I've always stood up for what's right and wrong', 'I've never taken things lying down'. What is difficult to gauge, however, is whether such women were/are equally formidable in their outside lives. I suspect that potentially they were/are. For these women, kicking-off can be seen as an organised and purposeful attempt to make sense of themselves, their imprisonment and their present and future lives. In so

doing, they often raise questions which transcend the here-and-now day-to-day experience of imprisonment. In their descriptions of the process (of campaigning), it is possible to identify the ways in which potentially empowering patterns of behaviour can develop to challenge networks of domination and subordination.

For most women prisoners, however, kicking-off can be seen as a qualitatively different process, usually involving relatively minor rebellions or infringements of the rules. Water fights, pillow fights, laughing loudly, singing, shouting, swearing, running instead of walking, were all ways in which the women, who are akin to Goffman's 'intransigent inmates' (1961 : 62), sought non-conformity:

> We do daft things we're not supposed to. We go down to the pond and make daisy chains and pick flowers. We're not supposed to pick the flowers, but we do (Claire).
>
> There's a group of us. I mean we just shout and bawl about the officers, that kind of thing (Carole).

Such strategies, which could be characterised as immature or child-like, provided the women with a sense of self-worth, a feeling that they were still capable of achieving something, albeit a small victory over the system. Women often embellished stories about how they 'got one up on the officers'. The women recognised, however, that these responses often reinforced the institutional perspective of them as incompetent 'non-adults' :

> If you get treated like a child for long enough, then pretty soon you start acting the part. I know it sounds stupid, but we do things just to wind the officers up (Judy).

The women were also well aware that such behaviour brought with it the risk of greater control, greater regulation, greater restrictions :

> You can get into some pretty heavy duty trouble for doing some pretty petty things (Liz).

In this respect, the women recognised not only that they paid the price for getting one over the system, but also that they legitimised their own powerlessness. As Cohen and Taylor (1972) point out, prisoners can suffer greatly for their unauthorised defiance and attempts to gain small victories over the system can have the effect of reinforcing its legitimacy.

For some women kicking-off involves more violent reactions against the forces acting upon the self. It has been said repeatedly that there is *more* violence in women's prisons than in men's (see, for example, Lloyd, 1995). This is often premised upon the number of offences against prison discipline committed by women versus men. However, as has been suggested, it is not clear whether these differences reflect different reporting practices by staff or whether they are a reflection of greater violent disruption. What is interesting to note, however, is that most women prisoners do not seem to be 'violent' before entering prison : only a small proportion are there for violent offences (PAC, 1996).

Toch (1994 : 94) has argued that when discussing prison violence, prisoners and officers alike often romanticise it and attach 'spurious dignity'. In reality, he argues, most incidents of violence in prisons are 'irrational, grubby and pedestrian, and lack panache and drama'. The women in this study described incidents which ranged from throwing trays of food, setting fire to or smashing up cells, attacks involving other prisoners, verbal and physical attacks on (and by) officers and a 'mini-riot' in one prison. Most episodes seem to begin with a relatively minor issue, which seems to escalate quickly to take on monumental proportions :

> You get stressed out with these officers and the food. I feel like smashing the tray and saying 'Would you eat this?' Because it gets me really angry. It adds to your problems. If you're entitled to something she gives you 103 reasons why you shouldn't have it and she says 'If you don't shut your mouth you're not getting this'. So I just feel like smashing the tray ... and that one time I did (Discussion Group 1).

> That's why I was put on report last week. It was cookery class and the table that's near the hot plate, I just went and sat there, that's all I did. Miss H got on my case and then Miss G started so I ended up saying 'fuck you all' and I got put on report. I couldn't have kept it inside me. I'm not a kid. I want to be treated like a woman (Discussion Group 4).

> The slightest things cause problems. For me, it was a plate of chips. It was a couple of weeks after I came in and this lady was giving me some real grief because she thought I hadn't given her enough chips. She was pointing in my face and before I realised I slapped her. I got two extra days and a fine for it ... once you are in prison it is very easy for them to put days on. So I'm serving six months and two days because I slapped this woman over a plate of chips. The system is very quick to clamp down on physical violence (Carolyn).

Mandaraka-Sheppard (1986) argues that violence is a *product* of the system, rather than of the women themselves. She identifies a number of institutional factors responsible for aggression in women's prisons including poor prisoner-officer relations, young and inexperienced staff, severe and inconsistent punishments and a lack of incentives for good behaviour[4]. She argues that inconsistent and harsh punishments are more likely to produce and exacerbate violent behaviour and that a regime characterised by frequent reporting and punishments rather than informal means of control has little chance of allowing good relationships to develop between prisoners and staff :

> Inmates perceived the process of reporting and punishments ... as an aggravating circumstance which induced further friction and defiance (Mandaraka-Sheppard, 1986 : 162).

O'Dwyer and Carlen (1985) reveal how violence constitutes a specific survival strategy for some women prisoners : the women who 'survived' did so by being the most vicious. They describe the ritualistic respect gained by women in disruptive episodes, particularly those involving officers. Women serving life sentences in this study described a similar form of respect accorded to them by other women. Here, it is ironic that these women (who by definition are in

[4] It will be interesting to see whether the current developments in incentive-based regimes will have any impact on the incidence of violence in women's prisons (see Liebling and Bosworth, 1995, for a discussion of incentives in prison regimes).

prison for violent crimes) seem to be those least likely, or least able to kick-off in this manner :

> I think I've been quite lucky... I think they [other women] respect me more because we do have respect in the prison.... I suppose it's a kind of hierarchy really. But violence, I've seen violence and it used to terrify me. If I heard raised voices I used to run... But we're [lifers] fortunate in many respects. You know when there's been riots and that, half the time we don't know anything about it. There was a riot recently and do you know what we did that night? We made sandwiches to feed the officers (Sue).
>
> You can't kick off. Well you can, but you're doing a life sentence, you've got a carrot dangled in front of you saying, 'Well you won't get your parole if you have a tantrum' (Diane).
>
> When you're in a long time, you've cried that much that you can't cry any more. And it's like a bomb, it builds up inside you and the result - you end up on the block for fighting and that doesn't do your case any good (Karen).

Violence and viciousness seem to be particular features of short-term, younger women's imprisonment, although the potential for violence pervades prison life and was evident in the accounts of all women. For the most part, however, it was younger women who discussed active involvement in violent encounters. These women were also those locked-up for the longest periods (Low Newton). They described 'smash-ins', 'bang- ins', 'hell-' and 'fire-raising'.

For some women, confrontation with authority seems to be one way of preserving a sense of self-identity (and of gaining respect). Others, become determined not be at the rock-bottom of the prison hierarchy, not to be its victims. Rather, they stake out their territory in a world controlled by others and wield their own limited power over those with even less :

> CS : How do you get on with the other women?
>
> I can't say we like each other. I guess we tend to just tolerate each other for the most part, because we haven't chosen to all live together. But there is a lot of bad feeling in here between

> the women. A lot of niggles and bitchiness which then gets out of proportion. When I first came in I didn't know what the rules were and I mentioned someone's name or something. And I was told 'You don't say things like that, you don't repeat what you've heard'. And I went into the shower and all these lasses came flying in after me. 'What have you been saying? Keep your mouth shut'. You really have to watch what you say (Tricia).
>
> There was this one woman, she was quite big really, and everyone used to take the piss out of her. Some of the girls used to pick on her and take stuff from her - cigarettes, phone cards and stuff. I actually used to feel quite sorry for her, but I was glad that while they were picking on her, they weren't picking on me (Liz).
>
> In here there's no staff on at night and you do get some that's a bit schizo, that'll just come for you in the middle of the night when you're fast asleep. You've got to sleep with one eye open. It's terrible (Tracy).

Adler (1994), in a study of fear in (men's) prisons, argues that prisons are frightening places and, for many prisoners, fear is a constant companion. As a consequence :

> [Prisoners] may develop physical or mental illness related to the stress of living under threat of attack or injury, whether perceived or actual. Prisoners who cannot cope with the prison environment sometimes take refuge in self-harm or even suicide (Adler, 1994 : 1).

Such fears are not far away in women's prisons either. In the questionnaire survey in this study, sixty per cent of women prisoners (n=129) reported being concerned about their safety and many of the women interviewed felt that they had changed in response to the perceived aggression of others :

> I know I've changed. Being in here has made me wiser but I'm more aggressive as well. At one time nothing bothered me. People could say anything. But not now. I just jump straight up. I get wound up easily... When I first came in I was frightened to death, but now I don't care. I don't care about anything. Nothing frightens me now (Iris).

> I've learnt a lot about self-survival. I've become a lot more aggressive. When I first arrived I'd come in with cigarettes and tobacco and I was put in this dorm with three other women. One of them asked me for a fag and I thought I was going to be beaten up. But I said 'no'. I thought I've got to be strong but I was absolutely shaking because I thought the three of them were going to jump on me (Olga).

> I've learned a lot about myself, I'm much stronger, much more assertive. In here you have to be or you get sucked under ... I don't know if anything you learn in here is actually conducive to a happy life outside which is actually about relationships. Being an island in here is all right, but being an island out there is not necessarily beneficial (Emma).

Violence and aggression, largely products of the prison situation, are often exacerbated by the day-to-day administration, where potentially violent encounters seem to be fostered rather than defused. The women interviewed described witnessing violent scenes of bullying and injustice and times when officers 'set-up' the scene (intentionally or otherwise) only to condemn women's behaviour for transgressing the acceptable limits of femininity :

> There was this one woman and she'd had her flat burgled and she'd only just heard and she was understandably upset. So she goes to the office to see if she can speak to someone about it and this officer kept her waiting and waiting. He kept saying things like 'Be a good girl and wait your turn' ... anyway in the end she'd been waiting ages and was getting more and more worked up and so she mouthed off at him and that was it : 'You're on report'. She ended up smashing up her cell (Lyn).

In a situation of hierarchical power, certain individuals often become scapegoats : the 'lowest of the low'. Women who fall easily into this category are women whose exclusion is more extreme; women at the bottom of the power heap; women whose behaviour has set them further apart from notions of appropriate femininity and domesticity : women accused of child abuse :

> 43ers are not helped by the general staff's attitude. There's a lot of staff got a problem with 43 house. And, when all well and good, if they don't want to work on here they shouldn't have to. But having said that, they ought to watch their mouths out

> there. How can we expect them people out there, especially the younger end, the smack-heads and that, to have any sort of idea. I mean there's bricks coming through the window, abuse hurled and all you get is 'Well, it's to be expected' and 'Nature of the crime isn't it'.... You can go out to the bins and the girls will hurl abuse and one set of staff will put them straight on report. But at other times, you're stood with an officer, they're stood with an officer and they're shouting and getting away with it (Steph).
>
> You get threatened every time you set foot outside the door. 'You dirty nonce'. And it wouldn't be so bad if it was one-to-one because at least you're in with a chance. But you're on about 20 ... I've not been physically hurt, I've been lucky. I've not been hit or anything but I've been there when stones have been launched through the window and other people have been hit (Fiona).

Lesbian women similarly described the homophobic attitudes of staff and other prisoners alike :

> I've had loads of comments, loads of grief. The women make little comments : 'pussysucker', things like that ... the officers are even worse. One asked me if I'd had an operation, a surgical strap-a-dick-to-me [laughs]. It's not funny really (Suzanne).

Those who are successfully targeted for exclusion, violence and aggression are often those who are already marginalised - because of personal characteristics or because of the crime that they are accused of. Defining such women as the 'lowest of the low' enables others in the hierarchy to define themselves as 'not quite that low'.

Women prisoners have few legitimate outlets for the expression of their emotional anxieties and frustrations. While some compensate for this via disruption and violence, others turn their frustrations upon themselves. Some women *use* their bodies as a mode of expression for solving their problems, and the same things which cause some women to kick-off may cause others to use substances and/or to self-harm.

Substance use, the body and the self

> Well in here, if you didn't smoke, well from my point of view, if I didn't smoke I would be buying all sorts of things from the canteen to eat and I would just eat and eat and eat. So for me it's either eating or smoking.... I feel that with smoking you seem to feel a lot better, a lot calmer (Debbie).

In discussing their own responses, and those they had witnessed in others, women prisoners often describe processes of coping involving a variety of substances, including tobacco, prescribed drugs, alcohol, illegal drugs and food. In this, as in other coping strategies, it is possible to recognise attempts by the women to do something for (and to) themselves, to attain a sense of self by their own self-initiated activities.

Most discussions about women prisoners, as substance users, have tended to focus on substances which can be regarded as 'mind altering' and/or 'addictive'. An analysis of the content of such discussions indicates that such terms as 'addiction' or 'drug (mis)use' may not adequately reflect women's relationship to a range of substances, mind altering or otherwise. Substance use within prison - which implies varying levels of dependency on a variety of substances - needs, therefore, to be viewed within the context of more general perspectives on women and dependency. This section seeks to explore some of the complex social issues that are related to women prisoners' use of tobacco, alcohol, illegal drugs and food (the use of prescribed drugs in women's prisons will be discussed in the next chapter).

Surviving by smoking

> If I have to survive without a cigarette then I may as well kill myself (Tracy).

Cigarette smoking has been identified as a major cause of disease and premature death in industrialised capitalist countries. Moreover, smoking patterns appear to be changing in ways which are tying cigarette smoking more

closely to gender divisions and to other hierarchies of oppression. In Britain, as in other capitalist countries, cigarette smoking is emerging as a habit acquired and sustained by those who occupy disadvantaged positions within the social hierarchy.

Jacobson (1981, 1986) argues that smoking is emblematic of women's subordinate status and inferiority. She suggests that women use cigarettes differently from men and the reasons for these differences are based on the politics of women's social positioning :

> Smoking is an outward sign of [women's] constant battle to control our unvoiced frustrations; controlling these means we can be 'nice' to everybody all the time. To feel in control of our lives is just as important to men as it is to us, but the ways to exert this control open to us are more limited. We will tolerate unruly or drunken husbands or angry bosses who take it out on us, but who can we take it out on? Surely not our children. So we reach for the cigarette instead (Jacobson, 1986 : 111).

What is known about women's smoking tends to come from quantitative surveys[5], which measure women's smoking status with little reference to the everyday experiences which sustain smoking behaviour. There are few studies of women's smoking in which the analyses stay close to the understandings that women have of themselves and their lives.

Graham (1987) argues that we need to understand women's smoking behaviour within the context of the social divisions which shape their identities and their daily lives. She argues that social and material circumstances are integral to the maintenance of women's smoking habits. They provide the contexts in which and against which women continue to smoke.

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5 Official statistics for 1990 reveal a smoking prevalence in the general population of 31% in men and 28% in women aged 16 and over (HMSO, 1992b). Smoking prevalence in prisons is, however, much higher : 81% in men (Bridgwood and Malbon, 1995) and 75% in women (see Appendix III).

Regardless of whether or not cigarettes are viewed as physically and/or socially damaging, they are consumed for a variety of social, psychological and emotional reasons by millions of men and women of all social classes in developed and developing countries (Ettorre, 1992). Yet, of the women who smoke in Britain, sixty per cent are women in working-class households (Graham, 1987).

Graham (1987) studied a group of mothers from low income families caring for pre-school children. She was particularly concerned with the impact of poverty and single parenthood on the caring responsibilities of these women. She found that smoking for women functions both as a *necessity* and a *luxury* when material and human resources are limited.

If we relate Graham's theoretical framework to the prison context, we can see that smoking for women prisoners functions as a necessity in that it helps women to re-introduce some structure into their lives when their usual structure starts breaking down :

> I'd be lost if I didn't smoke. I know it sounds daft, but I kind of pace the day around them. When I get up in the morning, I have a fag, then one after breakfast or at association. It gives me something to look forward to, a sort of break in the routine (Pippa).

> I smoke because when you're nervous, when you're upset, you know, you smoke. You have to do something to get through each day (Jo).

Smoking becomes a way of coping with stress and the experience of imprisonment. In a real sense it is a specific coping strategy. As a luxury, smoking is a leisure (a pleasure) activity. It helps women to relax. It represents a space and time for women to look after themselves. In this way it can be seen in terms of a woman taking space for herself in an environment where her actions are controlled and regulated by others : where there is little opportunity to take 'time-out' :

> It's the only thing I can do for my self in here. It's my decision when to have a cigarette or not ... and there's very little they can do about that (Beth).

It is not surprising that many women respond to prison, as they do to stress in their outside lives, by smoking. Women identified smoking as an important survival strategy within prison. Many smoked more than they had done previously[6] and some had actually started smoking on imprisonment :

> I didn't smoke when this happened. When my husband was killed everyone kept saying 'Have a fag, you'll feel better' and before I knew it I was smoking and getting sent cartons of 200 whilst on remand. So that was it, I was a smoker ... Smoking's like a crutch - you reach for it when something goes wrong, but it's all still there when you've finished it (Chris).

> I never smoke normally, and especially being pregnant, but I can't give it up because I need it. It helps me through. It helps me forget about things, puts my mind on something else (Sarah).

In prison, the woman smoker, whether she smokes as a necessity or as a luxury, is displaying a form of self-management. She is not only attempting to impose her own order on an institutionally ordered life, but also asserting herself, actively taking space or 'time-out' from her prison existence.

Women and alcohol

Alcohol consumption is deeply rooted within British culture and many women referred to times in their lives when they had been drinking heavily :

> For years and years I drank because when I drank and he beat me I didn't feel the pain. I did in the morning, I felt it then (Karen).

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[6] Those who said that they smoked less in prison did so largely because of limited resources, or because they didn't like rolling tobacco : 'I've always smoked. When I was at Durham I tried to give it up because I said I would never smoke roll-ups, but after a time ... the stress gets to you so I did' (Sue).

Several recognised that their crimes had been alcohol-related :

> CS : What got you into prison in the first place?
>
> Drink mainly. I was an alcoholic when I was outside. I don't know if it was just the drink but it probably didn't help. I'd been drinking for about four years... I didn't drink when I first met him. He did, but ... every Friday he'd get drunk and every Saturday he'd suffer a big hangover. Then it just got worse and worse ... well I was an alcoholic by then, actually an alcoholic... We were both drunk that night and his friend was there. We had quite a big fight. Normally I don't use knives, but there was a knife there and I just grabbed hold of the knife (Barbara).

Many women had been in trouble with the police as a result of teenage drinking bouts:

> I used to drink and drink and then I'd get into trouble. The night I got locked up I'd drank 15 pints, that was before I went to a night club. That's why I've got stomach ulcers because I drink that much. I'd need £120 a day to go out. From half seven at night until about four in the morning (Discussion Group 2).

Little is known about alcohol consumption in women's prisons. While many women were regular users of alcohol prior to coming into prison, only a few claimed to have used alcohol whilst in custody. Of those women who admitted using alcohol intermittently, it was either consumed on open visits :

> I just go mad when I go out. It's straight into the pub. For that short time I can just forget about everything and just get drunk (Julie).

or it took the form of illegal home-brew :

> I work in the kitchens so I can get yeast whenever I want. I've become quite skilled at making hooch out of all sorts - potato peelings, left-overs. It gives you a hell of a hangover (Iris).

While most women recognised the temporary escape provided by alcohol, they also realised the high price which could be paid for its consumption :

> I used to say that alcohol was better than drugs but now I'd say the opposite. And in here, you get into more trouble for alcohol than for heroin. So you see some girls going out on their open [visits] and coming back drunk and then getting into trouble, down the block. But the dope heads, the smack heads, just get away with it (Jane).
>
> When I was at Durham, I was friendly with a lot of the girls, one in particular. I came here [Styal] on the Friday and on the Monday I was called in. She'd committed suicide and I was devastated. The awful thing is I'd made hooch and she'd drunk it and that had given her the bottle to do what was necessary (Sue).
>
> One girl recently committed suicide. She had an argument with her [prison] girlfriend and she got her boyfriend to throw some booze over the wall. She O.D.'d on booze and slit her wrists (Kirstie).

Despite alcohol being socially acceptable on the outside, it is a difficult habit to maintain in prison (King and McDermott, 1995). Because of this women prisoners often resort to other ways of 'taking the edge off things.'

Getting out of it : Women and illegal drug use

Official statistics suggest that over one-quarter of the drug-using population are women. According to Home Office statistics, there were a total of 4,948 women users of notifiable drugs in 1990, accounting for 28 per cent of the total number of notifications (Home Office, 1991)[7].

On 30 June, 1994, 1,289 sentenced women were in custody of which twenty-five per cent (326) had been convicted of drugs offences (PAC, 1996). While this, of course, does not mean that all these women will have an addiction, it does imply a substantial level of involvement in drug culture. Moreover, it is likely that many more women are imprisoned for offences, such as theft, which were committed in an attempt to fund a habit.

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[7] These are registered drug users and the total number of users is likely to be much higher.

Within recent years illegal drug use in prisons has become an increasing focus of concern (HM Prison Service, 1995b) and there is evidence to suggest that drugs are now *the* prized currency of the prison barter system (O'Dwyer and Carlen, 1985). In 1995 Her Majesty's Chief Inspector of Prisons called for immediate action on 'drug abuse' among women prisoners at Styal (the unannounced short inspection took place whilst the fieldwork was in progress). The Inspection Report (Home Office, 1995) acknowledged the 'high level of illicit drug use' and warned of the need to ensure that 'clean' inmates arriving at the establishment were helped to avoid being drawn into the drugs subculture.

While it is difficult to determine whether drug-usage in women's prisons constitutes a specific 'subculture', many women discussed their own drug-usage and that witnessed in others. Here, it seems that the issue of illegal drugs within women's prisons can be viewed on two distinct levels. On the one hand, there are those women who continue to maintain a drug habit whilst in prison and, on the other hand, there are those who, as the Inspectorate Report notes, take-up the habit whilst in prison :

> They say that there is no drug problem, but there is. I mean I tried pot before I started studying seriously. But the hard stuff, there's a lot of it around ... there are a number of lifers who I know were clean when they came in but are now users. I guess it's just their way of coping (Sue).
>
> The last time I was in, I was off the booze right enough, but I went out hooked on smack! There's so much of it around, you can't help but get hooked (Discussion Group 2).
>
> I do smoke cannabis, I always have done and I always will (Sylvia).
>
> When you're under a lot of pressure and you just want to get away, they're the best thing (Kym).

Twenty out of the fifty women interviewed in-depth discussed either regular or intermittent use of marijuana whilst in prison and some reported using other drugs, such as : heroin, cocaine, 'crack', 'smack' and amphetamines.

It is, of course, difficult to judge the extent of illegal drug-use in prison (and even harder to determine levels of dependency) as the area is complicated by issues of law enforcement. Illicit drug-use in prison (as in the community) is a punishable offence[8]. Official statistics and survey reports are thus likely to represent only a minority of users and/or a select treatment population. This tells us little about the place of drugs in women's lives and there is a need to look beyond the drug treatment/punishment systems to the women themselves in order to have a clearer understanding of their initiation to, and use of, illegal drug.

Jeffries (1983 : 6) argues that drug-use should be seen as an aid in helping women to conform to a way of life which is intolerable. Intolerable because of its 'unnatural forced values and expectations, especially for those labelled wife and mother'. Add to this the label of prisoner.

The women in this study described how drugs helped them to retreat, although many recognised that drug usage did not alter their structural position : 'It's all still there when you come down' (Jan). Some women emphasised drugs' 'blanking-out' powers, which seems to be their main attraction. Several women saw drugs as a panacea, to help them escape the monotony, stress and anxiety of the prison regime :

> I was in prison for well over two years before I even touched a spliff. Then someone gave me this cigarette with heroin in it, but I didn't know it was heroin at the time, and the feeling I got, I knew I was here but I wasn't. It was great (Iris).
>
> I can get cannabis whenever I want. It helps me get through the day, through the boredom. In here we're locked in 23/7 [twenty-three hours a day, seven days a week] some weeks and smoking just makes it that little bit more bearable (Jo).
>
> I have taken drugs since being here. People take them because they're frightened of facing themselves (Pam).

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[8] The inherent contradictions between health and law enforcement in relation to illegal drug-use is discussed in chapter six.

> If you're a druggie, you've got a lot of mates ... The first time I had a spliff, I was in heaven and it was a beautiful place and then I came back to hell (Karen).

Ettorre, (1992 : 75), in her discussion of women and heroin, takes a critical look at some of the myths which surround women's use of illegal drugs. She argues that in the explanations for women's drug-usage, a specific image of the female drug user emerges : the 'polluted woman'. She argues that because of women's social positioning, the boundaries of behaviour are more clearly (narrowly) defined for women than for men. Because of this, the consequences of transgressing these social boundaries (poisoning themselves, being out of control) for women drug-users are more severe. In this sense, regardless of when, how and why women take drugs, such women are thought to have polluted their bodies and spoiled their identities as women.

Women's drug-use challenges traditional female stereotypes and notions of appropriate femininity. Perry (1979) reveals how the female 'junkie' or 'pusher' represents femininity misplaced, defied and defiled. Specifically, women drug-users embody women who have rejected their femininity : they are 'non-women'.

Nurco, Wegner and Stephenson (1982 : 78) similarly point to the low, irrevocable status of the woman drug addict. They contend that she is seen as 'trash, degraded, the lowest form of life, dope fiend, bum, bitch, stinking whore, despicable, dirty and they will do anything for a shot'. So, while women prisoners in general may be seen as 'spoiled' women, drug-users are spoiled women *par excellence* : doubly polluted, triply deviant.

Here, an incompatibility exists between the social expectations for women to be dependent, passive and to behave in 'conventional' ways, while at the same time being seen to be 'in control' (of themselves, and their domestic responsibilities). Women drug-users may consciously use drugs in order to cope or to maintain some control in their lives (or simply because they enjoy them). Yet, regardless

of how they see themselves, they are viewed as women out of control, in need of control. As a consequence, women drug users may encounter oppressive practices in the criminal justice and drug treatment systems.

Food and the imprisoned body

> Many female establishments now recognise that food, while as important to female prisoners as to men, can raise a number of different problems (HM Prison Service, 1992).

Food and eating practices are at the centre of new concerns in western societies about the body, self-control, health, risk, consumption and identity (Lupton, 1996). While there is no doubt that we need to eat to survive physically, responses to food and eating practices are shaped by the ways in which we interact with others and within specific contexts.

In prison, food assumes enormous importance (see King and McDermott, 1995) and food and eating habits in women's prisons can be viewed on two broad levels : food as a punishment and a comfort, and food as a form of resistance and rebellion.

Food as a punishment and a comfort

Lupton (1996) argues that food and eating are central to our sense of self and our experience of embodiment. That is, the ways we live in and through our bodies. Food, eating habits and preferences are not simply matters of 're-fuelling' or alleviating hunger pangs. For most of us mealtimes represent a break in the day, often a period of sociability. Occasionally, meals are looked forward to as opportunities to (over-)indulge ourselves. Eating habits also serve to mark boundaries between cultures and religions, to distinguish rituals, traditions and festivals, as well as times of the day.

Morse (1994 : 95) has argued that food is 'the symbolic medium par excellence'. In prison, food remains symbolic, representing, in many respects,

the prison experience. In outside society dietary habits serve to establish and symbolise control over one's body. In prison, that control is taken away as the prisoner and their body become the objects of external forces. Eating choices and preferences are restricted and the bodily experience of eating becomes mediated and controlled. Paradoxically, while women are normally 'accorded the major responsibility [for] organising the purchase and consumption of commodities' (Featherstone, 1982 : 24) and, in regimes for women we can see notions of appropriate femininity and domesticity, most women prisoners have no facility to cook for themselves[9].

Limiting an individual's food intake and controlling their dietary habits is an effective disciplinary mode, dislocating a sense of self-control. Variety, novelty, abundance, innovation, self-indulgence and excitement in eating are desired and valued by many people as part of constructing and presenting the self. In prison, there is little autonomy over food choice, little variety, little excitement and while bread and water punishment may be a thing of the past, for many prisoners prison food is experienced as punitive (King and McDermott, 1995) :

> It's like being on punishment here ... all we eat is cabbage and carrots ... I don't think they quite understand what a vegetarian is because every time there'll be fish, or chicken. So I tend to eat packets of biscuits. crisps, little things like this (Barbara).

Women prisoners describe the boredom of always having to eat the same types of meal. In response to the survey questionnaire, sixty-two per cent of women prisoners (n=133) rated the food as rather bad or very bad. Many of the women interviewed were concerned at the poor standards of cooking and nutrition and were highly critical of the food and its preparation :

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[9] Most women at Askham Grange and Low Newton eat in communal dining halls. At Styal, each 'house' has its own kitchen and 'house cook'. Women 'on' the LTI house are allowed to cook for themselves. For these women, the ability to exercise some choice over eating habits was symbolic and they described an intense pleasure in the (albeit limited) control they had over the food they could choose, prepare and eat. As King and McDermott (1995) note in their discussion of Gartree, the ability to cook for oneself, one's fellow prisoners and a grateful researcher (see Appendix I) represents one of the more 'humanising' elements of the prison regime.

> The kitchens are appalling. We had a sponsored clean of the kitchens so we're eating this week. Food is kept in bins on the floor, not covered. It's disgusting (Kirstie).
>
> You take what you can get so long as it doesn't look like there's a fly on it (Dawn).

Several women were worried about the effects prison food had on them including weight gain and loss, constipation, diarrhoea and vomiting. Some had also experienced bad bouts of 'food poisoning'.

While the women described the unappetising nature of the food, many recognised that their lack of appetite was not just about the food offered, but rather could be seen as an emotional response to imprisonment, an interaction between feelings of anxiety, stress, nervousness and grief:

> When I first came in I wouldn't tell the other women what I was in for. I was very much in shock, scared to death, so I thought I'm not telling you. So they decided that I was in for kids. And I got taunted and everything ... It just all took its toll - the isolation, the worry, I had nobody to discuss anything with. I didn't know how my children were ... worrying about my parents, how I could get this guy [co-accused] to tell the truth. So I just stopped eating. I just went down hill and it was like I was up there looking down on somebody ... I didn't care (Chris).

At another level, the women expressed their frustrations at having their dietary choices dictated to them. Here again they recognised that this was not so much an issue about the actual food but rather about the lack of power and control which characterise the prison experience.

The symbolic meanings of food for women (as individuals and as family members) have been well documented (see, for example, Chernin, 1983; 1986; Lawrence, 1987; Orbach, 1978; 1986), and many women respond to imprisonment, as they do to sources of suffering in their outside lives, by 'comfort eating'. Here, women eat in response to stress and food becomes a substitute gratification when other areas of life provide few satisfactions

(Hamburger, 1951). Like smoking, the strategy of eating food as a comfort seems to be a common response to women's lack of control in everyday life and should be seen as an attempt to re-establish control. Charles and Kerr (1988 : 92) argue that, if women 'can control their bodies through control of their food intake perhaps the dissatisfactions that they experience would go'. Of the 200 women they interviewed, many expressed the feelings of comfort and release from tension, loneliness and boredom they felt by indulging in their favourite foods. Their interviewees described situations in which they used food as a specific response to unhappiness.

In prison, women can not necessarily indulge in their 'favourite food'. However, the women described the ways in which eating food such as chocolate, biscuits and crisps provided a means of solace and comfort :

> You've got to get solace somehow ... so I eat. I eat the sweets because the dinner's disgusting, but also because it makes me feel better, cheers me up (Judy).
>
> If you're feeling good, you eat good food. If you're feeling bad, you eat bad food. When I'm feeling low I eat chocolates and biscuits because it's doing something nice to myself. I don't mean nice in the sense that it's healthy, but I like doing it (Discussion Group 4).
>
> I think I'm lucky not to have turned to drugs or alcohol throughout this whole period. I am a comfort eater, though, which might have caused the colon problem (Brenda).

Here, we can see notions of *good* and *bad* food. 'Good' food tends to be associated with the nutritious and the healthy and 'bad' food is associated with illness and disease. In a hostile environment, 'bad' food seems to offer companionship, comfort, reassurance. It becomes a source of 'guilty pleasure'. Here, it may be that women purchase and ingest food such as sweets and biscuits not just because of their tastes but because of their nature as 'bad' food, and the meanings attached. Such foods have a positive, anti-authority association as well as the negative associations of weight-gain, over-eating, guilt and self-disgust (Lupton, 1996). What is interesting to note is that most

prisoners would define the institutional food as 'bad' - 'all the food you get is fatty and stodge' (Helen). However, the important point is that crisps, sweets and biscuits represent the 'bad' food of their choice.

Food as a form of resistance and rebellion

Complaints about food are endemic in large institutions such as hospitals, schools, and particularly prisons where such complaints constitute one (legitimate) means of expressing dissent. Complaints about prison food are not new. Smith (1962 : 240) describes how 'convict women' at Liverpool in 1919 'complained bitterly' that their diet was 'monotonous' and the food 'stodgy and unappetising'.

Mealtimes in prison can be tense occasions where emotions such as resentment, anger and frustration often find expression[10]. Prisoners may express their feelings by leaving the table, shouting, banging trays, spitting food out or throwing it at staff. Such outbursts are not just about the food itself, but rather are about power and powerlessness. In this context, food acts as a prop to establish women's refusal to bow under authority. It becomes one means of countering attempts to dictate how women should conduct their bodily activities. Complaining about food provides a way of kicking-off at the system and for those with few ways in which to rebel, food provides one means of doing so[11] :

> There was nothing else I could do. I'd been bottling it up and bottling it up and then it just came to a head that one day in the dining room. She [another prisoner] said something to me and I just went for her and so it was down the block. We're quite good friends now (Karen).

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10 In Askham Grange this is compounded by the system for receiving mail - women are given their mail in the dining room before dinner.

11 Walkowitz (1980 : 215) illustrates this point well with reference to the 'soup riot' at the Royal Portsmouth Hospital in 1873, which lasted for two days and in which seven women were arrested and eight placed in solitary confinement. She states : 'angry and disappointed, the women lashed out at the conditions most immediately intolerable : watery soup ... Fundamental though, was a simple desire to get out'.

> I was feeling really low. I hadn't had a letter or something silly like that and I felt like I just had to get out of there so I just left my food and ran out (Ann).
>
> Mealtimes are the only times we're all together and you can imagine it gets a bit hairy. There's a lot of banter but there's also an atmosphere, how can I describe it? It's like there's something waiting to happen (Nia).

King and Elliott (1977 : 290-292) describe a series of incidents involving food at Albany prison which culminated in a four day ('Not fit for human consumption') protest. They illustrate the ways in which constant, concerted and 'orchestrated' complaining by prisoners, refusals to eat and active protest can achieve certain ends, including the provision of alternative meals and the transfer of two catering officers 'out of the front line'. Because of incidents like those described at Albany, communal dining halls in men's prisons have been progressively taken out of use (King and McDermott, 1995).

Complaints and protests about prison food are often used to highlight poor conditions in prison more generally (see, for example, Scraton *et al.*, 1991). Judith Ward (1993) points out that while most inmates' disgruntlement is focused on the food they are given, most prisoners, over time, become indifferent to the food. She argues that prisoners use the resentment over poor food, however, as a method of showing disapproval of the conditions :

> On the day in question, twenty-six women refused their meals. The press, already alerted, phoned the wing for details and so began a protest which called for conditions to be modernised and even for the closing of the wing on psychological grounds ... It wasn't a hunger strike in the sense that we were prepared to starve to death (although we didn't let the authorities know this), it was an attempt to better general conditions (Ward, 1993: 87).

While some women use food in an attempt to negotiate for better conditions generally, others take this further and are prepared to starve themselves to death to highlight their own particular grievances. Two of the women interviewed in this study had carried out intensive hunger strikes :

> It took two petitions, four MPs and a hunger strike before I could see my son (Pam).

Through the rejection of food for political reasons, the compliant prisoner becomes a determined rebel (consider, for example, the IRA hunger strikers), demonstrating autonomy by not ingesting food as well as through the embodied expression of food refusal : emaciation.

Prisoners have a choice about whether or not to eat and while some indulge in comfort eating, others use food as means of kicking-off at the system. For others, a refusal to eat can be seen as a political or negotiatory tool. For others still, the struggle with the body becomes more symbolic and some women seek self-control by deliberately attacking their bodies through self-starvation, binge eating, or self-mutilation.

Self-harm : disordered eating and self-mutilation

> I need my eating disorder ... it's the only thing I have any control over and it takes the pain away from whatever they want to do or threaten to do. However bad their punishment is, mine on myself will always be worse. There is nothing more painful than starving yourself to death (Discussion Group 5).

> The last time I was in [prison] I was anorexic and I was cutting-up (Lyn).

Self-harm can be seen as a form of violence against one's own body, and, while smoking, alcohol and drug-use may all be considered forms of deliberate self-harm, what I am concerned with here is what have become known as 'eating disorders' and self-mutilation.

Eating disorders such as bulimia and anorexia nervosa are largely specific to women (Ettorre, 1992). They affect more than one in a hundred women in Western Europe and may symbolise extreme attempts to exercise autonomy by refusing to eat or by bingeing on food (Dolan and Gitzinger, 1991).

Bray (1994 : 4) argues that in popular accounts of eating disorders, we can see a continued focus on the 'feminine grotesque hysterical body' : the stick-thin anorexic girl, intent on starving herself to death and the woman who stuffs food into her mouth in a frantic binge and then rushes to vomit it away. In such accounts, anorexia nervosa and bulimia nervosa are often explained in terms of women's susceptibility to mass media images of slim women as attractive : the attempts of vain women to be beautiful. In this representation, femininity is associated with vulnerability and passivity. Women are depicted as blank slates, brainwashed and manipulated by the media, 'pathologically susceptible to media images' (Probyn, 1988 : 203). This interpretation of eating disorders overlooks the socio-cultural, psychological and political pressures in which women are caught.

Chernin (1986 : xiv) suggests that eating disorders should be seen not necessarily in terms of the pathological but in terms of women's 'hidden struggle for self-development'. She analyses the issue of women and eating disorders by looking at a number of key areas including women's search for 'identity and selfhood'. Self-starvation, for example, now commonly described and diagnosed as the eating disorder anorexia nervosa, has actually existed for hundreds of years as a practice of the self, a means of constructing subjectivity[12]. While the meanings around it have changed over the centuries, and are culture-specific, what appears to remain constant, however, is the discourse of self-control over the desires of the body (Lupton, 1996).

The term 'anorexia nervosa', which literally means the loss of appetite due to a personality disorder, is misleading. Most people diagnosed with anorexia do not experience loss of appetite but in fact *voluntarily* starve themselves, regardless of any hunger they might feel for food. Indeed, it is an individual's awareness of their hunger, their desire for food, and their subsequent conquering of this, that is the main objective of self-starvation as a technique of self-control. Rather than being out of control, such women seek self-control.

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[12] See Bell (1985) for a detailed account of self-starving women in history.

For bulimic women, similarly, the main pressure on self-control comes from appetite : 'the whole point is not to control the binge, but to control my desire to do it' (Debbie).

Ussher (1991), in her discussion of the history of anorexia, argues that since the Victorian era (when anorexia nervosa became a recognised clinical syndrome) food has become a focal point for female distress, a symbolic communication, as well as one of the visible aspects of life over which women have some control. It is unsurprising, therefore, that food assumes such importance in the lives of women prisoners. Seven of the fifty women interviewed in-depth considered themselves to have an 'eating disorder' and many more described a problematic relationship with food. In the women's accounts we can see this complex relationship between eating, food and the struggle for identity and control :

> I don't like saying I'm anorexic because I don't think I am. I don't like putting weight on. I get angry with myself. I didn't have an eating disorder outside but when I came here I went through quite a few weeks without eating. I didn't want to eat then and I didn't even drink ... So it went on for months and months and that's when I started collapsing because I really didn't eat anything ... It just went on and on and on and then I wanted to go to open prison so I asked to go to Askham Grange and they said 'You can't go to AG until you start putting weight on'. So then I used to drink two pints of water when it was my day for weighing, fill my pockets with all sorts and then press down on the scales (Iris).
>
> I just prefer not eating ... it's almost as if I'm coping better when I'm not eating. I can do what other people can't (Pippa).
>
> All I do is eat and eat and eat. I've got an eating disorder... Bulimia. I binge and make myself sick ... well I don't make myself sick any more. I just eat a lot now, which isn't very good for my figure. So I wouldn't say it was bulimia now, I'd just say it was an eating disorder (Diane).
>
> Whenever I feel trapped or hemmed in I eat (Debbie).
>
> I think it's a control thing. When I feel in control of it (my eating disorder) I feel great, life is good. When I'm not bingeing I'm in

> control. But when I feel out of control or down about something then I just switch off and try to hide myself away, try to gain some control of things, do you know what I mean (Steph).
>
> I do have a problem with eating. I never used to before coming into prison. I can't stand fat and I go on binges now ... (An awful lot of girls in here have eating problems). I honestly can't put my finger on why I do it. Whether it's because of the life sentence. Whether it's the separation from my children. Whether I'm subconsciously punishing myself ... I don't know (Sue).

Women who misuse food, like those who misuse drugs, tend to be viewed as out of control because they 'defy' the acceptable female role (Ettorre, 1992). In a real sense, however, they are taking control, albeit extreme control, over their food intake. These women are ultimately saying that they will eat as much or as little as they want and 'there's very little they [the authorities] can do about it' (Pippa).

In the prison context, eating disorders may thus be seen as attempts by women (consciously or unconsciously) to exert some control over their bodies : 'It's the one thing I can control' (Iris). For such women, their participation (or not) in eating practices can become the most central aspect of their sense of self, to the extent of ruling their lives. Paradoxically, in an attempt to exert self-control, some women recognised that their coping strategy had the potential to control them :

> At the moment I feel in control but I do worry that I'm not going to be able to control it. That it'll take control of me (Sue).

Eating disorders can therefore be seen as strategies of resistance which have the potential to become their own prison. MacSween (1993 : preface) suggests that this is because 'they do individually what can only be done collectively - challenge the construction and control of women's bodies'.

In prison, all activities are planned and controlled by others and women prisoners seek out control in other ways of personal functioning. Here, the

body often becomes the focal point and the same factors which may make a woman vulnerable to the development and maintenance of eating problems may cause others to self-injure and/or damage their bodies.

Self-mutilation, like eating disorders, is more common amongst women than men and it is estimated that one in seven women prisoners will self-injure. The comparable figure for male prisoners is one in thirty-three (Benn and Tchaikovsky, 1987; Apps, 1988).

The extent of self-mutilation in women's prisons has been the subject of much comment (see, for example, Heidensohn, 1985; Dobash *et al.*, 1986; O'Dwyer and Carlen, 1985; Liebling, 1992a, 1994; Lloyd, 1995) and the practice appears to be a response to the pains of imprisonment and to low self-esteem. O'Dwyer and Carlen (1985 : 170), for example, argue that :

> Forms of self-mutilation are common responses to the pains and the tensions, to the emotional and the sexual deprivations experienced by women and girls in prison.

Self-mutilation involves anything from scratching with pins to swallowing safety pins and/or glass. Cookson's (1977) study of self-injury at Holloway included cutting or stabbing; tattooing; swallowing sharp or dangerous objects or dangerous substances; taking an overdose of drugs; burning or scalding; dashing the head or limbs against a wall or floor and self-strangulation. At its most extreme, it can involve putting an eye out but the most common manifestation of this form of self-harm in women's prisons is 'cutting'.

While only five of the fifty women interviewed discussed their own self-mutilation, others described self-injurous ideations and some were concerned that they might self-harm. Thirty-one per cent of women (n=66) in the questionnaire survey, for example, reported current concerns about cutting-up, self-harm or suicide. Moreover, many of the women I encountered in the course of the fieldwork bore the hallmarks of previous self-harm - scars on

wrists, arms and necks and amateur tattoos. These visible signs of disaffection or self-detestation endure beyond the prison walls and serve as permanent reminders of a woman's (ex-)prisoner status (Eaton, 1993).

The causes of self-mutilation are many and are complex (see Liebling, 1992a; Lloyd, 1995). One woman interviewed in this study, for example, described how she self-mutilated in an attempt to make others aware of her frustration and distress and also in an attempt to bring about a change of circumstances :

> At one point I was so down, I was slipping. I hated the house I was on. They put me on a regional house, which they shouldn't have done because I'm an LTI and on these regionals everything goes missing ... I'd put in for three house moves but no joy and I just felt so desperate ... I stood over the sink for three hours with a shattered Nescafe bottle in my hand and then I just cut and cut ... I was that desperate (Pam).

Here, there seems to be an inverted form of control. The woman seeks to regain some power by inflicting on herself a pain greater than that inflicted on her by others. In injuring herself, it seems that she is attempting to wield some power, albeit over herself. She continues :

> You are so powerless to change anything. I think that's what did it. I wanted to change things and the only way I could do that was by hurting myself (Pam).

Apps (1988), in a study of self-injury in women's prisons explores the complex relationship between the experience of imprisonment and discourses around appropriate femininity. She argues that while the experience of imprisonment may make women vulnerable to self-injury, the way in which *all* women are socialised to : be passive, not show anger, to cope and care for others, to be attractive to men, to be good in the home, (that is, to be acceptable women), is a key factor in understanding women's higher rate of self-mutilation in prison :

> They learn that their bodies are the most important asset they have, more important than anything else, including intelligence, on the path to achieving the rewards of 'normal' womanhood ...

> attitudes about themselves are tied up with perceptions about how they look (Apps, 1988 : 15).

Apps (1988) outlines five ways in which notions of femininity may contribute to deliberate self-injury in women's prisons. First, women prisoners are dispossessed of valued social roles (particularly, that of mother) : she is now a 'worthless woman, her body must be worthless - why not "brand" it as such' (Lloyd, 1995 : 180). Secondly, women are isolated from those encounters in which they receive positive reflections of the self : they lose self-identity and this may lead to self-injury (Apps, 1988 : 28-29). Thirdly, when women need help they may harm their bodies because, in a society which places an emphasis on specific forms of bodily appearance/attraction, women are 'always aware of [their bodies]' (1988 : 28). Fourthly, a woman who disfigures her body - her 'most important asset' - receives attention, although this is not to suggest that self-harm should be interpreted as *just* attention-seeking behaviour. Finally, women are brought up to repress their anger and frustrations (so as to cope with and care for others). Their anger is, therefore, turned inwards upon themselves : they harm themselves rather than others. In this sense, self-mutilation is a physical manifestation of women's anger.

The uncertainties and anxieties women experience on imprisonment, often related to concerns outside prison, may result in some women self-harming and, in the accounts of self-mutilating women prisoners in this study, we can see the complex interplay of factors which can lead (consciously or unconsciously) to self-injury :

> When I first came in I scratched my face and arms with a needle ... I just felt so frustrated being away from the baby, him [partner] being in prison as well, finding out I was pregnant ... I didn't know what was happening with the case, I couldn't contact anyone to find things out ... it all kind of came to a head (Tricia).

> When you cut yourself it reminds you know that you're alive, because as long as you're hurting, you're alive. It hurts like mad afterwards, but at the time ... (Discussion Group 2).

> Cutting-up is one way of getting through, of coping. When you're upset and there's no one to talk to, like when you're banged up for most of the day, you don't know how you're going to get through. I don't mean through the sentence, I mean through the next five or ten minutes (Tracy).

> I isn't really to do with attention-seeking (well not in the way that some people think). In fact, it's very embarrassing having to keep going back in order to get stitched-up. But it's difficult to stop when things get bad and the more you try to stop yourself cutting-up the worse it is in the end ... I usually feel sick afterwards and cross at myself and people think that you want to feel like that (Suzanne).

Cookson (1977), in her study of self-mutilation amongst women in Holloway, notes that self-harm has two positive effects for women prisoners : first, it distracts them (albeit temporarily) from other sources of suffering and, secondly, it provides them with a sense of some control. Liebling (1992a) argues that it constitutes one way of manipulating a hostile environment. Here, it is the issue of control, the need to gain and to assert control, that can be seen as an important factor in the development and maintenance of self-harmful behaviour, whether it be deliberate self-injury or disordered eating practices. Here, harming one's own body seems to enable the individual to gain control over the self and over the body.

Women prisoners who deliberately self-harm cannot expect sympathetic treatment from prison authorities. Liebling (1992a : 233) points to the ironic situation whereby prison staff tend to interpret self-harm as a 'cry for help' and yet help is rarely forthcoming. The women interviewed in this study described a tendency for prison staff (including medical and nursing staff) to either ignore women's self-injurous behaviour (and hence their distress) by distancing themselves from the women : 'They just seem to ignore your pain, your suffering' (Suzanne) - or to medicalise it by interpreting self-harm in terms of individual pathology (also see Scraton *et al.*, 1991, and chapter five).

Women who seriously damage themselves (or their surroundings) are often confined to the 'strips'. One woman in this study described the process :

> They took me again to the back cells. I was on a concrete slab. It's a concrete room with a concrete shelf and lights on all the time. And there are two vents which can either blow hot air or cold. And for four days they blew cold air ... I had no mattress, just a nylon sleeping bag. Every fifteen minutes they had to see me so I was woken up every fifteen minutes and I wasn't allowed to put my head under the sleeping bag or get off the concrete slab. My legs were blue with the cold, quite numb. I wasn't eating or drinking ... this sort of treatment is carrying on now, not twenty years ago, not ten years ago, but now (Pam).

The institutional response is punitive. The women's pain is denied and she is further punished[13].

Some women respond to imprisonment with the ultimate self-harm : suicide. The relationship between self-harm and suicide is complex (see Liebling, 1992a). Self-evidently, many prisoners who injure themselves, some repeatedly, do not go on to kill themselves and in the accounts of those who self-harm there is often little indication of an intention to die :

> It's not like I want to die, not really. I just want people to know how much I'm hurting (Tracy).

However, while most self-mutilators choose a 'safe' method, mainly cutting arms and wrists, a significant proportion of prisoners who commit suicide have a history of self-harm (Liebling, 1992a). The number of prisoners taking their own lives in prison has not diminished in the 1990s despite more coherent policies on bullying, self-harm and suicide and the support of the Suicide Awareness Support Unit since 1991 (Dockley, 1996a). Moreover, the rate of suicide amongst women prisoners is as high as the rate for men (Liebling, 1994). However, because of the relatively small numbers of women in prison (and hence, the *absolute* number of suicides being small) the issue has received little systematic attention : 'there has been an assumption that this problem

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[13] Women who self-harm in the community also often receive unsympathetic treatment from hospital/medical staff. Their behaviour is often interpreted as *just* attention-seeking and is effectively (and punitively) dismissed. As a student nurse, I once witnessed a woman's self-inflicted wounds being sutured without local anaesthetic.

overwhelmingly concerns men' (Liebling, 1994 : 1). Liebling (1994) argues, however, that there are specific features of suicide in women's prisons which may relate to qualitative differences in men's and women's prison experiences. She identifies a number of factors associated with suicide risk, including : a history of psychiatric treatment, previous suicide attempts, alcohol or drug misuse, socio-economic disadvantage, a history of physical and/or sexual violence (1994 : 3-4), which, together with the particular impact of imprisonment upon women (in terms of the sources of suffering previously discussed) may increase the vulnerability of women prisoners to suicide :

> The devastating and gender specific effects of custody upon a woman ... are undeniably part of the dynamics of female prisoner suicide (Liebling, 1994 : 4).

Eaton (1993 : 53) argues that 'the final act of the self is the destruction of the self'. Suicide, then, may represent the last decision taken by the denied self. Thirty out of the fifty women interviewed in this study discussed having had suicidal thoughts at some stage in their sentence and some described failed attempts. In their accounts we can see that concerns outside prison are often an essential part of the explanation for their behaviour :

> I've thought about suicide loads of times. It would an easy escape. You lose so much when you're in here - family, friends. Some die, some move on and you get to thinking sometimes, 'What have I got to live for?' (Kym).

> When I first came in I was pregnant ... they took the baby off me. I was obviously upset about that, my other children had been taken into care, I had no word whether they were OK or not ... I had a piece of glass and that was that (Angie).

> I attempted suicide waiting for the trial. After that I saw a counsellor for clinical depression. While I don't think I'd attempt suicide in here, I have thought about it. When times have been very bad, when I can't communicate with the people outside (Kirstie).

Suicide and self-harm are acts of the self turned against the self. They can be seen as extreme attempts to intervene with the self that women see shaping before them. Such actions say much for the conditions within which they occur and the sources of suffering engendered. They are emblematic of a woman's response to imprisonment. In death the prisoner has escaped and death represents the ultimate price to be paid by those for whom other strategies of response prove unsuccessful.

Finally, the governmental strategies of women's imprisonment are directed, as we have seen, at fostering certain types of subjects and certain types of bodies. These strategies *do* succeed, as is apparent in the ways some women respond to imprisonment, but not for *all* individuals, and not *all* of the time. While some women may accept a discredited self, others actively seek out strategies for maintaining positive self-images (by legitimate and illegitimate means). What is clear is that the conditions for subjective change do exist within women's prisons (Goffman, 1961). The women interviewed in his study recognised that they had indeed changed in response to the environment :

> I've learned how to stand up for myself. I've got a broader outlook. I've met different kinds of people. I know who to stay away from, who to befriend. What to do, what not to do. How to act in a certain situation. How to adapt. How to keep my cool. A lot of understanding because you meet a lot of different people with different problems. I've learned so much ... I guess I've changed. I'm a completely different person (Diane).

The strategies of prisoner response so far discussed represent women's attempts to deal with their anxieties and the threats to their self-esteem as best they can. Such responses are, in the main, ad hoc attempts to cope with day-to-day prison life. In such strategies we can recognise attempts by women to assert some independence and to hold on to a sense of self while defying a system of dependence. In prison, women are expected to be submissive and dependent and women who appear to resist 'the system' run the risk of being beaten by a regime which may change them both physically and psychologically.

Women who repeatedly kick-off (legitimately and otherwise), who use illegal substances or self-harm quickly assume a 'prison identity' which is equated with their behavioural reactions : they *become* 'smack-heads', 'junkies', 'cutters', 'slashers, 'smashers'. To them is ascribed the status 'awkward', 'difficult', 'violent', 'inadequate' - labels which *confine* the individual to the level of their behaviour, yet *confirm* a specific role for them within the prison. Such women run the risk of further punishment (the 'block', loss of days and/or privileges, transferral to another prison[14]) and psychological control (psychotropic drugs, the imposition of psychiatric labels, transferral to special hospital).

The power of the institution in denying a woman's sense of self, by redefining her behaviour, constitutes the subject of the next chapter.

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[14] In the questionnaire survey, fifty-eight per cent of women prisoners (n 125) reported being concerned about being moved around the prison system (see Appendix III).

CHAPTER 5

'Health', health care and the regulated body

> As regards health and the use of prescription drugs, I feel that prison staff, which includes doctors and nurses, seem to have an innate fear of crying, anger, sadness. So women are not encouraged to express these emotions. If they do, they are diagnosed 'depressed' and given anti-depressants, when, in reality, they are grieving (Discussion Group 5).
>
> I've seen the doctor twice recently. The first time was for the parole report and he overstepped his responsibility. Rather than asking about health and well-being, he asked me what I was in for (Darelle).

In chapter four I discussed the ways in which women prisoners respond to the imposition of state power into their lives. This chapter and the final one consider the institutional responses to women's behavioural reactions through an analysis of health care in women's prisons. This chapter is predominantly concerned with exploring the relations and power structures involved in the doctor-(woman)prisoner/patient relationship; medical dominance in prisons; the vulnerability of women prisoner-patients and their capacity for resistance. The chapter is divided into three key sections :

- 'Sick' women? : Patterns of ill-health in women prisoners;
- The utilisation and organisation of prison health services;
- Power relations and the medical encounter in women's prisons.

While the focus on the prisoner-patient's perspective is extended from previous chapters, I also consider the demands and constraints facing prison health care staff which may shape their interaction with women prisoners. In so doing, I hope to explore the complex relationship between imprisoned women and medicine.

'Sick' women? : Patterns of ill-health in women prisoners

> I think happiness comes into healthiness ... a lot of it's in the mind. If you're feeling down all the time, or you're anxious about something, then you don't feel well. I don't feel healthy in prison although I've never been really ill (Jane).

In 1946, the World Health Organisation (WHO) defined health as a 'state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity'. This definition, while oft-quoted, has been much criticised (see Downie *et al.*, 1990), not least because it is seen as unrealistically Utopian. Another criticism is that it implies a static position, whereas life and living are anything but static. For this reason, some writers argue that health means having the ability to *adapt* continually to constantly changing demands, expectations and stimuli (Ewles and Simnett, 1985).

Ewles and Simnett (1985 : 5-6) identify a number of overlapping dimensions in the concept of health :

1) ***Physical health*** : perhaps the most obvious dimension, which is concerned with the mechanistic functioning of the body.

2) ***Mental health*** : the ability to think clearly and coherently.

3) ***Emotional health*** : the ability to recognise emotions such as fear, joy, grief and anger (and to express such emotions appropriately), and the ability to cope with stress, tension, depression and anxiety.

4) ***Social health*** : the ability to make and maintain relationships with other people.

5) ***Spiritual health*** : for some people this concerns religious beliefs and practices. For others, it is to do with personal creeds, principles of behaviour and ways of achieving peace of mind.

6) ***Societal health*** : a person's health is inextricably related to everything surrounding that person and it is difficult to be healthy in a 'sick' society.

The identification of these different aspects of health serves a useful purpose in illustrating what a complex concept health is. What is evident is that health and ill-health are not just 'medical' or 'clinical' issues. Rather, a number of factors can influence the health of an individual or population : including, biological factors; lifestyle; environment; social and economic factors, and the use of, and access to, health services.

Little attention has been paid to the health status of women prisoners or to their health needs in the literature on prison health (Tomasevski, 1992). A recent OPCS *Survey of the physical health of prisoners* (Bridgwood and Malbon, 1995), conducted on behalf of the Prison Service Health Care Directorate, equates 'prisoners' with the male sentenced prison population, thereby effectively ignoring women prisoners, as well as those remanded into custody. Tomasevski (1992), looking at health care standards and practices in European prisons, argues that women's health problems and needs are not perceived as important because of the relatively small numbers of women in prison. Other writers suggest, however, that because of the low rate of offending in women, women prisoners are so unusual that they *all* tend to be regarded as 'sick' and are treated accordingly (see chapter 1).

In 1967 Professor Gibbens and colleagues conducted a survey of the health of every fourth woman admitted to Holloway prison (n=638). They found a number of what Gibbens (1971 : 281) describes as 'abnormalities in women prisoners' : among women remanded into custody fifteen per cent were found to have a major physical health problem and twenty per cent a major mental health problem. Among the sentenced population twenty-one per cent were found to have a major physical health problem and fifteen per cent a major mental health problem.

While Gibbens' work has been much criticised (Dobash *et al.*, 1986; Maden *et al.*, 1994)[1], his figures have been repeatedly used to support the contention that

[1] The full study has never been published, so it is difficult to determine what definitions and methods were used.

'women prisoners carry a greater load of physical and mental abnormality' than their male counterparts (Smith, 1984a : 631). The statistics are often supported by anecdotal accounts from prison staff. In an article in the *British Medical Journal* in 1984, Richard Smith, for example, states :

> The doctors at Holloway, some of whom have experience in men's prisons, told me that they *thought* that women's prisons had twice as many medical problems as men's prisons. And Miss Joy Kinsley, the governor, told me quite bluntly that Holloway was 'mopping up the problems that the NHS wouldn't take' (Smith, 1984a : 631, emphasis added).

Women prisoners are, according to this argument, mentally and physically 'sicker' than men prisoners (Heidensohn, 1985). There are, however, two important aspects to understanding ill-health in this setting : prison as a context into which women 'carry' their ill-health and/or prison as a possible aetiological factor in its own right.

There *are* major differences between the sexes in modern industrial societies in terms of both mortality and morbidity rates (OPCS, 1995). Women generally live longer but seem to suffer from more health problems during their lifetime than men (Miles, 1991). Research has consistently found that women experience and report more illnesses, more daily symptoms and higher rates of all types of acute conditions than men at all ages (Hunt *et al.*, 1985; Blaxter, 1985; Verbrugge, 1986; Cox, 1987).

Verbrugge (1985), in a review of health surveys conducted in the USA, found that women obtain substantially more prescription medicines per year than men in all age groups. They spend approximately forty per cent more days in bed per year as a consequence of illness on average than men and, in the age group 17-44, women have twice as many visits to the doctor and hospital stays. Men, she concludes, are more likely than women to suffer from threatening diseases and from diseases which cause more permanent forms of disability and early

death. Women, in contrast, are more frequently 'sick', although their illnesses are typically short-term and minor.

These differences may be explained in a variety of ways, some of which have been previously discussed (see chapter one). Miles (1991), for example, offers three general explanations : *genetic, artefact,* and *social causation.*

According to genetic explanations, sex differences in morbidity and mortality are influenced by a range of biological factors. Waldron (1982, 1983), however, in a review of the evidence, found that while genetic factors may contribute to differential morbidity patterns, they do not, *on their own,* provide a complete explanation. Thus, for example, differences in reproductive anatomy and functioning may have an important bearing on differences in patterns of illness between men and women. However, as Waldron argues, the effect of a given genetic factor on ill-health also crucially depends on the environmental conditions, including, in this example, the availability, nature and practice of obstetric and gynaecological services.

The second general explanation poses that differences are apparent rather than real, the supposition being that while women's health is no worse than men's they may be more inclined to take notice of symptoms and readier to consult doctors and to undergo treatment. This willingness to report may be the result of a greater ability for women to verbalise complaints as 'sickness'. Women may also recall their health problems in a more precise and exact manner than men (to doctors and to researchers). Thus, there may be differences in the 'vocabulary of illness' available to men and women (Turner, 1987 : 109). Women may have more developed vocabularies of complaint in relation to the 'sick-role' within a culture which *expects* women to verbalise their health problems. Finally, doctors may be trained into a medical culture which emphasises the health problems of women, effectively constructing *women as patients,* and labelling women as *sick.* Here, there may exist a vicious circle where women report their symptoms more frequently and more readily than

men and medical practitioners are trained to expect women to so describe and discuss their experiences. The expectation and the behaviour are, thus, mutually reinforcing.

The social causation thesis argues that certain aspects of women's (and men's) lives render them more, or less, vulnerable to ill-health and that different kinds of lives lead, in complex ways, to different patterns of illness. Miles (1991) points out that not all women's lives (nor all men's) are the same and not all women in a given society experience the same degree of ill-health. Social class, (un)employment, marital status and ethnic origin all greatly influence the extent and nature of morbidity (see, for example, Townsend and Davidson, 1982; Whitehead, 1988). High levels of ill-health amongst women, have thus been attributed to the various pressures women face which make them more vulnerable to ill-health : the deprivations, both material and social, which many women experience and the stress of caring for others, with few resources and in unsuitable conditions.

In accounting for sex differences in ill-health, feminist writers have frequently been criticised for wanting the best of all worlds (Sedgwick, 1982). On the one hand, some writers proffer artefact explanations, tending to see the labelling of women as 'sick' as evidence of patriarchal power (Chesler, 1972; Ehrenreich and English, 1979). On the other hand, some writers contend that the observably high levels of ill-health in women illustrate how women's oppression makes them 'sick' (Oakley, 1974; Brown and Harris, 1978; Orbach, 1986). These two explanations are not, of course, mutually exclusive. In practice, they converge on one issue, summed up by Turner (1987) :

> Medical disorders are associated with low social status and the absence of power where medical doctrines, because they reflect dominant values, tend to express and reinforce existing hierarchies of control (Turner, 1987 : 110).

This issue is fundamental when considering women's health in prison. As *women* coming into prison - as predominantly poor *women*, as divorced and

separated *women*, as lone parents, as unemployed *women*, as substance-using *women*, as black *women*, as abused *women* - they are likely to 'carry' certain health problems, whether socially produced or socially constructed, in with them. This, then, raises fundamental questions about whether prison can mitigate such problems or whether conditions are such as to make them worse and perhaps even create a few new ones. These questions will be addressed by looking at three key areas of women's health in prison : their general health; their reproductive health, and their mental and emotional health.

The general health of women prisoners

There is little detailed information on the general health status of the prison population[2]. The collection and recording of health information tends to be limited to the initial medical examination conducted on reception. As a consequence, there is a lack of information on the health of prisoners *leaving* prison, and so the health effects of imprisonment are difficult to determine.

There are many reasons for this lack of information, not least the status of health problems and health care in prison : prison health is marginal to *both* prison and to health (Tomasevski, 1992). It may, of course, not be 'cost-effective' to collate detailed information on prisoners' health given the average length of prison sentences. Moreover, information collected 'in house' may not be available for public scrutiny. There is also a discrepancy between the image of the prison population being pre-dominantly young, male and 'healthy', and the available data on the health status of prisoners which suggests that they are relatively 'unhealthy' when compared to the general population (Bridgwood and Malbon, 1995). This paradox is further reinforced by data on the use of health services by prisoners which indicate that prisoners utilise health services to a greater extent than the community averages (I discuss this in more detail below). Finally, because all issues of prison health are influenced

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[2] This is not just a feature of the British prison system. Tomasevski (1992 : 8), in her study of international standards and practices in Europe, argues that systematic 'information on prison health - both on the health needs of inmates and on ways of meeting them through the prison and/or health administrations - is woefully lacking' in most European countries.

by imprisonment, the 'over-use' of health services during imprisonment may not necessarily reflect health status. However, the lack of systematic data prevents any debate on the extent to which the *actual* utilisation of services reflects *genuine* health needs.

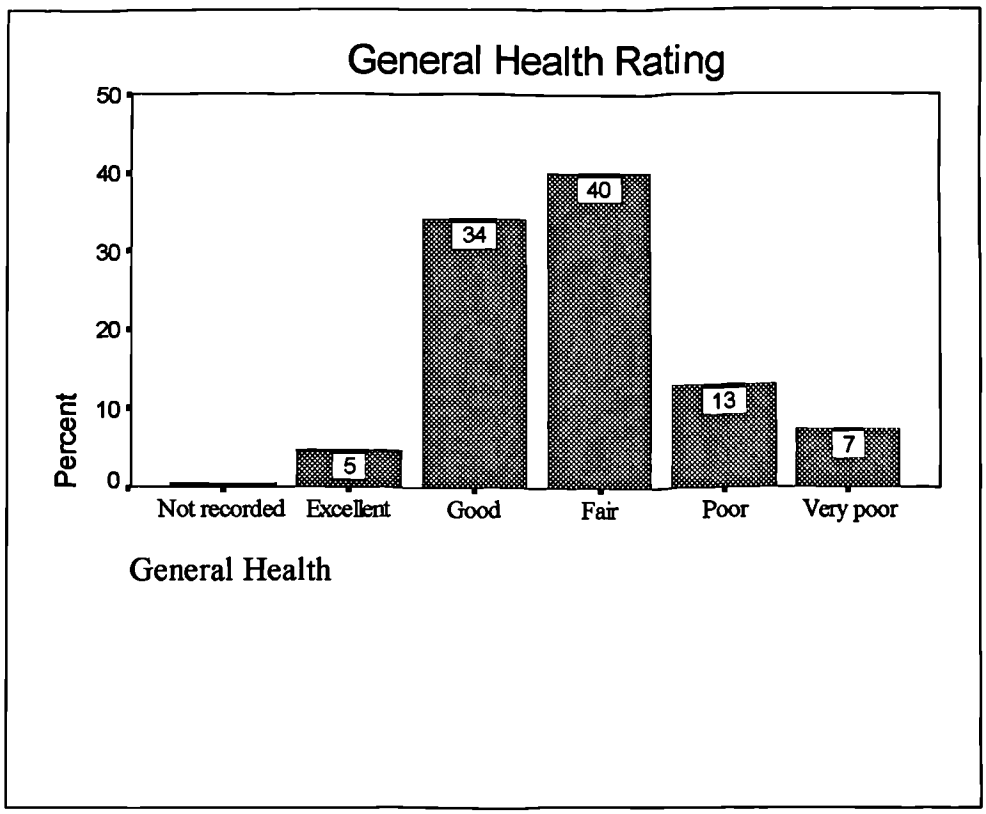
Alternative sources of information include non-governmental agencies working for and/or with prisoners (for example, NACRO, The Prison Reform Trust, Physicians for Human Rights, The Samaritans) who generate some information on prison health and, of course, prisoners themselves. The women interviewed in this study were all asked to describe their general health. In their responses, the women identified a number of factors contributing to whether they considered themselves to be 'healthy' or not :

> CS : How would you describe your general health?
>
> Disastrous. When what happened happened, I got a collapsed lung through stress ... so that set off asthma. And the more stress you get, the more asthma you get (Emma).
>
> I've always thought of myself as being relatively healthy. But in here, the stress, the lack of control, everything adds to how you feel. I wouldn't class myself as healthy in here (Mair).
>
> I'm as fit as can be expected under the circumstances (Fiona).
>
> I'm all right but I do feel a bit depressed sometimes. Not so that I would do any damage to myself or anyone, just a little low (Sylvia).
>
> Well I'm not a fit person ... you can't do what you would do at home. You can't go for a walk on a nice day. You're stuck in (Debbie).
>
> If it's bad weather, you're down and depressed thinking 'another day here' and then your thoughts turn. Then when it's nice, you're thinking 'I could be down the parks with the kids'. So you see you never feel well, really well (Angie).

In the questionnaire survey thirty-nine per cent of women prisoners (n=83) said that their health in general was 'good' or 'excellent'. The majority of women

considered their general health to be 'fair' (see Figure 5.1)[3].

Figure 5.1. Self-reported general health.



Fifteen of the fifty women interviewed in-depth and just over a third of the women in the questionnaire survey (35%) said that they had a long-standing illness, health problem or handicap[4]. The most common problems among women prisoners were menstrual disorders, anxiety, depression and/or bad nerves, musculoskeletal complaints and respiratory problems, particularly asthma (see Appendix III). These are also the conditions most frequently reported by women in the general population (Miles, 1991).

The women also reported a range of minor health problems (collectively described by those interviewed as 'gaol grey' or 'gaol pale') which are categorised under the International Classification of Diseases as 'symptoms,

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3 In the OPCS survey sixty-one per cent of male prisoners considered their general health to be 'good' or 'very good' (Bridgwood and Malbon, 1995).

4 Almost half of the men in the OPCS survey (46%) reported having a long-standing illness or disability.

signs and ill-defined conditions', which include headaches, fatigue, tiredness, nausea, and skin eruptions (see table 5.1).

Table 5.1. Percentage of women prisoners reporting having had the following symptoms in the past two weeks (questionnaire survey)

	n	*Percentage*
Persistent cold/flu	73	34
Skin problems	88	41
Persistent cough	55	26
Diarrhoea or sickness	33	15
No appetite/off food	64	30
Difficulty sleeping	136	64
Feeling tired	133	62
Sore throat	46	22
Constipation	55	26
Headache	121	57
High temperature	17	8

The women interviewed related such symptoms to many of the features of prison life, including the food, overcrowding, poor ventilation and heating, a high turnover of prisoners, and 'the stress' :

> If one gets something, we all get it. There is no fresh air, no vitamins in the food. It takes its toll on your health. You become lethargic, just sitting around doing nothing. It's very very boring in here (Mair).

> Whenever I'm stressed the spots come out. I've never had so many spots in all my life. I had a headache for about three months on the trot, every day (Darelle).

> I've had a lot of headaches, but that's stress and tension and things (Anwen).

> I've felt sort of run down but that's probably due to the stress and being here ... like ulcers that I normally get if I'm a bit low (Ann).

> I get mouth ulcers, spots, my nails stopped growing and they break easily, a lot of colds. I feel drained and they say it's all normal (Kym).

While there are many features of the prison environment which are potentially disadvantageous to health, attention has tended to be focused on the physical conditions, particularly the problems of overcrowding and insanitary conditions.

A key goal of the Prison Service is to 'provide decent conditions for prisoners and meet their needs, including health care' (Prison Service, 1995a). As outcome measures by which to judge the Service's success, or not, in achieving this goal, two 'key performance indicators' (KPI) have been chosen : 'the proportion of prisoners held in units of accommodation intended for fewer numbers (KPI3), and, 'the number of prisoners with twenty-four hour access to sanitation' (KPI4).[5]

The problem of prison overcrowding has been well articulated, particularly in relation to the male prison population (see, for example, King and Morgan, 1980; King and McDermott, 1989, 1995; Stern, 1987), and, as King and McDermott (1995) point out :

> There can be no doubt that successive prison administrators and virtually all commentators have attached great importance to finding a solution to the problem of overcrowding, seeing it as the foundation stone upon which decent prison conditions might be built (King and McDermott, 1995 : 150).

In the current study, two of the prisons within which the research was conducted were, throughout the fieldwork period, consistently over their Certified Normal Accommodation (CNA) limits[6]. Moreover, the issue of overcrowding in women's prisons is further complicated by the fact that many

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5 Interestingly, there is no KPI by which to judge the standard of health care.

6 Askham Grange, an open prison, often functioned below the limit of it's CNA. This seems ironic given that most women in prison are non-violent offenders, are serving sentences of less than three years and are without a history of absconding - the criteria for allocation to open conditions.

women are accommodated in 'dormitories'. Here, space (physical and personal) is often limited :

> There's six in the room including myself ... I'm upstairs on what they call 'the ward'. This is the best room, the penthouse. It has its own 'bathroom' [laughs] ... I think that's the worst thing, having to share your personal space with someone you have never met before in your life, didn't want to meet and know ... We have an unspoken law that everybody's bed is an island and when someone is on their bed that is their personal space ... that is the only piece of space that you get that you can call yours.... We also have unspoken rules about when to make eye contact with people. If you went into a room and somebody is sat on the loo and you are sat on the bed, then you make a point not to make eye contact, even though you are in the same room. You try to give them that personal space. It is almost as if you can have that pretend moment of privacy because there is nothing private in prisons (Carolyn).

> You can't escape. There's about six of you in a dorm, so you know it's not even like being in a single cell where you can slam your door at night and just cry your eyes out for three hours. You can't even do that here (Jane).

While some prisoners may, for a number of reasons, prefer to share cells/rooms, few enjoy the close proximity of one prisoner to another and the lack of privacy and space which characterise the 'dormitory experience'.

In 1980 King and Morgan argued the case for an objective space standard by which to measure the extent of prison overcrowding (the current measure of overcrowding relates to the *proportion* of prisoners sharing accommodation meant for fewer prisoners), and, in 1994 the Prison Service issued its new *Code of Operating Standards* in which it was stated that :

> The minimum size of a cell or cubicle for refurbished accommodation should be 5.5 square meters (HM Prison Service, 1994).

The standards act merely as 'benchmarks', however, and since March, 1996, women prisoners have been accommodated in cells at the refurbished

Eastwood Park which measure thirty per cent smaller than the minimum size laid down in the official standards (*The Observer*, 25:2:96; Sampson, 1996). Sampson (1996) questions whether adult male prisoners would have been treated in this way. He argues that it represents another instance of women's interests being sacrificed or ignored in the name of short-term expediency. Given the present trends in sentencing, more women are now being imprisoned and will be imprisoned in the future in cramped and overcrowded conditions, a point made by one prison officer interviewed in this study :

> We're under so much stress to make spaces here. No female must ever be locked out of the system. Therefore, we have to make sure that there are beds for them all the time. If you've been round, you've seen the state of the houses. I mean would you like to live in them? (Senior Prison Officer).

Sanitary conditions for both men and women prisoners have generally improved in recent years, although insanitary conditions have been reported on mother and baby units (*The Guardian*, 12/3/92), and the decision by the new chief inspector of prisons to pull his inspection team out of Holloway in December, 1995, was due, in part, to a deep concern about the physical conditions within which women prisoners were accommodated (*The Guardian*, 20/12/95).

Complaints about the toilet and bathroom facilities loomed large in the accounts of the women interviewed in this study. They also described the problems for menstruating women, particularly the assaults to a woman's sense of personal privacy resulting from having to ask for sanitary towels and tampons :

> There's a total lack of privacy and it's very difficult when you've got your period and you have to go to the loo all the time ... on our landing there's two toilets to forty women and four baths between sixty (Brenda).

> You have to ask for towels when you're on, when you need to go and change ... I don't know about you, but I'm really funny

about things like that, I'm a really clean person so I like to change myself quite often and it gets really embarrassing (Lyn).

Having your period is embarrassing. You have to shout for a guard to bring sanitary towels and you can't keep the packet just take a few out. It's embarrassing especially if it's a male guard (Beth).

I hate having a bath. At home I was always in the bath, I loved it. But here, you don't know who's been in it before you ... well, sometimes you do and that makes it worse. You don't know whether they've cleaned it properly or anything. People have different standards of personal hygiene and mine are quite high (Pippa).

The toilets and showers are disgusting. The other day we found someone's works in the bath ... the needle was sticking out of the plug hole (Judy) .

When the girls are turkeying [coming off drugs] ... and you've got to go to the bathroom, you go in and there's sick all over it and nobody cleans it up. They don't clean it up. It's just all over and it's the same week out, week in (Emma).

The government's commitment to the ending of 'slopping-out' has recently been met (*The Guardian*, 13 April, 1996), meaning that all prisoners now have twenty-four hour access to sanitation, either through an unlocking system or through the installation of sanitary facilities in each cell/room. For those women in cells/rooms with integral sanitation, this can be something of a mixed blessing, however :

I guess there's more dignity than having to slop-out but there's not much dignity knowing that you're living and sleeping and eating in your toilet (Jan).

The toilet hasn't even got a lid on. Now I think that's disgusting myself. Some of the loos don't flush properly, so ... it's like living in a septic tank (Discussion Group 2).

I sit here sometimes just staring at the toilet (because there's nowhere else to look) and I just feel as if that says it all. It's as if my whole life is going down that toilet ... it's kind of symbolic (Debbie).

There has been little detailed and systematic research on the physical and/or psychological effects of being imprisoned in such conditions (Tchaikovsky, 1993). King and McDermott (1989) argue, however, that the impact of the physical environment is likely to vary depending on the nature of the regime within which it is rooted. The Women's Equality Group/London Strategic Policy Unit (1986 : 164) illustrate this point with reference to women serving long sentences in Durham's H-Wing :

> All women there are kept under constant and mind-numbing surveillance ... The toilets for day time use have only half doors, denying women any privacy.... Prisoners from Durham's H Wing have said that the physical and psychological effects of being imprisoned in such conditions are considerable and include loss of hair, disorientation, debilitating depressions, apathy, loss of weight, and sight problems.

Some of the women interviewed in this study similarly reflected on the claustrophobic 'H-wing experience' and the impact on their health :

> Durham was beyond hell. There is nothing that can compare. Nothing can stimulate me to say a good thing about the place. It's a tomb. You live in a tomb. There's no proper air or lighting. I came here grey and pasty, as if locked in a dark room for some time. That's how you live, no air, it's stagnant. I thought, 'if this is H-Wing, God help me about hell' (Kym).

> Styal is like paradise (in inverted commas) compared with Durham. Durham is so inhuman, it's unbelievable. They try and absolutely destroy you at Durham.... When I first went in it was like I'd been entombed and I didn't know when I was going to see daylight again. Before I left I started losing a lot of weight because it was just so, you know (Olga).

At the end of the eighteenth century British prisons had their own disease - gaol fever, a form of typhus. At this time, conditions in prisons were particularly grim - insanitary, dirty, overcrowded and with limited facilities[7].

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[7] It was John Howard's campaigns for reform at this time which resulted in the 1774 *Act for Preserving the Health of Prisoners in Gaol and Preventing the Gaol Distemper* (Howard League, 1990). Howard advocated the appointment of a doctor to each prison and such an appointment become a statutory requirement in 1823, some years after his death.

While there have been major improvements in the physical conditions in British prisons since the days of gaol fever, imprisonment, it seems, remains prejudicial to good health :

> I think my health has deteriorated since I came in here. Stress is always a big factor with your health. I think you are always under stress because of the cramped conditions you live in. You put human beings in blocks of flats or any cramped conditions and you are going to get problems ... Today we have forty-seven in and I believe this gaol should take thirty-six, so we are up on numbers to start with. The exercise yard is small and there is nothing to do ... we get half an hour's exercise in the morning and half an hour in the evening, providing the weather is good, which is nowhere near enough. I mean if you look at the RSPCA dog kennels, by law every kennel has to have an outside run that the dog can get out into twelve hours a day. The RSPCA are treating its animals a lot more humanely than the prison service (Carolyn).

Reproductive health : Women's problems or problem women?

> They think I'm going through the change of life. I don't think I am but that's not important ... When I'd been in this prison for three years I went to see [MO] who said, 'When are you going Home? I think you're pregnant'. Now that would have been a miracle, wouldn't it [laughs] (Karen).

While women prisoners in this study described a range of general physical complaints, gynaecological problems appear to be widespread. In the questionnaire survey forty-eight per cent of women (n=102) reported having menstrual or menopausal problems and the women interviewed variously reported increased pre-menstrual tension (PMT), painful menstruation (*dysmenorrhoea*), excessive menstruation (*menhorrhagia*) and the complete cessation of menstruation (*amenorrhoea*) :

> My periods have always been erratic, but they got heavier when I came into prison. It got to the stage where I was having permanent periods. After several D and Cs, I had a hysterectomy (Kym).

> What I have found while I've been in prison is that your periods go all to pot. It could be to do with stress, depression. What a lot of us have noticed - there's sixteen of us living on one house - and we all tend to start our periods at the same time. I've heard it happens with nuns as well! (Olga).
>
> My periods didn't stop when I came into prison. Some do, it's the shock. At Durham, mine ... I had three periods in a month and they took me to hospital and they operated on me (Sue).

Genders and Player (1988 : 153), similarly, found a high level of menstrual complaints amongst women serving long sentences at Durham's H-wing. They also point to the seemingly high number of hysterectomies carried out and the 'consequent anxiety which a gynaecological referral generated in the women'. The women in the current study described a range of medical interventions, treatment for various menstrual problems : from hormone therapy, dilation and curettage (D and C), through to partial and total hysterectomy.

There are, however, a number of difficulties in interpreting women's reports of menstrual symptoms. McKeown (unpublished, 1994 : 4), in an in-house study of the differences in the effect of imprisonment on women versus men, argues that 'another dimension of stress for a female in prison is linked with gynaecological and hormonal problems which seem to surface when a woman's life slows down and she has time to dwell on these problems and become introspective'. It may well be, therefore, that imprisonment sets up the circumstances in which women are more likely to reflect on menstrual symptoms and to define them in terms of illness.

Schneider and Conrad (1980) argue that women's accounts of menstrual change, their perceptions of normality and abnormality, should be viewed against a backcloth of the 'menstrual taboo', which remains a feature of patriarchal societies such as Britain and the USA. In such societies, early socialisation engenders girls to anticipate and experience the commencement of menstruation - 'the curse' - with apprehension, rather than seeing it as a *rite de passage*. Laws (1990), in her study of male and female perceptions of

menstruation, similarly, argues that the language of white male British culture - usually derisory, crude and sexist - serves to maintain the requirement that women remain publicly silent about menstruation. She concludes that there are a number of aspects to male perspectives of menstruation, all of which are based on a view of women as inferior to men. First, menstrual blood is seen as offensive - the butt of schoolboy humour. Secondly, the connection between sex and menstruation - many men express revulsion at sexual intercourse during a woman's menses (Arnot and Jackson, 1996) - emphasises the way men view women as existing to service male sexual desire. Thirdly, men see women as ruled by their hormones : moody and less reliable as a result of their menstrual cycles (Laws, 1990).

Trained to perceive menstruation as something unpleasant, undesirable and to be concealed, women seem quick to reflect and reproduce cultural stereotypes by associating it with distress, often with symptoms of illness. The experience of unpredictable menstrual change (or the symptoms associated with it such as psychological or somatic discomfort), may consolidate this perspective[8], increasing the likelihood that women will seek medical attention.

Issues of interpretation are not, of course, confined to women themselves. In biomedical-speak, menstruation depends on :

> [A]n intact hypothalmic-pituitary axis, normal ovarian function, a functionally responsive uterus and an intact outflow tract, i.e. cervix and vagina. A disturbance of any one of these components may result in disordered menstrual function (Elder, 1988 : 34).

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[8] Here, it is interesting to note the findings of another in-house study of the 'Cross Cultural Perceptions and Experiences in the Pre-menstruum' of women prisoners at Styal (Fleming, 1992) : British women reported more physical and emotional changes and more cyclic changes than the African, West Indian and South American women in the sample. These findings, according to Fleming, uphold the theory that PMT is a Western culture-specific disorder.

In practice, however, the menstrual cycle is less well understood by physicians than is commonly assumed and medical understanding of disorders associated with menstruation is also limited (Laws, 1990; Scambler and Scambler; 1993).

Scambler and Scambler (1993), in a detailed study of menstruation and menstrual disorders, explore the nature of those medical diagnoses which form the basis for 'appropriate' medical intervention. They point to the considerable variation of blood loss amongst women in general, but note that medical diagnoses (which are commonly followed by various forms of drug therapy and sometimes surgery) are often contingent upon women's subjective assessments of blood loss rather than on objective diagnostic measurements. They argue that women's own assessments rarely correlate with actual measured blood loss and question, therefore, the value of diagnostic concepts such as menorrhagia. Here, the important point is that there is no clear dividing line between normal and abnormal blood loss. The legitimacy of diagnostic processes (as established on an assumption of scientific actuality) is, therefore, mootable.

Providing an historical overview of medicine's treatment of women, the Scamblers (1993 : 13) go on to argue that medical perspectives on menstruation are 'neither wholly scientific nor wholly neutral' but contain elements of *negativity*, *uncertainty* and *irrationality*. They sum up their commentary in terms of four key themes which pertain to the discussions on woman, medicine and social control discussed in chapter one.

First, they argue that the institution of science, as a social institution, is neither fully autonomous nor fully value-neutral. Secondly, and relatedly, medicine, even at its most 'scientific', reflects and reproduces patriarchal values. Here, the Scamblers point to the *negativity* in medical perspectives on menstruation, which, they argue, is to be found deep in its 'models and metaphors' as well as in the attitudes of its practitioners. This, however, is not merely a reflection of medicine's entrenchment within patriarchal culture. Medicine also serves to legitimise and reproduce that culture : on the one hand, medicalising and

de-medicalising menstruation in response to third-party influence (for example, the need for women workers), and, on the other hand, constructing menstrual disorders in line with 'folk wisdom' to prevent women becoming practitioners (Ehrenreich and English, 1974; Sayers, 1982).

Thirdly, menstruation, like other female reproductive processes, represents a prime candidate for medicalisation (Miles, 1991, Hunt, 1994). This owes much to the continuing medical *uncertainty* about the menstrual cycle and disorders associated with it (Laws, 1990). Such uncertainty provides physicians with considerable freedom to apply diagnostic labels and to treat 'menstrual disorders'. The Scamblers (1993) argue that medical *irrationality*, in this context, is a function of the 'already increasing medicalisation of menstruation against a background of uncertainty'. Here, a lack of any clear differentiation between 'normal' and 'abnormal' menstrual phenomena is significant because, effectively, *any* presenting menstrual problem can potentially be diagnosed as 'menstrual disorder'.

Finally, women can find themselves in a catch-22 situation in their dealings with the medical profession over menstruation and menstrual disorders, not least because of this tendency towards medicalisation. The medical perspective on menstruation seems to be an amalgam of *male* science and *male* folk wisdom, creating a number of unresolved tensions. There is, for example, a tension between an acknowledgement that menstruation is normal and natural for women and a willingness to define and treat it as pathological. In effect, women who pursue medical 'treatment', thus seem to affirm that what is biologically *normal* is socially and medically *unacceptable* (Scambler and Scambler, 1993).

Sayers (1982 : 124) has pointed out that menstruation, like other female biological processes has 'real effects on women's lives and these effects are not to be dismissed as merely the result of the ideas that societies entertain about it'. However, the broader *experience* of menstruation and menstrual disorders

can be seen as a result of a complex interplay between bodily sensations and social and cultural expectations. For women prisoners, bodily changes are often perceived to be due to the stresses and pains of imprisonment :

> My periods went all to pot, but I think that was due to the stress and everything. You know, coming in here, having to sort everything out (Jan).

However, conditioned to interpret such change in terms of illness, to regard it as problematic, women are more likely to help-seek. Here, the issue of gender, which has invaded the medical perspective on menstrual disorders, creates difficulties for women in their dealings with the medical profession which, together with the progressive medicalisation of menstrual phenomena, can have serious implications for women's 'treatment' :

> So I went to see the MO and he put me on a course of tablets, you know, to make them more regular. I've also got a hospital appointment booked for a what's it called? ... a D and C (Jan).

Research evaluating the outcome of medical treatment for menstrual disorders is limited. Coulter (1991 : 129), in a review of the studies which do exist, concludes, that 'they present a fragmented and inconclusive picture'. In a summary of the costs versus the benefits of hysterectomies in cases of menorrhagia, Coulter states :

> On the benefit side, the operation will result in the cessation of menstrual bleeding, thus removing the problem for which she sought help; she will no longer have to worry about contraception; she will no longer run the risk of uterine cancer; and there may be other social and psychological advantages to her. On the cost side, she will have to undergo a major operation with associated risks to mortality, morbidity and complications ... she will no longer be able to bear children; if her ovaries are removed at the same time, she will undergo an immediate artificial menopause, and she will probably have to undergo a course of hormone replacement therapy with other associated risks; and she may risk other social and psychological complications (Coulter, 1991 : 125).

On current rates, at least twenty per cent of women in the general population (England and Wales) will have a hysterectomy before the age of 65. However, it has been found that about a third of all uteri removed at hysterectomy are pathologically normal (Scambler and Scambler, 1993).

Mental and emotional health

> I feel like I could leave here to an asylum because it's sending me round the twist. Yet, I know I won't. I'll have the odd down day but basically I'm not going to allow that to happen. As long as I remember that and work on it I'll survive (Kym).

So far in this chapter I have been primarily concerned with the experience and interpretation of physical symptoms with little reference to emotional and mental health. For most people, however, a sense of personal identity and of uniqueness (that is, the factors which mark us as distinct types of human beings with various personality traits) lies predominantly in the mind (Skrabanek and McCormick, 1989). While physical illness may damage one's self-image (see Charmaz, 1983), it does not necessarily threaten one's fundamental sense of self. Mental illness represents a much more personal threat in that it implies that it is the very self that is diseased.

Women prisoners are generally believed to have a high incidence of mental ill-health (see, for example, Turner and Tofler, 1986). To support this theory, it is frequently pointed out first, that there is a high rate of disciplinary offences committed in women's prisons, secondly, that there is a high rate of deliberate self-harm, and thirdly that a disproportionate number of psychotropic drugs are prescribed and consumed in women's prisons. But, do these factors mean that women prisoners are more likely to be mentally abnormal than men? If so, is this because women sent to prison are already disturbed or because imprisonment, being a more oppressive experience for women, drives them into mental disorder? Alternatively, can mental illness be viewed as a label inappropriately applied to women in general, and to women prisoners specifically, as a means of social control?

In support of the first contention is the widely-held perception of women prisoners as 'abnormal' women. Here, the low rates of offending in women and their relatively small numbers amidst the prison population have contributed to the tendency to assume that abnormality in a *statistical* sense can be equated with abnormality in a *psychiatric* sense (Maden *et al.*, 1994). In this viewpoint, we can recognise a number of the *assumptions* about women offenders which were noted in previous chapters. But what of the empirical evidence? Does the available evidence support the contention that women entering prison *are* more likely to be mentally abnormal than their male counterparts?

The main empirical evidence remains Gibbens' reception survey of women entering Holloway, which, as we have seen, reported 'mental ill-health' as a 'major problem' in fifteen per cent of sentenced women and in twenty per cent of those women remanded into custody (Gibbens, 1971 : 281). Gibbens concluded that women in prison have high rates of psychiatric disorder. A more recent study by Turner and Tofler (1986 : 652), of women admitted to Holloway, similarly concludes that 'there seems to be high psychiatric morbidity among women brought to Holloway'.[9]

Morris (1987) points out, however, that psychiatric morbidity in male prisoners is also high. Indeed, a study by Gunn *et al.*, (1978) found that twelve per cent of sentenced men had a history of psychiatric inpatient treatment.

There are, of course, a number of important caveats which should be noted when extrapolating from such 'evidence', not least because there is little agreement as to what constitutes mental or psychiatric illness. The criteria which are used for the diagnosis of mental illness are vague and there is little objective agreement between different schools of psychiatry (Skrabanek and McCormick, 1989). Skrabanek and McCormick, (1989 : 77) argue that the diagnosis of mental illness is largely made on the basis of *unusual* or

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[9] While Turner and Tofler (1986 : 652) recognise the limitations of their data, they conclude that the results are 'likely to underestimate the cohort's *potential* psychiatric morbidity' (my emphasis).

unacceptable behaviour : 'unusual sadness is depressive illness; unusual worry, anxiety neurosis; ... excessive or unacceptable use of drugs, alcoholism or addiction'.

Diagnostic uncertainty allows psychiatrists (and researchers) considerable freedom to categorise a whole range of behaviours as psycho-genic, and, effectively, *any* behaviour can potentially be so defined. Turner and Tofler (1986), for example, used drug-use, self-harm and a history of psychiatric treatment as *indicators* of psychiatric disorder in women prisoners. Other studies use different indicators and different methods of obtaining data, making comparisons of dubious value.

Maden *et al.*, (1994) argue that there is a need for a study in which identical methods are applied to comparable samples of men and women in prison. Indeed, in their survey of women prisoners they included a sample of the male sentenced prison population for comparison purposes (262 women and 1751 men). In brief, they found no significant sex differences in rates of psychoses and whilst women had a higher prevalence rate for some disorders, (mental handicap/learning difficulties, personality disorder[10], neurotic disorders and substance abuse), women were outnumbered by men in *all* diagnostic categories (that is, overall prevalence rates).

While there is, then, some evidence of mental ill-health amongst women (and amongst men) in prison, the available evidence suggests that this is only true for a *minority* of prisoners. Maden *et al.*, (1994 : 188), describe the needs of 'a handful of severely disturbed' women prisoners and raise questions about the efficacy of global psychiatric 'treatment'. Most women in prison are not disturbed and many resent a regime which, for them, seems inappropriate :

> A few weeks ago ... I was just laid down and I burst out crying and I didn't even know what for ... And I was crying and crying and people must have thought 'God, she's cracking up'. And,

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[10] See Carlen (1985) for a critical discussion of the inappropriate and contradictory application of the label 'personality disorder'.

> one of the officers says, 'Shall I take you over to the health centre? Shall we put you on the hospital for the night? We can get you some tablets'. I said, 'Look, I'm crying, I'm upset. I don't need a shrink and a tablet. I'm just upset'. But they can't see that and they can't handle that. And all you're doing is lying down and having a cry. What other emotion have you got? I mean what can you do? You can't sort anything out (Diane).
>
> Over the years I've become very aware of a situation where women who really need help don't get it - there's two guys here now, trained psychiatric nurses, and there's girls on Brown House who desperately need that kind of help but they don't bother with them - and yet the rest of us, if we show any sign of emotion then it's a prescription for pills and a referral to the shrink (Sue).

The second argument, that women find prison more oppressive than do men and that its effects are more traumatic for them has widespread support, not least because of the continued evidence of their behavioural reactions (see chapter 4). Here, it is suggested that the nature of protest in women's prisons - specifically violence and self-harm - is fundamentally different from that found in men's, and that this reflects the disturbed nature of the majority of women prisoners. In this argument, we can see an implicit assumption that women's behaviour, like unusual or unacceptable behaviour by male prisoners (such as *excessive* violence), represents irrationality in the face of rational regimes (Scraton *et al.*, 1991). On the other hand, however, the strategies of prisoner response discussed in the previous chapter may well be considered sane and rational responses to circumstances. They are certainly responses which women prisoners themselves recognise as important to their survival.

Sapsford (1981) argues that it is difficult to conceptualise 'rational' or 'realistic' behaviour in prisons because of the contradictory pressures facing prisoners :

> The inmate is faced with the impossible task of adapting simultaneously to two worlds; [s]he must 'fit in' with the life of the institution, but [s]he must also remain fit for the outside world (Sapsford, 1981 : 69).

Sapsford (1981) suggests that, in order to do this, *being* anxious may, paradoxically, be the best strategy : anxiety reminds the prisoner of the 'incompatible worlds' of which he or she is to be a member. Thus, in order for a woman to hold on to a sense of self, to avoid the acceptance of a discredited self, *remaining* anxious may serve a useful purpose. When a prisoner is no longer anxious, it is likely that they have ceased in their attempts to secure a positive self-image.

In the questionnaire survey, forty-seven per cent of women prisoners (n=100) reported having problems with anxiety, depression or bad nerves. Moreover, anxiety does not seem to decrease with time : the women lifers interviewed in this study described a sense of 'permanent suspended apprehension' (Discussion Group 5) :

> The day I wake up in the morning not feeling anxious will be the day I know I've got no hope (Kym).
>
> Being on edge reminds me that I'm functioning at least. It reminds me that all of this is not a normal experience (Angie).

There is much evidence to suggest, that *both* men and women prisoners suffer a great deal of anxiety and distress. Whether one looks at Goffman (1961) on mental hospitals, or Cohen and Taylor (1972) on long-term maximum security prisoners, or Morris and Morris (1961) on short-term prisoners in Pentonville, or Scraton *et al.* (1991) on long-term prisoners at Peterhead, or Genders and Player (1987; 1988) on women lifers in Durham H-wing, or Carlen (1983) on women's imprisonment in Scotland, or, in fact, any prison-based research, a familiar pattern emerges : imprisonment *is* a stressful experience :

> It's the stress. You are under continual stress. You're worried, well I am, I'm worried all the time. If I don't do this right, you know, I'm going to get into trouble or I might upset that person and it might cause a nasty atmosphere and ... on the other hand, I'm thinking about things outside (although I try not to). Where my children are, whether they're all right, whether they ever think about me, things like that ... You can never escape from

> the stress in here. It's all around you. Even when I'm asleep I think I'm stressed (Olga).

For women, the stressful features of prison life relate to concerns both inside and outwith the prison walls, and, more fundamentally, to dominant ideologies around appropriate femininity. And, the ways in which they respond to such stress tends to be itself socially mediated rather than pathologically determined. This then raises fundamental questions about the *identification* and *interpretation* of mental illness within the prison context. While we have explored the potential *causes* of mental and emotional ill-health, it is important now to examine the *responses* to it, and it may well be that it is in the institutional response to women's behaviour that sex differences lie.

The most commonly cited data in support of the claim that most women in prison are suffering from some form of mental disturbance are the statistics relating to the use of psychotropic drugs in women's prisons. However, this is not a clear cut issue and there is a need to provide some understanding of how women get started on such drugs; what pressures exist to continue with their use, and how far the prescribing doctor associates their usage with mental disturbance. These questions will be explored in the remainder of this chapter within the context of a wider discussion of women prisoners' help-seeking behaviour, their use of prison health services and the nature of the doctor-patient relationship in women's prisons.

The utilisation and organisation of prison health services

The woman prisoner who finds herself beset by concerns, who is unhappy or who is no longer able cope, or to conform, appropriately is likely, eventually, to come into contact (by design or by default) with the prison medical enterprise where she may well be given a psychiatric label and/or be offered a medical 'solution' for her problems.

There is evidence of a tendency for prison officers to medicalise women's problems and to push women towards health professionals rather than deal with problems 'on the wing'. Here, women are often referred to prison health services not so much for advice and/or treatment, but rather for 'containment' on the hospital where they may be secluded for much of the time. This tendency is apparent in the cases of women considered 'at risk' of suicide (see Liebling, 1992b) and those considered 'at risk' of harm by other prisoners. Throughout the course of this research prison medical staff complained that they felt constrained in their ability to deal with women's problems because of the emphasis laid on security requirements and 'risk' factors at the expense of patients' health needs :

> Our hands are completely tied. We get all sorts thrown at us ... women who don't need health care as such but who need keeping an eye on. There's no time to talk to them or to find out if anything's bothering them. All we can do is keep them here (Nurse).
>
> We've got four women in [the hospital wing] at the moment. Two are here for their own protection. They're not ill as such (Prison Doctor).

The knowledge that behaviour is constantly scrutinised, appraised and potentially medicalised by prison staff severely inhibits any display of emotion, anger or frustration :

> I don't think that prison officers are trained to deal with women or with anyone who shows the slightest emotion. If you are crying (maybe you've had a bad letter or a bad bit of news) then there's no sympathy. It's 'Go over to the health centre, they'll sort you out'. What they mean is they'll give you something like pills and that when really all you want is for someone to put their arm round you (Liz).

The tendency for prison staff to direct some prisoners towards prison health services is also clearly evidenced in the case of 'disabled prisoners'. Here, disability seems to represent a 'problem' for the system rather than for the prisoner herself. Two disabled women prisoners interviewed in this study (who

were both accommodated 'on' the health centre) described how their disabilities were interpreted by prison staff in terms of illness. Such prisoners seem to find the prison experience particularly problematic, not least because prisons seem to have been designed with the able-bodied in mind :

> Because I was in a chair, I wasn't able to go onto what they call the wings. I had to go onto the hospital. And it was just traumatic. I mean the first thing they said to me was 'Well you can forget about that chair, you're going to walk'. I said 'But I haven't walked for ten years'. 'Well you'll just have to learn won't you', that was their attitude. For disabled people they just don't cater ... When they brought me from Risley to here even the officers all told me 'You're not stopping on here, you're going to hospital, you're in a wheelchair, we can't cater for you'. That was their thing - you're disabled you need to be in a hospital out of the road (Steph).

> When they first brought me here [to the health centre] I couldn't believe it. I said 'I'm not ill, why do I need to be in hospital'. And they said 'It's because you can't walk properly'. So instead, I'm up here on the second floor of the health centre when I know damn well there's ground floor rooms on some of the houses. Where's the logic in that? (Gwen).

There has been increased attention in recent years in the sociological literature to the issue of disability (see Scambler, 1991). Here, it is recognised that it is the interaction between a person's particular and permanent physical or mental characteristics and the environment in which the person functions that makes a person *disabled.* Thus, the actual nature, status and degree of disability will be determined by the precise characteristics of one or both sides of the interaction. Prisons, it would seem, are particularly *disabling.* The assumption that disabled prisoners represent a 'problem' further undermines their self-determination and independence.

While some women prisoners may encounter prison health services by default, others voluntarily consult. Here, it seems that women may actively collude in their own medicalisation. How does this come about and what are the consequences?

While the preservation and maintenance of health is of paramount importance to most people, prisoners, on the whole, seem to be particularly concerned about their health and well-being (Genders and Player 1987; King and McDermott, 1995). King and McDermott (1995), for example, found high levels of concern about health and about physical deterioration in their study of (predominantly young) male prisoners. While few of the men in their sample reported having been concerned about their health outside prison, over eighty-four per cent said that they were quite concerned or very concerned about their physical condition deteriorating whilst in prison.

Genders and Player (1988 : 152), in their study of women lifers at Durham's H-wing, state that the women's 'day-to-day existence was characterised by uncertainty about their future prospects ... accompanied by an overwhelming fear of deterioration in their physical health and psychological well-being'. The women in this study, similarly, reported concerns about their physical and mental health : in the questionnaire survey seventy-three per cent (n=157) of women prisoners reported being concerned about their physical health and fifty-seven per cent (n=122) reported concerns about their mental health. Given the relatively young age of the sample (seventy-one per cent were under 35 years of age), this seems a high level of concern.

Women serving long sentences were particularly concerned about their health deteriorating whilst in prison :

> I'm forty-nine this year and I know my body is changing. I'm concerned that my health ... that my body is going down hill. I don't want to be a physical and emotional wreck when I get out (Sue).

> I think my health has really deteriorated ... I used to work on the gym at New Hall at one time and I was quite fit.... But I had a hysterectomy about nine months ago and I've just gone weird since then. I mean my eyes have gone funny. My back, I get a lot of back ache. My feet have gone weird. My nails are all dropping to bits ... everything (Barbara).

> I'm not a particularly healthy person, but I came in [six years ago] healthy for me ... and my tariff date is the year 2005. A lot can happen in that time. I'm going to have to fight if I want to go out a healthy person. If you don't look after your health in here no one will (Kym).

Bodies, imprisoned or not, inevitably age and decay, and, while it is reasonable to assume that most people dread old age and fear the prospect of death, in prison concerns about ageing seem to relate to two main issues : first, that life is uncontrollably 'passing by', and, secondly, that the propensity and strength to survive (literally and metaphorically) might be weakened :

> I'd give the whole world to be out and you see these girls get released and two weeks later they're back. All you do, all I live and know is waking up in the morning and seeing the same room over and over again. You face the same faces day in, day out, seven days a week.... When you pass your forties it seems that there's a part of you missing, a big part of your life disappears. Sometimes you walk around in space and think 'Will it ever end?'. As every day, every week goes by, you're not getting any closer, that's what it seems (Karen).

> I sometimes think 'God, what if I never get out. What if I just get old and die in here'. Thinking about these things rationally, I know that's stupid. But, sometimes you worry that one day you might not be able to cope with it all, to physically and mentally cope. At times like that you really need to talk to yourself, talk yourself through it because there's no one else to talk things through with (Barbara).

Lasch (1980 : 207), in a discussion of dominant trends in the formation of self-identity in capitalist societies, has argued that ageing 'holds a special terror for people today'. This 'terror', perhaps, assumes a special intensity in prison, particularly for those serving very long sentences. A tendency to view the prison population as young and able-bodied has, however, precluded any real discussion of the process of ageing behind bars and the problems affecting older prisoners.

King and McDermott (1995) point out that concerns about health and about physical deterioration may not relate to one's actual state of health. They found,

for instance, a correlation between the proportions of men in their study who described themselves as 'very concerned' about their health and the time spent locked up in cells with limited access to sports and recreational facilities. They argue that being locked up in one's cell is likely to 'give prisoners time to dwell upon and perhaps magnify signs and symptoms that they are actually experiencing' (King and McDermott, 1995 : 181). Whatever a prisoner's actual health status, imprisonment may thus provide the context within which women and men are more likely to worry about their health. This, in turn, increases the likelihood that they will help-seek.

A high rate of utilisation of prison health care services seems to be a common, although paradoxical, feature of prison life. Prout and Ross (1988) argue that :

> The prison population is young ... and generally healthy. Yet, when given free access to medical attention, as much as 30% of the prison population will show up every day for sick call. Utilisation of services far outstrips medical need (Prout and Ross, 1988 : 12).

The excessive utilisation of services is not surprising given that prisoners who have a headache or a sore throat, for example, cannot take a Paracetamol or an Aspirin without permission. They cannot stay in bed if they feel poorly, or 'under the weather', without permission. In outside society, only a small minority of people consult a doctor for their health problems. Most *self*-manage. But for the prisoner, self-management is not an option. Prisoners lose the authority to act as they would normally and the simplest of actions is curtailed by regulation and *enforced* dependency.

While *all* prisoners seem to make greater use of prison health services, women in prison, as in outside society, make proportionately *greater* use of medical services than men. Women prisoners tend to see prison doctors more frequently and take more medicine than men, and, while women make up less than four per cent of the prison population, they make up, on average, twelve per cent of those reporting sick (NACRO, 1986).

It is easy to understand why women prisoners might turn to prison medical services with their concerns : there may not be anyone else to turn to and the doctor may be the only person who can offer immediate relief. The problems facing women prisoners are not by and large *medical* concerns. Yet they often become so, once they cause, as they inevitably do, stress, worry, anxiety, fatigue, sleeplessness and mental exhaustion. The doctor can give immediate (albeit temporary) relief, by prescribing pills which induce sleep or which lift depression. By consulting doctors, women thus potentially medicalise their emotions and frustrations.

Taking their concerns to doctors may have additional benefits for women prisoners : many women feel tremendous guilt feelings about their offence, about their children, about their relatives and partners. They may look to doctors to 'solve' their problems, allowing transference of their concerns (that is, their guilt) to the doctor : if failure (real or imagined) can be attributed to illness then self-blame may be lightened (Miles, 1991). However, the benefits brought by imputing emotional, social or family concerns to illness, are dearly bought.

Before looking at the price some women pay and the question of why doctors seem willing to accord diagnostic labels to women's concerns, questions arise as to the structure and functioning of prison health care.

There is no easy way to answer the question : how good are prison health services? The quality of health care in any particular prison is determined by many factors : including, the health care infrastructure; the personnel; resource allocation; the type and size of the prison; the local level of health care outside prison, and, most importantly, by the particular approach to providing health care in this context.

The National Health Service is intended to provide health care from 'the cradle to the grave' for every individual in the UK who wishes to receive it. There is

one exception : if you are imprisoned then your medical needs are met by staff who form part of a separate health care system administered by the Home Office (see Candy, 1985).

Three types of doctors work in prisons : full-time medical officers (PMOs) who are civil servants; general practitioners (GPs) based in the local health community and working in prisons usually on a part-time basis, and visiting specialists. Several writers have discussed the relative isolation and invisibility of prison doctors (see, for example, Smith 1984b, 1984c; Thomas and Costigan, 1992). Many full-time medical officers, for example, work largely away from the mainstream of the medical profession and are not exposed to effective peer assessment. In each of the three fieldwork establishments, however, women prisoners were attended to by a part-time (male) doctor who was also a local GP.

Nurses are also employed and carry out much of the routine care. At present, over fifty per cent of nursing staff have nursing qualifications. That is, qualifications recognised by the UK Central Council for Nursing (Prison Service, 1995a). The remainder are hospital officers : discipline officers with some *basic* nurse training. The selection and training of hospital officers has been a central focus for concern and it has been recognised that they often bear medical responsibilities beyond their training and experience (dispensing drugs, for example) and are often overburdened with administrative tasks (see Smith, 1984d; PRT, 1985). Such criticisms have led to the closure of the training schools for hospital officers and a re-structuring of the post so that all *new* health care staff should have formal nursing qualifications. Nursing care in women's prisons has always been provided by fully trained nurses (many of whom also have disciplinary training), providing some evidence for the view that women prisoners are considered 'sick' and in need of treatment rather than punishment *per se,* although the distinction between medicine and discipline is less clear cut than this might imply.

The function of prison health care services would seem to be relatively straightforward : they are there to attend to the health of prisoners. This function is perhaps made more important by the fact that not only do some prisoners suffer from a variety of health problems coming into prison, the prison environment and regime often compounds these problems and creates a few of its own.

Prison health services operate under many constraints, however, not least due the political and ideological climate within which they operate, and the provision of medical care to prisoners is necessarily influenced by their being *prisoners* as well as *patients.* What is constructed as a health problem is in many respects determined by sentencing policies and practices rather than any health needs assessment exercise. As a consequence, prison health personnel often have the task of dealing with problems over which they have no control, be it the overall number of persons sentenced to imprisonment, for example, or the number of drug users or the number of mentally ill offenders. Throughout this research health personnel complained that they could only offer *reactive* rather than *proactive* care :

> What we provide here, is sticking-plaster care. That's all we can give. By the time we see these women the harm's already been done in most cases and our hands are tied. If people are in for a short time, a couple of months or so, there's very little we can do for them in that time apart from patch them up, deal with their immediate problems, and send them back out (Nurse).

Prison health staff, like their colleagues in the community, work within a climate characterised by low morale, insufficient resources and uncertainty. This is compounded by the inherent incompatibility between their role of providing care in conditions that are punitive, coercive and often humiliating for prisoners. Moreover, their role is also constrained by the mutually contradictory public expectations regarding the standards of health care in prison. There is, for example, the predictable public outcry if these standards fall *below* an acceptable level but also an outcry if these standards are deemed

too *high*. Principles of less-eligibility ensure that any raising of standards in prison beyond those found in the outside community leads to accusations that prisoners 'don't know they're born' and that prisons are 'health camps'. These views are pervasive in both the professional and the public imagination :

> My wife has to wait months to get an appointment to see a specialist (for women's problems) and these women, they come in and are seen within a week. Now that can't be right. They come in, they can see a doctor, a dentist, an optician, whoever, and then it's, 'thank you very much, bye bye', they're back out and the tax payer is left to pick up the tab (Pharmacist).

> I have to pay to keep my son in a local crèche while I'm in work and they come in here and there's nursery nurses and nursing staff all on hand. They're laughing (Prison Officer).

In 1995 the Prison Service published, for the first time, *Health Care Standards for Prisons in England and Wales* (Prison Service, 1995b). In 'the Standards', the key stated aim is 'to give prisoners access to the same quality and range of health care services as the general public receives from the National Health Service' (1995b : 3). A number of 'underpinning values', important to the achievement of this aim, are identified, including :

> [A]n **ethos of care**; **respect** for the patient; **time** for care in all its aspects; **confidentiality**; **communication to the patient** (of diagnosis, proposed treatment, the care plan); **involvement of the patient** in decisions; **informed consent**, [and] strict adherence to **professional standards and ethical codes** (HM Prison Service, 1995b : 3 emphases in the original).

This rhetorical commitment to 'equivalent care' is likely to be compromised, however, by the fact that prison health personnel are responsible not only for providing general medical care to prisoners but also for implementing prison rules. The contradictory nature of this dual role is evident. Whether it be the protection of confidentiality, the enforcement of disciplinary sanctions or the experimentation with new drugs and treatments, the core problem is always this duality : prison influences the way that health services are provided, and their effects on prisoners are also modified by prison (Tomasevski, 1992).

Medical staff are responsible for a range of managerial duties such as compiling reports on prisoners for the courts or the Parole Board, investigating disciplinary offences (including body cavity searches and drug testing) and for 'fitting' prisoners. The whole concept of 'fitting' is an interesting one : doctors in outside society are generally responsible for certifying *sickness* and for legitimating the 'sick-role'. In prison, however, they are also responsible for certifying *fitness* for punishment in solitary confinement, *fitness* for work duties and for participation in sports (if over thirty years of age) :

> Over 30, you have to be checked over before you go to the gym and that ... but I'm fitter than a lot of the under 30s. It's crazy, you have to have permission from him if you're over 30. You have to get his permission to get fit (Anwen).

They also advise on food, hygiene, working conditions, fitness of members of staff, accidents to, and assaults upon, prisoners and staff, as well as overseeing the physical and mental health of the imprisoned.

A fundamental conflict arises in that not only must medical staff serve the needs of prisoners, but, in the name of 'good order and discipline', they must also fulfil duties which may not be in the prisoner's best interests or in the interests of health. Health personnel thus run the risk of being perceived as being actively involved in containment, control and the wider punishment regime (Genders and Player, 1988; Thomas and Costigan, 1992). Prisoners themselves make little distinction between discipline officers and health care staff :

> They're all the same. I don't trust any of them ... they're not nurses, they're just screws in different uniforms, they don't care (Suzanne).

> There is no such thing as patient confidentiality in here. On the outside you know that if you consult a doctor or see a nurse that whatever information, whatever you discuss is confidential. In here, the concept doesn't exist ... If you go and see the doctor and you've got a really big problem or something is bothering you (whether it's related to health or a problem you might have with another prisoner or something), you can be sure that it'll be all round the prison the next day. They'll tell the screws and then

> it'll be stored up and used against you, maybe not immediately but at some point in the future (Carolyn).
>
> It's all wrong, they march in and say 'What's wrong with you?' and then write it all down on a piece of paper and put it to the Home Office (Diane).

That health personnel are involved in the management and punishment of prisoners blurs the boundaries between duties owed to the prisoner-patient and those owed to the institution (Lee, 1983). This then raises fundamental questions about the nature of the medical encounter in prisons.

Power relations and the medical encounter in women's prisons

> He doesn't even talk to you. He doesn't even look at you. He just says 'Fit and well?' So long as the answer's yes then that's OK. You don't even sit down, you have to stand up (Carolyn).

In spite of the inherent difficulties of access, doctor-patient interaction has received its fair share of research : consultation processes; patterns of communication and *mis*-communication; sources of satisfaction and dissatisfaction, have all received attention (see, for example, Stimson and Webb, 1975; Armstrong, 1982; 1984; Tuckett *et al.*, 1985). Such studies reveal that not only do doctors and patients employ different languages of health, ill-health and disease, but often they have conflicting interests (Turner, 1987).

Several writers have examined the ways in which the medical encounter is managed as a social activity (see, for example, Stimson and Webb, 1975), and, a number of studies have looked at the impact of a patient's sex on doctor-patient interaction.[11] While doctors may subscribe to ethical

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[11] The current study presents an analysis of the relationship between male doctors and female prisoner-patients. This is because in each of the three fieldwork establishments the doctor *was* male. Implicit in the analysis, however, is an assumption that male and female doctors are socialised into the same professional culture. See Turner (1987) for a detailed account of 'professionalisation' and Miles (1991) for a discussion of the differences in attitudes between male and female doctors.

requirements of not differentiating between patients on the grounds of 'class', 'race' or 'gender', they do not, in practice, think about or treat their patients in an objective manner.

Research has shown that doctors regularly categorise patients as 'good' or 'bad', as 'problem' or 'easy' patients (Lorber, 1975; Stimson, 1976; MacIntyre, 1977, Fisher and Groce, 1985). Indeed, *the* 'problem patient' is now firmly established in medical discourse. The categorisation of a patient as good or bad, however does not seem to relate solely to how much trouble they cause doctors, but also to normative judgements as to whether they are good or bad individuals : for example, a *good* wife, a *bad* mother (Miles, 1991). These judgements are not made according to any medical criteria, but according to the doctor's personal, culturally-determined normative values.

MacIntyre (1977), in her study *Single and Pregnant*, found that doctors tended to categorise pregnant women as 'good' or 'bad'. 'Bad' women were seen as 'promiscuous', 'easy-going' or 'immoral' according to the values of the doctor, and were seen as having become pregnant as a result of 'bad' behaviour. 'Good' women, in contrast, were seen by the doctor as 'innocent', who became pregnant because they had been 'taken advantage of'.

Such stereotypes are pervasive within the criminal justice system, and it is likely that prison doctors, like the police, judiciary and probation services (see chapter two), work with a series of gender-specific assumptions about women offenders and about the needs of women prisoners. Here, there may be some foundation for the view that, because only a certain 'type' of woman ends up in prison, the distinction may not be between good and bad women prisoners but between 'bad' and 'worse'. A tendency for prison doctors to view women prisoners as 'bad' women is evidenced in their attitudes towards them, as the following extract from my fieldnotes reveals :

> Sat in on the 'sick-parade' (well, stood in) ... Doctor X saw a whole succession of women (and babies) with various problems

> in a very short space of time. In that time, he not only 'diagnosed' whatever he thought the problem was and 'prescribed' the relevant treatment (well, told the ever present nurse-chaperone - patients don't go away with a prescription like in the outside world which creates problems for them knowing if and when the consultation is over), he also took a lot of blood. When I asked him why he was taking blood (from one woman who had actually consulted in relation to her baby!) he turned to me and said (with a wink), 'Well you know what these women are like, they like the feel of the needles'.

There was a feeling that, as the doctor enters into the women's lives, he does so more as a 'social spectator' than as a doctor. This then raises questions about whether he assesses prisoner-patients legitimately as a doctor or whether other issues are at play. Women prisoners themselves recognised the influence of a doctor's values and attitudes on his medical practice :

> One MO called me a junkie because he thought I was taking drugs and that I was the run of the mill. I had bruises ... marks on my arms from where the nurses had taken blood and from them giving injections. I said, 'I'm not a junkie and don't ever call me a junkie ... I'm doing a life sentence and I'm here because I feel ill'. He gave me two paracetamol [laughs] (Kym).

> The doctor I saw at Risley did absolutely nothing. I was breast feeding and was in a terrible state ... [and] the doctor was of no use to me at all. I was leaking milk everywhere and he couldn't have been bothered at all. He asked me if I was on any medication and did I need anything and I said 'no'. So he said 'fair enough' and that was it.... I think because I wasn't on any medication and I wasn't a drug addict then I wasn't really of any use to them ... I think they look at you differently because you're a prisoner (Ann).

While such observations may tell us something about a doctors own perceptions, they also have implications for medical management and several studies have demonstrated that the treatment accorded to patients may vary according to the cultural views and values held by doctors. Thus, MacIntyre (1977) found that doctors, having categorised women who consulted with unwanted pregnancies as 'good' or 'bad', discriminated in their willingness to

terminate a pregnancy according to such judgements. This clearly demonstrates how *cultural* judgements can influence *medical* management.

Research suggests that doctors are inclined to view a variety of complaints made by women as emotional or psychological in origin, not to be taken too seriously, while similar complaints made by men are more thoroughly investigated (Lennane and Lennane, 1973; Leeson and Gray, 1978; Bernstein and Kane, 1981). Central to this argument are the stereotypical notions of women as weak and unstable, given to complaining and exaggerating their discomforts. If doctors think that women tend to *maximise* their discomfort and complain unduly, they may *minimise* their medical care.

The women in this study complained that doctors routinely dismissed or minimised their problems. They argued that symptoms were often trivialised or were not taken seriously and that knowledge of one's own body was often denied :

> The doctors are very closed-minded. One of the stock phrases of one of the doctors was 'it's because of your age, because you've done a long time in prison and because of the sentence you're doing', whatever you went with. They never examined you. I have never had a full medical since being in prison [12 years] ... when I had the gall stones I went to him because I was throwing up and had crippling pains in my stomach ... and he said 'have you had any bad news over the weekend?' (Angie).
>
> I've been poorly a couple of times but the doctor in here is just rubbish. I know my own health. I know when I'm poorly and I had to plague him. You know I was weary, I knew what I needed - my age, the stress and everything - and I had to get my own stuff from home, vitamins and herbal calmers, because they're not bothered about you.... I suppose they have to take the rough with the smooth and think 'Oh you're blagging it', but I never ... they don't even know us (Mair).
>
> When I had the cancer, he threw me out of the office because I had no outward sign. I just knew that something was wrong. I went and asked for a smear and he wanted to know why I thought something was wrong ... I said 'I just know my body

> and a change in my body'. And he said 'Don't be ridiculous. Get out' (Olga).
>
> A few years ago I hurt my hand ... and I went and I said, 'My finger's not right'. And I kept going and saying, 'My finger's not right'. And it was seven weeks by the time they sent me out to have it x-rayed and by that time it had stuck. So anyway, they operated but it's slipped back and I'm stuck with it ... I used to be able to type with all my fingers but I can't anymore (Sue).

Here, there is a sense that a woman's own experience is devalued by comparison with that of doctors' expert knowledge. Women prisoners describe this as a distressing and demeaning experience and many complained of their humiliations and frustrations at such treatment.

A tendency for doctors to dismiss prisoner ailments as 'psychosomatic', 'hypochondria' or 'leadswinging' has been identified by a number of writers (O'Dwyer *et al.*, 1987; Prout and Ross, 1988; King and McDermott, 1995). Prout and Ross (1988), for example, describe how 'prison-wise physicians' are clued up on the various 'con games' which are themselves a reaction to prison conditions and the proverbial boredom of prison life :

> [Prisoners] with nothing to do but think how to outsmart the correctional and medical authorities are, not surprisingly, often quite successful. Patients feign angina and emphysema, hoping to be transferred to more desirable facilities. Other inmates complain of a bad heart and hyperventilate to be relieved of work duties. A prisoner pulled what turns out to be a fairly common trick of swallowing a razor blade wrapped in waxed paper. The paper does not show on X-ray but the razor blade lodged in the patient's esophagus appears with alarming clarity. Prison-wise physicians watched the patient but did nothing. The blade passed and no surgery was needed. Less-experienced and skeptical physicians, on the other hand, were easy prey for the con games by bright, imaginative, and angry inmates (1988 : 65).

Prison medical staff themselves often admit that they discount the symptoms that many prisoners present with :

> In here it's guilty until proven innocent ... you take them all with a pinch of salt. Most of the women will do anything to get out of work or because they don't think they're getting enough attention. When I first started here I took every case as it came, but you become very very cynical (Nurse).
> I have to admit that when they first come along my immediate reaction is 'What are they after?', because they're rarely here because they are ill (Prison Doctor).

The women prisoners interviewed recognised that some prisoner-patients - the habitual consulters - did indeed cause the medical staff a lot of hard work. However, they were also concerned that this had the effect of discrediting *all* women's symptoms, so that 'genuine' problems were not addressed :

> We're not all hypochondriacs (Chris).

> They've got no interest at all in the actual health of the people they're dealing with ... I think they get burnt out by the whole process - junkies coming for pills, any pills - and so they don't work hard enough for the health of the women. They don't see us as human beings (Iris).

> There are some women in here who are out for all they can get and they will bug them and bug them and bug them until they get what they want. But that's only a small minority. Most of us are genuine cases ... If they only looked at my record they would know that I very rarely go and so if I do go then there must be something wrong with me. But they don't know us, they just see you coming through the door and you're just another prisoner for all they care (Mair).

> There's that many people saying they're poorly when they're not, and not going to work because they don't want to go to work, that they have started a system that if you don't go to work you can't have your temporary releases ... Now for somebody who doesn't get poorly and when they do they're frightened to go and tell anybody because they want to go out. They should pin-point the people that are doing it rather than punish everybody (Emma).

King and McDermott (1995) have pointed to the paradoxical situation which can arise as a consequence of such discreditation : concern that one's problems are not being taken seriously, together with uncertainty and anxiety about one's

body failing, effectively ensure that prisoners 'return for a second [third, fourth, fifth] time ... thereby confirming the doctor's original judgement' (King and McDermott, 1995 : 181). This would go some way towards explaining the apparently excessive use of health services by prisoners.

While, on the one hand, doctors often attribute (and effectively dismiss) women's complaints to emotional or 'psychogenic' causes, on the other hand, there is evidence which suggests that doctors *over*-medicalise women's complaints. Verbrugge and Steiner (1981), for example, studied the medical response to male and female patients consulting doctors for a range of common non-specific conditions such as chest pain, back pain, headache, fatigue and dizziness. They found a systematic difference in doctors' medical management of male and female patients which resulted in women receiving *more* medical intervention, including more prescription medications, than men.

Psychotropic drugs comprise one of the most commonly prescribed categories of drug (both in prison and in the community) in industrialised countries and, over the years, the frequent usage of these drugs has become a matter of growing concern. Brand names of some of the more well known drugs include: Librium, Valium, Amitriptyline, Mogadon, Prozac, Ativan; drugs which Melville (1984 : 7) describes as 'the nearest thing to bottled happiness you could get'. What is interesting to note, is that while most 'addictive' substances tend to be self-administered (see chapter four), psychotropic medications are most commonly mediated through a doctor who provides patients with their first prescription. If prescriptions are offered on a repeat basis, pharmacological addiction is likely to follow.

In Britain, social scientists working in the field have played a valuable role in mapping out the social meanings of psychotropic drug use (Cooperstock and Lennard, 1979), investigating the consultation process in which prescriptions are given (Raynes, 1979) and in providing information on the drug users, their health status and social characteristics (Ettorre, 1992).

Several writers have pointed to the over-prescription of psychotropic drugs to women (inside and outwith prison) and have focused on the key social issues relating to women's use and misuse of these substances. Ettorre (1992), for instance, argues that women more often than men are characterised by doctors as 'depressed', 'psychoneurotic', 'psychotic' or as suffering from 'non-specific disorder'. In effect, within a medical framework, women's distress is viewed in psychiatric terms and more often than not psychotropic drugs are seen as the treatment of choice.

Why are doctors willing to accord psychiatric labels to complaints which seem to have little or no aetiological basis? Individual doctors (whether GPs or psychiatrists) have much pressure on them to provide 'treatment'. Doctors, it seems, do not like sending patients away 'empty-handed' (metaphorically in the prison context). Doctors feel best when making diagnoses (this is, after all, their job) and providing treatment for complaints. As one prison doctor interviewed in this research comments : 'We feel we should try to offer them something. It makes us feel better'.

Liebling (1990 : 23) illustrates this point in her discussion of women lifers. Prison doctors, unable (or unwilling) to 'do anything' about the circumstances of women's confinement offer medical solutions to women's distress :

> One inmate developed a rash on her face - the doctor told her it was eczema, probably stress-related. She was sent to the visiting psychiatrist. He asked her if she was under any stress. 'I said, "I'm in *here* doing a *life sentence*, and you want to know if I'm under any stress" ... He couldn't do anything about my life sentence' (1990 : 23-4, emphases in the original).

Increased emphasis on 'prevention' in recent years has also (ironically) put pressure on doctors to provide treatment for unhappiness in order to forestall the *possibilities* of mental disorder. Richman and Bury (1985) argue that this has meant that doctors increasingly psychiatrise a whole range of socio-behavioural problems. While this does not apply solely to women, it is

women who, for the reasons previously discussed, receive *more* medical attention and psychiatric labelling. Pressure on doctors to assign diagnostic labels arises because treatment can only follow diagnosis. As there is no medical diagnosis for 'frustration' or 'unhappiness' or 'concerns', doctors frequently use what Scheff (1966) has called the 'dustbin' category of medical diagnosis : depression, anxiety or neurosis.

It is well known that many women prisoners 'get through' their sentences on 'official dope' (Carlen, 1985; Mandaraka-Sheppard, 1986), and the phenomenon of 'doing your bird on your pillow' is familiar to many prisoners (Eaton, 1993 : 30). What is less clear, however, is how many women come into prison already on a treatment regimen and how many are prescribed psychotropics drugs for the first time whilst in prison.

Smith (1984a) argues that more women than men arrive in prison taking such drugs and prison medical staff frequently point out that women prisoners often 'demand' psychotropic drugs and expect this type of assistance either because they have previously been prescribed such preparations or because they have been encouraged by the experience of other prisoners. Many of the women prisoners interviewed in this study had taken psychotropic drugs at some stage in their sentence and recognised their stress-relieving benefits :

> I'm on Amitriptyline. It's a calmer and a sleeper as well I think ... it gets me to sleep, gets the day over with. That's all I'm bothered about. I get that day over with and the next one comes. I get that over with (Iris).
>
> Prozac underwrites things so I don't go down too far (Brenda).
>
> Durham [prison] is an awful place. I don't know how I survived it ... inevitably I had to go there - at that stage nearly all lifers went there - but when they took me there I couldn't believe that they could keep human beings in this place. I remember looking up, seeing this suicide netting, well I was on Valium within ten minutes and I'm not a pill-popper. I was in such a state and I was saying 'You can't keep me here there are murderers here', and they said 'Well Chris that's what you're supposed to be'. I was terrified (Chris).

In this respect, the reasons why women use psychotropic drugs seem to be similar to the reasons why women might get depressed in prison, and psychotropic drug use can be seen as an escape from the oppressive nature of the prison regime. In the structurally powerless position of prisoner, women attempt to gain whatever comforts, joys or pleasures they can (see chapter four). Women prisoners describe how such drugs, not only help them to escape from an intolerable situation but also how they help them to cope in their relationships with people outside prison :

> If there's more than three people [on a visit] I get panicky so I'm on treatment for that so I can get through a visit. I have my drug at dinner time just so I can make it through a visit ... they're little pink things. I must admit the first time I took one I went for my next visit and it helped. Before I was getting that I'd make up any excuse, tell them that you had some work to do just to get out of the visit. I was getting that het up. I just couldn't stand it. It's also helping us to sleep which before I used to have trouble sleeping. It seems now I'm getting more into a regular sleep pattern you know. So it's helped for that as well. It's helped us get through and now it's helping me sleeping (Debbie).

Many women (prisoners and otherwise) are often unaware, however, of the adverse effects which repeated consumption of psychotropic drugs can generate, especially when such drugs have been legitimately obtained via a doctor :

> The doctor kept giving me these little, funny shaped pills. I think they were to help me sleep. I thought they must be OK because the doctor had given them to me (Molly).

For some, a catch-22 situation can arise where they are unhappy about taking such drugs, but they also recognise the benefits :

> I'm on antidepressants. I get them every day and I take them. I don't want to take them but you have to. They don't make you take them but you think, what else am I going to get? So you take them. I've never been on a tablet in my life but you feel as if you've got to have something to make you function. You know,

> you don't want to get up for work in the morning, you think, why should I? And the wages you get are rubbish. That's something else that adds to your stress, so you keep taking the tablets ... a lot of people are on sleeping tablets because you literally can't sleep when you're in here and you just sort of snowball and you really could take handfuls of tablets and they still wouldn't make you feel any better. They make you feel a bit better, you can cope, but I don't think you should be put in a situation like that. It's not an illness, it's the situation that you're in and it's not getting any better (Emma).
>
> Prozac isn't the answer I know, but at the time you need something (Diane).

Here, the pattern seems to be of the usefulness of these drugs when first prescribed, followed by diminishing confidence in their benefits when used in the long-term. Some women had experienced side-effects including weight gain, motor impairment and dependency. A major problem which follows long-term reliance on drugs (prescribed and otherwise) is trying to come off them:

> Doctors don't know what withdrawal means, they didn't believe me when I tried to explain that I *needed* the tablets but *wanted* to come off them. Even the loss of one tablet would have been a major disaster. But I didn't get any help, counselling or anything ... they just kept giving me the tablets. It was as if either I was given them or I wasn't. There was no in between. The same applies to the girls taking drugs. I had a pad mate who was turkeying and she had no help or anything (Discussion Group 1).

At another level, the women interviewed in this study argued that medical staff were far too quick to prescribe psychotropics. For those who sought medical help, many were not prepared to accept that psychotropic medications constituted appropriate 'treatment' :

> I didn't want any anti-depressants but he insisted on prescribing them. I said 'Look, it's a free country, I don't want these things'. And he said 'My dear, you are not a free person'. Later I found out that I didn't have to take them but at the time ... They stand in front of you and hand the tablets to you and ... they check

> your mouth to see if you've taken them. I didn't want the anti-depressants but I took them (Kirstie).
>
> All they do is stuff me up with pills all the time and not get anything done (Molly).
>
> They don't want to listen to you. All they want to do is pump tablets down you. They pump tablets down you for something that doesn't need it (Diane).

Such women saw psychotropic drugs as destructive, mind-altering and as masking genuine symptoms. Many recognised that what was needed was a different response :

> You can have whatever pills you want. They'll just dish out anything ... but if there was more sympathy and empathy than pills then that would be better for people (Brenda).

A number of writers have revealed how psychotropic drugs have become an important mechanism for maintaining order and control in women's prisons (Owen and Sim, 1984; Carlen, 1985; Mandaraka-Sheppard, 1986; Sim, 1990), and the term 'liquid cosh' now popularly describes the misuse of such drugs for control, disciplinary and/or security purposes (Whitehead, 1985). Thomas and Costigan (1992) refer to this as part of a process of 'medicalising control', where prison doctors conflate 'disturbing' and 'disturbed' behaviour such that non-compliance (with the prison regime) is dealt with as a medical problem. Thus, drug-usage can be seen as an instrument of *control* as distinct from an element of *treatment*.

Prisoners themselves and also some doctors claim that psychotropic drugs are used to deal with those prisoners who are viewed by the authorities as 'difficult'. Such preparations are thus used for disciplinary rather than therapeutic purposes :

> I guess it makes their lives easier : dope them up and shut them up. Certainly, some of the girls are on another planet, they're out of it ... and they call it treatment (Sue).

> The stress just builds up inside you and then one day you just explode and then it's down the block for fighting. I think I'm seen as a trouble-maker because I'm always getting in trouble for fighting ... I was given these drugs by one doctor. I didn't know they were powerful - the druggies take them to give a buzz - and I was on them for four days. I'm not kidding but for four days I was as happy as Larry but I didn't know what it was (Karen).

> I think we're in a catch 22 situation really. You may get someone coming to you saying 'I can't cope. I'm depressed. Can you give me something?' But at the same time we've become much more aware in recent years of the dangers of addiction and dependence ... but at the end of the day, we've also got to think about what's best for the peace and harmony of the prison. We do have to think about whether it's better to keep people happy. If this means giving them something, then that's OK if it can keep the place quiet. It makes life so much easier. In some respects I think it was better before we were all so concerned about dependence (Prison Doctor).

The medical regimen may be seen as part of the wider system of control through which a woman prisoner is denied her own authority. Certainly, some women prisoners seem 'drugged to docility' (Eaton, 1993 : 29), as the following extract from my fieldnotes illustrates :

> Today I visited Brown [House] with one of the nurses. It wasn't the time for medications but I was interested to note that the sight of the [nurses] uniform brought a number of women out from nowhere in true Pavlovian fashion. These women associate the uniform with drugs (extract from fieldnotes).

The over-prescription of psychotropics in prison has probably been *the* most controversial issue in the whole debate about prison medicine in recent years[12] with the result that prison doctors and administrators have had to review their own prescribing practices (this has also been due to cost considerations). And, while there is some evidence to suggest that prison doctors (like their colleagues in the community) have generally cut back on their use of such preparations, prescribing practices in women's prisons remain an important area of concern :

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12 See Whitehead (1985) for a detailed discussion of this debate.

> This is a drug prison. You go to them and they think you're coming for medicine ... I don't like pills but since I've come to this prison I've had so many pills I rattle (Jen).

Viewing women prisoners' unhappiness and their behavioural reactions to imprisonment in a psychiatric perspective results in *minimising* the problems and *discrediting* the women who complain. This sends a dual message : first, by locating the problem in the woman herself - in her inabilities and inadequacies - and, secondly, by assuring the woman that she is 'ill' and cannot help being unable to cope, or inadequate. Paradoxically, there is evidence that some prisoners are refused medication when there are good reasons for giving it, whilst others are given medication against their wishes or for little or no reason.

This then raises serious questions around the issue of consent to medical treatment which, for prisoners, is much more complex than for persons at liberty. Prisoners are all in prison *compulsorily* and have effectively lost many of their normal civil rights (Whitehead, 1985). Hence, the whole question of consent to treatment is a thorny one because there are strong pressures, as we have seen, on individuals to conform. Thus, if a doctor prescribes a drug and/or any other form of 'treatment', the prisoner may take it apparently willingly, but may, in reality, be afraid to refuse or feel that they cannot refuse :

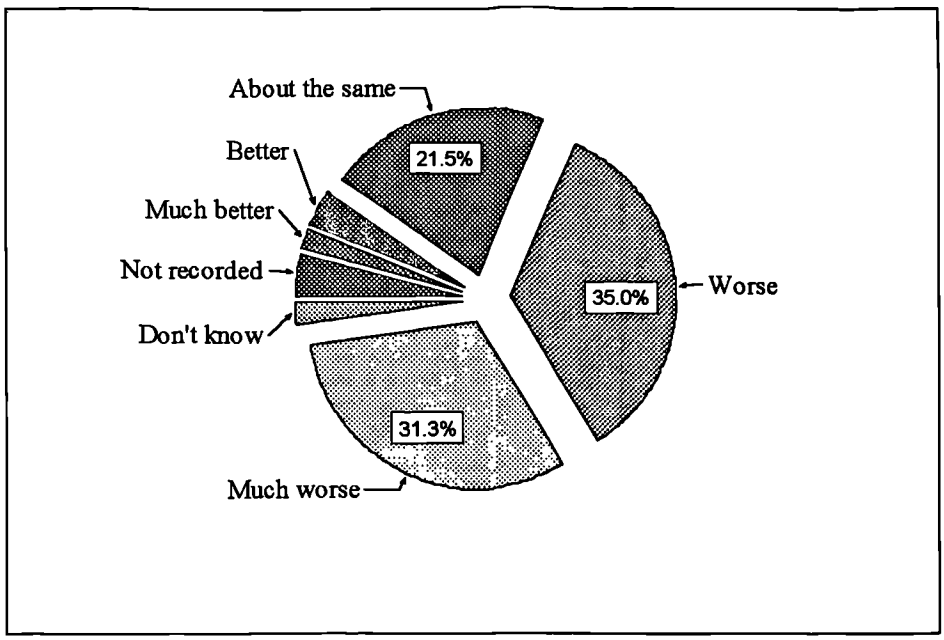
> You're in prison, you're a prisoner and if they say jump you jump. So, when the doctor prescribes pills, you take them. It's as simple as that (Anwen).

The women in this study frequently described the alienation experienced in the medical encounter and a sense of impotence to affect treatment decisions. As a consequence, the women often felt that they had been inappropriately diagnosed and treated by the prison doctors they had consulted.

The women's narratives highlight the estranging effects of the conveyor belt system of seeing prisoner-patients, and many described feelings of detachment from one's own body. In the women's accounts, medical staff (nurses as well as

doctors) are portrayed as lacking humanity, as treating the prisoner-patient like a 'piece of meat'. The gap in power and authority is clear and the depersonalising effects of the 'sick-parade' in many respects mirror the depersonalisation of becoming and being a prisoner. When asked to rate health care services, the women prisoners in this study consistently rated them lower than those in the outside community (see Figure 5.2).

Figure 5.2. Health care rating (questionnaire survey)



Wherever health professionals constitute part of the prison administration, the quality of the care they provide may not necessarily be their most important task. As we have seen, the duties and responsibilities of prison doctors and nurses encompass a broad range of tasks, many of which reach far beyond protecting (let alone promoting) the health of prisoners. They are substantively involved in prison administration and management, and also in maintaining and enforcing prison discipline. Such a range of tasks raises doubts about the ability of health personnel to combine their roles. Protecting the health of prisoners while participating in decision-making on prisoners' disciplinary punishments

are difficult tasks to reconcile, and illustrate the difficulties inherent in giving the same personnel three distinct responsibilities : custody, punishment, care. At the end of the day, one of these responsibilities may be jeopardised.

Postscript : Resistance to medical control

Medical power is pervasive and predominant in women's prisons and yet this does not mean that opposition and resistance to such power is precluded or rendered ineffectual (see Sim, 1990). While some women prisoners become the passive victims of doctors' ministrations, others actively challenge the dominance of medicine in prison health care services. Prisoners usually have a choice over whether or not to consult prison medical services[13] and some women, for example, simply avoid medical encounters :

> I just don't go. You don't put yourself up for that kind of abuse (Chris).
>
> The way I see it, you can't get ill in prison, you can't get ill because nothing's going to be done. Wait till you get out and then be ill (Diane).
>
> I don't want to be offered a fistful of tablets every time I feel a little down, so I avoid going. I avoid it like the plague [laughs] (Sue).
>
> I won't go across to the doctor because all he'll say is 'You're all right really'. You just get a negative response everywhere so you just don't bother (Emma).

Some (campaigning) women become more involved by directly opposing medical power. Here, penal reform groups have provided an important channel through which women prisoners can articulate their grievances around medical care and the structures for its delivery. Medical authority in women's prisons has also been challenged through alternative approaches :

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13 The initial medical examination on reception into prison is *compulsory* and prisoners have no right to refuse it. Compulsory medical examination has been accepted in human rights law because its main purpose is to provide safeguards against the torture and ill-treatment of prisoners (Tomasevski, 1992). For some prisoners this may be the only contact they have with medical personnel throughout their sentence.

> I was on conventional medicine [for rheumatoid arthritis] but I didn't want the side effects ... I believe in natural health medicine so I genned up and wrote to the arthritis society. So I went to the doctor when he was to renew the prescription and said I didn't want it. I'm now only taking natural medications and I'm also having aromatherapy from another prisoner. It's a process of healing which works (Angie).
>
> I look after my health myself. I wouldn't trust that lot [at the health centre]. I get vitamins and herbal remedies sent in (Mair).

Such findings suggest that there is the potential for women to resist the submissive prisoner-patient role. However, it should be emphasised that there are limits constraining the extent to which prisoners can do so. Convicted prisoners have no *choice* over who is responsible for their health care. This lack of freedom of choice seems particularly pertinent for women prisoners, many of whom have experienced violence and/or abuse in their relationships with men. Here, it is likely that the women themselves enter the medical encounter with a certain set of gender-specific expectations. The sex of the doctor may thus be important, not because of any perceived interpersonal, medical or technical skills, but because of the threat posed by masculinity in and of itself :

> If you've got any sort of gynaecological problems it's very embarrassing going to a man. Many of the women have been abused and it can bring everything back (Olga).
>
> [The smear] was done by a man who never spoke to me. The nurse got me onto the couch and got me ready and I thought she was going to do it and then suddenly this little figure rushed in, went to the end of the bed, stuck his spatula up and buggered off again and that was it. He didn't even say hello or goodbye. It was horrible, it was like being raped all over again (Pam).

Women prisoners may not want or be able to challenge doctors' authority : the very environment, as well as the nature of the problem for which they are help-seeking, will have an obvious impact on the extent to which they may feel 'empowered' to take control in the medical encounter. Moreover, women

prisoners may feel so anxious that they are desperate to put their treatment into the hands of someone else.

Finally, medicine is a powerful institution and the relationship between medicine and imprisoned women is, as I have suggested, a complex one, characterised by a tendency to trivialise, individualise and pathologise women's problems; by attempts to regulate and control women's behaviour, particularly their physical and psychological reactions to imprisonment, and by women's resistance to that control and to medical and psychiatric labelling.

The interests of prisoner-patients and the prison regularly collide and the participation of health professionals in the investigation and punishment of disciplinary offences continues to create controversies over the self-contradictory role they play in prison security and discipline versus health care. The next and final chapter explores these controversies further with reference to contemporary 'public health' and 'health promotion' discourses : the governmental tactics of modern medicine which may be harder to resist.

CHAPTER 6

'Healthy Prisons' : A contradiction in terms?

> Rehabilitation is shite ... Rehabilitation means the surrender ay the self (Irvine Welsh, *Trainspotting*).

From what has been described in previous chapters, it is difficult to view women's imprisonment as a health promoting experience : excluded from society and all that is familiar, women prisoners are subject to disciplinary routines and practices which may well change them both physically and psychologically. Current developments in prison health care, however, promise *enhanced* health benefits for prisoners and the promotion of health has become a central feature of prison health care policy. This final chapter presents the background to these changes, considers what they are likely to mean in practice and explores the policy implications of matters discussed in the preceding chapters. It provides a description of the emergence of health promotion within the prison context at the level of both rhetoric and implementation. It discusses the governmental nature of contemporary health promotion, locating prison-based initiatives within the context of wider socio-cultural changes. The chapter is divided into three key sections :

- 'Healthy Prisons' : The institutional context of health promotion;
- Health promotion : Rhetoric and reality;
- A captive audience : Health promotion in women's prisons.

While the chapter looks at these issues separately, the broader aim is to consider whether health promotion policies and practices can be divorced from prevailing ideologies about women's role in society and about the needs of women prisoners. The chapter and the thesis concludes with a brief discussion of possible alternatives to a medical paradigm of women's imprisonment.

'Healthy Prisons' : The institutional context of health promotion

> A healthy prison is almost a contradiction in terms, isn't it? (Chris).
>
> You can't be healthy in prison ... there's no way you could be healthy in this prison (Discussion Group 3).

Prison medical services have long been the subject of intense criticism from both within and outwith the prison walls[1]. The 'culture of criticism' (Thomas and Costigan, 1992 : 325) has focused on several key issues, not least the conflicting roles performed by prison medical workers discussed in the previous chapter. The quality of care has also been severely questioned as has the service's separate identity from the National Health Service (NHS) and it has long been felt that many of the problems which surround prison medical services could be alleviated by their incorporation into the NHS (see Candy, 1985).

Those of us who have worked in the NHS (particularly in the last fifteen years) will question whether the integration of prison health care services into the NHS would, in itself, be the solution that some writers suggest : the 'cure-all for the ills of the prison system' (Candy, 1985 : 25). Re-organisation does not necessarily lead to an improved service. Moreover, as far as medical services for women are concerned, much of the day-to-day medical care is already conducted by doctors whose principal employment *is* with the NHS. And, as I have suggested, the apparent refusal to take women's illnesses seriously, on the one hand, whilst medicalising their distress on the other hand, does not seem to be peculiar to (male) prison doctors.

Criticisms of prison medical services have led to close official examination in the form of an intensive enquiry by the Social Services Committee (House of Commons, 1986); detailed annual reviews by the Chief Inspector of Prisons

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[1] See, for example, Lee, 1983; Prison Reform Trust, 1985; Sim, 1990; Tomasevski, 1992. As well as Genders and Player (1987) on prescribing practices; Hindson (1988) on the treatment of mentally ill women; Liebling (1992, 1994) on suicides, and Thomas and Costigan (1992) on HIV/AIDS.

since 1989; a Royal College of Physicians Working Party Report in 1989 (Home Office and Department of Health, 1990), and a rigorous Efficiency Scrutiny in 1990 (Home Office, 1990), which provided the impetus for many of the recent changes to prison health care and the structures for its delivery.

The Scrutiny Report recommended a number of changes in the way that prison medical services operate. The key recommendations included :

- the role of the of the PMS should be widened to that of a Prison Health Service more closely aligned with the NHS, and with an increased emphasis on the promotion of health and preventing illness;
- clinical practice and medical management should be more clearly distinguished;
- the Prison Service should become a purchaser (through contacts with the NHS and other providers) of health care services rather than a provider (Directorate of Prison Medical Service, 1991 : 1).

The Scrutiny Report was welcomed by politicians (virtually all of the eighty-three recommendations in the report were accepted either in full or in principle) and penal reform groups alike (despite the narrow terms of reference of the Efficiency Scrutiny which explicitly ruled out any discussion of the continued existence of prison medical services outwith the NHS : see PRT, 1991).

In 1992, the Prison Medical Service was relaunched as the Health Care Service for Prisoners, the change of name being emblematic of the new commitment to health promotion, illness prevention and treatment. Other symbolic name-changes since then include : hospital officers have become 'health care officers' and medical officers have become 'prison doctors'.

Since 1992, the Directorate of Health Care, as well as being responsible for policy formulation, strategic planning and the development and monitoring

health care standards in prisons, has facilitated the development and implementation of prison-based health promotion initiatives in a small number of 'pilot prisons' (including Styal).

A political commitment to health promotion in prisons has also been made by the Government in its *Health of the Nation* strategy (HMSO, 1992b). This political will has been supported by the World Health Organisation (WHO) whose programme of health promotion in prisons in European member states was launched in October, 1995. The WHO aim to develop an international network of 'Healthy Prisons' following the model of health settings projects such as 'Healthy Cities'[2] and 'Health Promoting Schools'. In discussing the 'Healthy Prisons' Project and the role of the UK Prison Service, Dr Cees Goos (1996 : 22), WHO Lifestyles and Health Coordinator, states that the Prison Service is to become a 'major "police force" in Europe for health promotion in prisons'.

A commitment to implement the policies set out in the *Health of the Nation* and to develop the WHOs 'Healthy Prisons' initiative was made in the Prison Service 1995-98 Corporate Plan (HM Prison Service, 1995a).

Is it possible to 'do' health promotion in prisons? Before addressing this question, more fundamental questions arise : What is health promotion? What should health promotion attempt to do? What are its politics?

Health promotion : Rhetoric and reality

> Health promotion, health education, whatever you want to call it, is cheap. If it works, the Government can take the credit. If it doesn't, then we can always blame the individual for not doing what they're told (Prison Doctor).

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2 See Ashton and Seymour (1988) for a discussion of the development of the WHO 'Healthy Cities' Project.

> Health promotion is a buzz phrase, it's essentially meaningless (Prison Doctor).

Preoccupation with health seems to be an outstanding feature of late twentieth century Western societies as is apparent in the ways people articulate their concerns about health. Ill-health is costly and inefficient for the state and for the individual it usually involves unpleasant bodily sensations. The desire to avoid ill-health can thus be seen to be a common interest between the collectivity and the individual. This has led to a heightened interest in prevention and in such vague concepts as positive health, health empowerment and health promotion.

The notion of health promotion has its origins in the 1970s when governmental reports in countries such as Canada (Lalonde, 1974), Great Britain (DHSS, 1976; SHHD, 1977) and the USA (US DHEW, 1979) acknowledged the limitations of an approach to health based merely on the provision of hospital and medical services. These documents, to varying degrees, reflected a scepticism that the provision of services *alone* could improve the health status of the population (see Bunton *et al.*, 1995; Lupton, 1995). The fact that health policy had become increasingly dependent on 'high-tech' medical interventions and on expensive (and often invasive) hospital-based techniques was thought undesirable on many grounds, not least financial (the pressures for cost-containment in Western economies was particularly relevant in the 1970s due to what has been termed the 'fiscal crisis').

In April 1974 the Canadian Ministry for Health and Welfare published the Lalonde Report in which the term 'health promotion' was first introduced. In the report, Lalonde unequivocally questioned the popularly held belief that the level of health equates to the quality and quantity of medical care. His argument was that the public's health could best be improved by avoiding the curative treatment of illness in favour of prevention.

The Lalonde Report was hailed as a turning point for public health activities and as marking the beginning of a 'new era in public health' (Lupton, 1995 : 50). The report threw light on the debate concerning which elements of health policy were likely to be most effective for the future, outlining a conceptual framework for re-orienting health policy : the 'health field concept'. This concept emphasised the significance of four broad elements as being important to health : human biology; environment; lifestyle and health care organisation. Lalonde argued that while the bulk of health care expenditure focused on health care organisation, the major potential for prevention and health promotion lay in the other three elements of health.

The Lalonde Report was criticised by several writers, not least for its neglect of the influence of socio-economic factors on health and its failure to question why 'unhealthy lifestyles' had become so widespread (see Labonte and Penfold, 1981; Ziglio, 1983). It was seen to embody individualistic assumptions about health-related behaviour (RUHBC, 1989). Moreover, post-Lalonde, Canadian public policy did very little, in fact, to control environmental factors, concentrating instead on 'healthy lifestyles' through mass media campaigns to modify individual behaviour. Tsalikis (1980) argues that the Canadian government supported efforts to change certain habits which conventional morality perceived to be 'faults' in the individual such as drinking, smoking and illegal drug-use. He adds :

> While unchecked economic growth is increasingly producing health risks, government and voluntary campaigns concentrate on teaching individuals how to protect themselves against these risks. Moreover, producers and professionals have moved with full exploitive force to promote all sorts of commodities and services for anyone in pursuit of a new lifestyle from special jogging outfits to behaviour modification programmes for new ways of living (Tsalikis, 1980 : 99).

The individualisation of modern health problems inherent in the Lalonde Report is reflected in the succession of other governmental reports and policies which followed in its wake. In Britain, this included the publication of the Department

of Health and Social Security's consultative document *Prevention and Health : Everybody's Business* (DHSS, 1976). This document sought to achie n important reorientation in the planning of health care in Britain. It shifted the health care debate away from treatment towards prevention, although it did not fully grasp the notion that health is created largely outwith the health care sector. Instead, the document focused primarily on the provision of preventive services such as screening and the individual's responsibility to adopt healthy behaviour patterns. The discussion paper explicitly ignored the influence of social and cultural factors :

> Many of the current major problems in prevention are related less to man's outside environment than to his own behaviour; what might be termed our lifestyle. For example, the determination of many to smoke cigarettes in the face of the evidence that it is harmful to health and may well kill them (DHSS, 1976 : 17).

Since 1976, policy objectives for health have increasingly emphasised preventive measures, health promotion, and the development of 'responsible' attitudes to health on the part of the individual and the community.

'Health promotion' as a term and concept is extremely broad, and could conceivably encompass any activity directed at 'promoting' 'health'. The WHO (1984) defines health promotion as 'the process of enabling people to increase control over, and to improve, their health', although the term is now generally used to describe those specific activities directed towards the 'management' of the population's health (Lupton, 1995). The language of health promotion emphasises health needs assessment, planning, programming, consultation and evaluation (see Hawe *et al.*, 1990), and the major focus of health promotion rhetoric is on fostering 'positive health', on developing performance indicators based on specific 'health targets' and on working in partnership with communities to develop health-enhancing behaviours (Tones, 1986).

Health promotion, described by Armstrong (1995 : 395) as 'surveillance medicine', is thus directed not only at those who are sick, as in traditional medicine, but at *all* individuals and at *all* levels of the population. In so doing, health promotion has moved from the clinic and hospital out to all major social sites. Most social issues have now become subsumed under the rubric of health and therefore have been rendered appropriate problems for health promotional intervention (Stevenson and Burke, 1991). As Armstrong argues :

> A cardinal feature of Surveillance Medicine is its targeting of everyone. Surveillance Medicine requires the dissolution of the distinct clinical categories of healthy and ill as it attempts to bring everyone within its network of visibility. Therefore, one of the earliest expressions of Surveillance Medicine - and a vital precondition for its continuing proliferation - was the problematisation of the normal (Armstrong, 1995 : 395).

Is prevention better than cure, however? Skrabanek and McCormick (1989 : 87) argue that 'prevention has a price and sometimes the price may be exorbitant' : it was, for example, in the name of prevention that clitorises were excised in deviant women in the nineteenth century (see chapter one). It was a fear of national degeneracy that drove Nazi public health officers to call for the elimination of 'racial poisons' (Skrabanek, 1992 : 989). And, as we have seen in chapter five, the prescription of psychotropic drugs may be considered a preventative measure. Skrabanek and McCormick state :

> While a 'stitch in time saves nine', this may not apply to everyman and every preventive measure. If the 'one stitch' has to be inserted one hundred times to save one individual from the 'nine', it may be unwise to queue for stitching. Similarly the cost of one hundred stitches exceeds by a large amount the cost of nine (Skrabanek and McCormick, 1989 : 87).

Becker (1986 : 15) argues that 'danger lurks in the Garden of Health Promotion'. He points to examples of fallacious arguments and faulty logic often put forward by those fostering 'the Holy Grail of wellness' (Carlyon, 1984: 27)[3]. First, Becker describes what I term the 'fallacy of scientific bases' :

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[3] Also, see Skrabanek and McCormick (1989) for a 'fistful of fallacies' in medicine.

considerable disagreement exists among health professionals and 'scientists' as to the validity and interpretation of the data underlying much health promotion advice. Is alcohol, for example, good for one's health or not? The research community seems divided. Rather than waiting for a 'coalescence of scientific information', Becker argues that recommendations have been made to modify individuals' life styles. As a consequence : 'reasonably content people have had their fears aroused and feel compelled to attempt significant behavioural changes'. This situation is compounded by the media who, aware that we are a society obsessed with health, often increase our dilemmas by attributing an unjustified degree of certainty to new health-related findings, portraying minor advances in research as 'breakthroughs', thus often exaggerating the risks posed by potential health hazards (consider the current beef-mania).

Secondly, this rather cavalier approach to science has led to a number of unfulfilled health promotion/disease prevention promises : the 'fallacy of cheating death'. Engaging in certain behaviours may, for some, increase the *risk* of undesirable health outcomes, but avoiding them is no guarantee that untoward health events will not occur. Environment, heredity, accidents and so forth all play an important role in determining health and longevity.

Thirdly, Becker (1986) suggests a 'fallacy of cost-containment' : 'do what we tell you to do and ultimately the costs of medical care will be dramatically reduced' (1986 : 17). While we may be living longer, we are not living with fewer chronic illnesses. Moreover, some health promotion programmes may actually cost more than the medical treatment for those affected because they are directed at large numbers of people only some of whom *might* have fallen ill without such interventions.

Becker (1986) argues that heightened attention on the behavioural determinants of health and a subsequent (re-)allocation of resources has led to a fourth fallacious argument : the 'fallacy of the wages of sin'. The research

community's relentless search for 'risk factors' has resulted in *any* behaviour potentially being considered 'risky' :

> Could wearing a wrist watch cause cancer? Possibly. After all, there is often skin irritation: the luminous dial might be trouble; perhaps watching time fly by leads to stress, depression, heart disease, or suicide. Handled properly, this idea contains three [research] grants, five papers, and a movie (although, for the experiment, we will have to devise a method for attaching a watch to a mouse's foot) (Becker, 1986 : 18).

A crass example? Perhaps. However, the pages of the academic medical press are littered with fallacies of association being causal. A letter in the *Journal of the American Medical Association* (JAMA) in 1985, for example, reveals that 'impulsive homicidal and suicidal behaviour can be connected with low-cholesterol levels' (Virkkunen, 1985 : 635-36). This being so, not only should one consider carefully who is invited to dinner, it also provides one explanation for the prison diet being 'all grease and stodge'! (Tracy).

O'Connell *et al,* (1987) illustrate the problems of taking small relative risks too seriously in their study of smoking, drinking and breast cancer in women. The researchers reveal that alcohol consumption increases the risk of breast cancer just less than two-fold, while smoking decreases the risk by half. The obvious conclusion : if you are a woman and you drink, for God's sake smoke as well!

Castel (1991) argues that we are on the verge of a medical revolution characterised by a shift from 'dangerousness' to 'risk'. This change will see : the demise of the one-to-one doctor-patient relationship; a new role for health professionals as health strategists, and an increasing emphasis on the profiling of populations. The target of medical care is likely to focus less and less on the symptoms of patients and more and more on their risk profile.

Finally, Becker (1986 : 18) points to what he considers the 'most disturbing aspect of the contemporary health promotion movement' : its tendency to locate the responsibility for both the *cause* and the *cure* of health problems in

the individual - the 'fallacy of individual responsibility' - thus deflecting attention away from the problem of the social environment, which both *creates* some behaviours and *inhibits* the initiation and/or maintenance of others.

Health promotion, as a concept, has support from both ends of the political spectrum. At its most radical, it is recognised as a means of facilitating major social changes through 'community development' and the encouragement and 'empowerment' of citizens to group together to challenge the state (see Minkler, 1989; Grace, 1991). At its most politically conservative, it is presented as a means of enjoining individuals to take responsibility for their own health and, in practice, (and in spite of a rhetorical acknowledgement of the environmental contribution to ill-health) this has been the main thrust of health promotion to date. This has, according to Draper (1986), suited the interests of most stakeholders : it accommodates the medical model of health and disease prevention (thus keeping doctors in a job) and yet allows governments to commit themselves to the health promotion *idea* without confronting the complex socio-political questions that a more structural approach would imply. On the one hand, it is now common to find governmental statements acknowledging poverty, unemployment and other forms of social deprivation and social inequalities as detrimental to health. On the other hand, comprehensive strategies to tackle such issues are rare (Townsend, 1979; Blaxter, 1983; Illsley and Mullen, 1985).

Several writers have focused on the ways in which the programmes and technologies of health promotion serve, not only to monitor and regulate populations, but also to *construct* new identities (see, for example, Arney and Bergen, 1984; Nettleton, 1992; Armstrong, 1995; Lupton, 1995). Contemporary health promotion techniques penetrate into the lives and minds of subjects and such techniques can contribute to the creation of the 'health promoting self'. Health promotion techniques, therefore, involve more than the creation of healthy lifestyles and healthy bodies but also healthy minds and subjectivities.

Health promotional discourses often represent 'the enemy' as the failure of *self*-control, the invasion of weakness, lack of *self*-discipline, against which the individual should be ever-vigilant (Lupton, 1995). Consider the moralism that is extended to people who become ill because of a failure to regulate their 'lifestyle' with sufficient discipline. 'Being ill' is redefined as 'being guilty' : smokers, for instance, 'have no will power' and the obese have 'let themselves go'. Health has become, according to Skrabanek (1992 : 990) a 'new religion' and the unproselytised are treated as 'deviant.'[4] As a consequence, health promotion fosters a 'dehumanising self-concern' which replaces societal health goals with personal health goals (Becker, 1986 : 20). Illness *is* punishment for those who have not seen 'the light'.

But whose 'light' is it? Like many other contemporary institutions and agencies, health promotional discourses and practices privilege a certain type of subject : a self-regulated, 'health'-conscious, middle-class, rational, civilised subject (Lupton, 1995). They also privilege a body that is contained and controlled and the governmental strategies emerging from health promotion, sponsored by the state and other agencies, are concerned with fostering such subjects and such bodies.

Nettleton and Bunton (1995) argue that ideas about healthy living are promulgated by those who are white, middle-class, and often work with sexist, racist and homophobic value systems. This has the effect of contributing to the marginalisation of certain social groups who may be earmarked as 'targets' or 'deviant' (see, for example, Plummer, 1988; Watney, 1988; Patton, 1990).

The targeting of certain social groups or health problems may have the potential to act as a mechanism for 'deviance amplification' and can reinforce the stigma attached to illness or disability. It can, for example, serve to project an image of disablement as personal tragedy rather than a socially produced

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[4] On a recent visit to New York I was amused by the following anecdote provided by a tour guide : on a trek around Manhattan's business district a Japanese tourist was impressed by how well-dressed the prostitutes (smoking in darkened doorways) were. An urban myth? Probably, but a symbolic one!

state. Furthermore, it creates the sense that if illness is so bad then it must be avoided at all costs. What impact will this have on those people who *are* ill or on those with chronic conditions? There is a possibility that health promotion activities can operate, therefore, to create further socio-structural divisions between the 'healthy' and the 'not so healthy'.

Such an approach to health thus fosters victim-blaming and the identification and exclusion of marginalised groups who are considered to be 'unhealthy' or 'risk-takers' : like the leper, they are 'caught up in a practice of rejection' (Foucault, 1977 : 198).

Members of the working classes, for example, have historically been represented as the archetypal 'uncontrolled' body in public health discourse. So too in contemporary health promotion discourses, members of the middle class are commonly represented as capable of the valued qualities of self-denial and self-efficacy, while working-class individuals are typically portrayed as those who frequently fail to take up the exhortations of health promoters, who deliberately expose themselves to health risks rather than 'rationally' avoiding them, and who, therefore, require greater surveillance and regulation.

In sum, then, the current health promotion/disease prevention movement has the potential to create or exacerbate several undesirable outcomes : including, the (re-)allocation of scarce resources to a relentless search for 'risk factors'; over-zealous exhortations to the public to make behavioural changes (with frequent reversals of advice); a confused and sceptical public; an academic community which, abetted by the media, rushes tentative research findings to print; the problematisation of the normal, and an approach to health and illness which fosters victim-blaming and stigmatisation and which ignores socio-economic and environmental issues which have major impacts of health. Illness becomes *symptomatic* of an unhealthy 'lifestyle' and is, therefore, the fault of the individual : the 'wages of sin' described in the statistical language of 'risk factors'. The net effect? :

> An increased medicalisation of life, an epidemic of apprehension and an iatrogenic contribution to ill-health (Skrabanek, 1992 : 990).

Health promotional policies and practices thus raise questions about such negative aspects as increased surveillance of the population, state interference with *private* lives and the erosion of civil liberties. This situation is, perhaps, magnified when one considers potential and actual interventions in the lives of 'captive audiences'.

A captive audience : Health promotion in women's prisons

> Many of the women we see have had unhealthy lifestyles before coming into prison (Prison Officer).

> How can you give up smoking in a place like this? (Emma).

Why 'do' health promotion in prisons? In answer to this question, Goos (1996) points out that addressing the subject of health in prisons constitutes a direct consequence of the WHO's *Health for All by the Year 2000* policy (WHO, 1981) :

> The main social target of governments and WHO in the coming decades should be the attainment by *all* citizens of the world by the year 2000 of a level of health that will *permit them* to lead a socially and economically productive life (WHO, 1981, emphasis added).

One of the principle features of *Health for All* is 'equity' : 'opportunities for health, access to health care and access to health promotion must be equal for all citizens. This is a basic human democratic principle' (Goos, 1996 : 23).

There is increasing consensus, both nationally and internationally, that prison health services should be 'equivalent' to those of the community (see chapter five). The implementation of equivalence as an operative principle in prison

health care in England and Wales is evidenced by the movement towards the sharing of responsibility between the HCSP and the NHS. However, this process is likely to be hindered by a number of obstacles, not least by the position of health care vis-à-vis the prison : does general health legislation, for instance, apply to the prison population or does prison legislation take precedence over health?

If we consider the examples of illegal drug 'abuse' and mental 'illness', the answer to this question becomes clear : both issues are fraught with the inherent contradictions between health and concerns over security and the maintenance of order. Moreover, both issues raise questions about the likely nature of health promotion in prisons.

A reading of the literature on prison health, and accounts from prison staff, suggest that illegal drug-use and mental ill-health are *the* health problems in women's prisons :

> CS : What are the main problems affecting the health of women prisoners?
>
> Prison Doctor : They fall into two main categories - there are the inadequate adults, the ones who get violent and out of control ... then in the last 5 to 10 years we've seen an increase in drugs-related problems. I'd say that these are the main issues.

However, this is not a clear-cut issue and, while it is recognised that drug users (particularly drug-dependent users) and the mentally ill may need medical assistance, such individuals may not, on the one hand, necessarily consider themselves to have a 'problem'. On the other hand, these may not be the most *prevalent* health problems in prisons. Rather, they may represent issues which are problematic for 'the system'. These issues tend to be *problematised* because of their association with crime and with issues of security and the maintenance of order in prison.

The consumption, possession or purchase of illegal drugs in prison, for example, pertains to issues of security and law enforcement rather than health. The WHO themselves have concluded that the imprisonment for drug use is 'a punitive measure without noticeable preventive effects' (WHO, 1990 : 63). Moreover, prison authorities respond to prisoners' drug-use by principally trying to prevent the supply of drugs into prison. This has implications for prisoners in terms of reception procedures, visits and home leave. Women prisoners in this study had *all* experienced the effects of increased security aimed at reducing the supply of drugs into prison, including visitors being searched (and arrested in one case), the imposition of closed visits and the refusal of home leave :

> The other week my sister came on a visit and she brought the baby with her ... and they searched her, the baby and the baby's carry cot for drugs. I don't just mean looked through her bag or something, they had dogs and everything and the baby was screaming. The screw said to [sister], 'Can't you shut up his bawling?' (Anna).

> I was eligible for home leave and it was refused ... They're really clamping down at the moment because of drugs, escapes and that ... but it's unfair on those of us that don't cause problems, that keep our noses clean (Anwen).

Such preventive measures are not, however, completely successful, evidenced by the fact that some prisoners *become* drug users during imprisonment. At the same time, this policy often results in demands upon health care staff to participate in the enforcement of prohibitive measures such as body cavity searches for drugs or needles, or compulsory testing to detect drug use. Illegal drug-use is a disciplinary offence and prisoners are liable to a range of disciplinary actions including additional days, loss of privileges and fines. Its detection, however, raises a number of questions especially when it involves *compulsory* or *mandatory* testing for drug use.

Mandatory drug testing (MDT) was introduced on a phased basis into prisons in England and Wales in 1995 (incidentally coinciding with the 'Healthy Prisons'

project) as part of the Prison Service's drugs strategy (HM Prison Service, 1995c). Under the programme, prisoners are required to provide a urine sample for testing purposes and those who refuse are subject to disciplinary action. MDT powers can be used in a number of ways : including, at random; on reception; on suspicion, or with frequency in the case of persistent offenders.

It is too soon to assess the impact of MDT on the extent and nature of drug usage in prisons (evaluative research is currently being conducted). Preliminary findings suggest, however, that MDT performs well in *identifying* drug users and allowing these to be *targeted* (Prison Service Custody Group, 1995) : that is, targeted for further testing and disciplinary action. In discussing the likely impact of the MDT programme, women prisoners interviewed in this study seemed particularly nonplussed (also see Trace, 1995; 1996; Wallis, 1996) :

> The main reasons for taking drugs in prison are boredom and family problems. There's women in here who had never even tried drugs before and they now need them just to help them get through. How will urine testing solve these problems? If anything it'll just add to them (Chris).

> A lot of the women (including me) come into prison as users, others pick up the habit because of the people they muck about with or as a way of coping. Now there are courses and that which you can go on but by the time they're sorted out it's time to leave, do you know what I mean. What the Prison Service should be looking at is how to speed up the process of getting help (if that's what's wanted and a lot of people don't want help). Drug testing only delays that process (Mair).

> You can't win. If you take the test and you're positive it affects your case and that. You're also then seen as a druggie which means that they're likely to test you over and over. If you're negative there's no pat on the back or anything and, if you refuse the test you're in trouble anyway so you may as well get into trouble for something worthwhile. It's crazy (Beth).

The legality of compulsory urinalysis in prisons has been challenged before Canadian courts where the procedure has been revoked on the basis of its incompatibility with human rights protection (Tomasevski, 1992). In England

and Wales, however, it represents an inroad into prisoners' lives promoted as a preventive measure[5].

Contradictory aims between health promotion and security also exist in relation to mentally ill prisoners, not least because of the problems of definition already discussed. It is something of a truism to say that the mentally ill should not be in prison (see Ross and Bingley, 1985). They are often there, however, because of a complex relationship between medicine and the law in defining mental illness : for example, the discrepancy between the legal criteria for defining criminal responsibility and the medical criteria for the identification of health impairment. In prison, those defined as mentally ill often encounter a harsh disciplinary regime legitimised by concerns over 'good order' rather than by concerns over health protection. Such concerns are often premised upon a notion of 'dangerousness' : itself an assessment presupposed upon *predictions* of behaviour as much as on actual behaviour.

The important point here is that the very *definition* of what constitutes a 'health problem' in prison, be it mental illness or illegal drug use *determines* not only the perceived nature of health problems (which may have little to do with prevalence rates), but also the patterns of response (that is, the targeting of certain populations).

The inherent contradictions between health 'care' and control are further evidenced in the treatment of pregnant women prisoners. Pregnant prisoners have received quite a lot of attention in recent years. In April, 1994, when Susan Edwards was handcuffed to prison officers while giving birth to her baby, there was a public and professional outcry. At that time the Home Secretary pledged it would never happen again. However, since then, there have been various stories of prisoners being 'shackled' up to and during labour (Dockley, 1996b).

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5 See *Criminal Justice Matters* (No. 24, Summer, 1996) for an overview of the current drugs debate including the MDT programme in prisons.

Dockley (1996), for instance, cites the story of the routine cuffing of a pregnant woman, imprisoned for eighteen months for DSS fraud, who was taken to hospital when she developed stomach cramps :

> Whilst in hospital she remained cuffed and attached to officers using a closeting chain both day and night. She complained that she was unable to rest and that her blood pressure increased. Ann said that while in hospital she suffered jibes from an escorting officer which she ignored. A little later she went to the bathroom to shower. At first she was chained to the bathroom railings. Ann said she felt like a dog chained to a post ... while she was washing [a female] officer continually opened the door to check on her. This meant that the other escorting officer, who was male, could see into the bathroom. Ann commented on this and it is alleged that the officer came into the bathroom and grabbed Ann's hand leading to an altercation. This resulted in Ann being fully restrained and placed on her stomach with an officer putting pressure on her back (1996 : 32).

Such 'chainings' are particularly symbolic in reinforcing the woman's prisoner status, pregnant or otherwise, and are about as far removed from health promotion as it is possible to imagine.

Prisons *do* represent an area of special concern health-wise, although the nature of health problems may be qualitatively different to those recognised in official discourses on prison health. There is evidence to suggest that the physical and psychological health of the prison population *is* worse than that of the population outside prison. However, anecdotal evidence suggests that such problems may well be 'reactive' or 'situational' rather than inherently pathological and, as such, they are unlikely to respond to medical 'solutions' alone. We know that lower socio-economic groups are over-represented in the prison population, as are minority ethnic groups. We also know that prison is a potentially disadvantageous environment for good health : dispossessions, isolation, discreditation, stress, anxiety, overcrowding, insanitary conditions, limited facilities and opportunities all have an impact on health and all represent valid reasons for conducting health promotion in prisons. However, neither current penal policies and practices nor health promotional discourses render it

likely that *these* issues will be addressed adequately by any prison-based health promotion strategy.

Goos (1996) points to the resources already available within the prison setting to facilitate health promotion, including the potential cadre of health promoters: the health care staff. Neither their skills nor their commitment can be assumed, however, and while many health care workers may embrace the principles of health promotion, the reality of 'the job' often dictates different priorities :

> You start out with lots of good intentions and ideas, health education sessions and things like that but you gradually realise that you are alone. The support is just not there (Nurse).
>
> I started a well-woman clinic some years ago and it went down really well with the women but we couldn't continue with it because it was just myself and another nurse (there was no system) and it was basically just down to us to do that on top of the task of having to treat women who were ill. It just became too much effort, I know it sounds terrible but there is just not the time or the good will or the necessary organisation to do anything about health promotion (Nurse).
>
> It's a nice idea but it's not part of my job description to promote health (Health Care Officer).

A study of diabetic care in prison (Gill and MacFarlane, 1989; MacFarlane *et al.*, 1992) highlights some of these issues. The writers found that prison medical staff regularly misinterpreted poorly controlled diabetes as 'acting up' by prisoners. Similarly, diabetic ketoacidosis was often seen by staff as evidence of prisoners 'manipulating' their conditions in order to be transferred to an outside hospital. The writers found, however, no evidence of such manipulation. Rather, they found that concerns around disciplinary duties often meant that staff did not adhere to the most appropriate procedures of medical management. For prisoners, standards of care, let alone health protection and health promotion, may thus be jeopardised in the interests of security and discipline.

While it might be expected that the HCSP could provide the basis for a health promotion service, fundamental role conflicts exist which raise questions about to whom the prison health promoter owes his or her allegiance : to the prisoner or to the organisation? Prisoners, for example, may be justifiably concerned about issues of confidentiality and privacy. Moreover, the development of the health promotion movement outside prison has been premised upon a questioning of the relationship between health and the quality and quantity of health services and it seems somewhat ironical that the HCSP has been delegated principal responsibility for the development and implementation of a health promotion strategy.

Finally, Goos (1996 : 25) argues that, in prison, there is 'an audience, a target group ... for health promotion and what is special here is that the target group has time available'. The targeting of captive audiences, however, raises a number of fundamental and serious ethical questions and, while the (over-)prescription of psychotropic drugs to women prisoners may represent an overt example of the abuse of captive populations, current health promotional discourses may, in the name of 'health', have a number of undesirable consequences for women prisoners. In particular, a tendency to medicalise women's problems may, as we have seen, lead to inappropriate and ineffective solutions. Moreover, health promotional strategies may place responsibility for health firmly on women prisoners themselves without recognising their relative powerlessness to effect change.

Daykin and Naidoo (1995) identify ways in which sexism has influenced the design and delivery of health promotional strategies generally and it is likely that 'health police' will have already made significant inroads into the pre-prison lives of women prisoners.

Women (prisoners and otherwise) have been particularly subject to health promotional strategies because of their assumed responsibility for the health of others : health promotion within the family, through the inculcation of healthy

lifestyles and the provision of informal health care for children, spouses and other relatives (Graham, 1984; 1988). Informal health promotion activities are assumed to *belong* to women because of their caring nature. Health promotion discourses thus *construct* women as carers and *naturalise* gender inequalities. Women's responsibility extends from maintaining and protecting the family health through to everyday activities such as cleaning, washing, cooking, though to the 'emotional housework' of dealing with the stresses experienced by other family members.

Assumptions about women's role in society and about the needs of women prisoners may therefore inform health promotional activities directed both overtly and covertly towards the constitution of a certain type of subject : one who is self-regulated and 'health'-conscious. Such activities confer responsibility onto women without recognising the powerlessness that underlies their health-promoting work. The outcome may well be to increase stress and ill health for women : the paradox of 'responsibility without power' (Lupton, 1995 : 63). For example, healthy eating campaigns are often targeted at women because of their supposed role as food providers for 'the family'. However, providing a 'healthy' diet may well be beyond the means of many women on low incomes. Moreover, research suggests that household priorities often dictate that women and children eat lower status foods than men (Charles and Kerr, 1987). As a consequence, health promotion campaigns may merely serve to make women feel guilty because they cannot conform to health promotion directives.

Smart (1989 : 99) argues that health promotion is not 'intrinsically good' and the pursuit of 'good' health may have certain consequences for women whose 'bodies are constructed as so central to the health of others'. She points to a number of processes directed not so much towards women's health but towards the health of their children - from information on healthy eating to medical surveillance and intervention during pregnancy and childbirth - which may be oppressive to women's bodies (also see chapter one). She takes the discussion

further to illustrate the potential consequences of the *legal* promotion of 'good health' :

> We can envisage, for example, an extension of the use of law to 'imprison' pregnant women in hospitals for the sake of the health of the foetus ... As with the Contagious Diseases Act of the 1860s, we might witness the growth of new forms of lock hospitals in which women are now imprisoned because their bodies are a threat to the health of others (Smart, 1989 : 99).

Health promotion discourses are difficult to resist, however, as is apparent not only in the ways people discuss their health but also by the 'health-enhancing' activities in which they engage. Here, there is an assumption that the individual's desire for good health is akin to the desires of governments, employers, the law and medicine to preserve the health of the state. Arguing against legislation to promote the nation's health is thus like 'arguing against virtue' (Smart, 1989 : 99). As a consequence, health promotion seems to be largely exempt from ethical considerations. This exemption has something to do with the general belief that prevention *is* better than cure and the corollary that the self-evident benefit needs no ethical defence. This view ignores the reality that many preventive strategies can become extremely punitive, doing more harm than good.

Health promotion strategies *do* succeed (smoking, for example, has moved from being normative to being deviant, to being sin) but not, however, for *all* individuals and not *all* of the time and, while the governmental strategies emerging from health promotion may have much to offer those individuals who possess the appropriate economic, cultural or symbolic capital, for others their directives may go unheeded or they may be adapted or contested. Lupton argues :

> If people do not find themselves interpellated [*sic*] by governmental discourses, if they do not recognise themselves therein or have no investment in these discourses, they will not respond accordingly. The practices of everyday life in particular are sites at which cultural norms are 'transgressed and

> reworked', taken up and used by individuals for purposes that may or may not coincide with the governmental goals of the state (Lupton 1995 : 131).

One powerful example of this relates to women smokers. Smoking cessation campaigns aimed at women (prisoners and otherwise) tend to be based on a theoretical model in which smoking is seen as an *irrational* form of behaviour. Health promotion within this model often seeks to make good supposed deficits in women's knowledge through information campaigns. However, women demonstrate high levels of knowledge about current medical 'evidence' relating to smoking : all the women smokers in this study, for example, said that they were aware of the potential health effects of cigarette smoking. This awareness does not seem to influence women's smoking behaviour, which seems to be related to the deeper patterns of class and gender divisions which shape their lives (see chapter four). For women prisoners, smoking seems to offer a means of coping. Cigarettes help by creating a structure for the day, providing a break from the routine and allowing physical and emotional distance from a situation where there is no alternative outlet or escape.

When people are living in an environment in which everything else seems out of their control, where the expression of emotions such as anger and frustration carry their own penalties, the very act of smoking constitutes one means of release. The pleasures and consolations of smoking, however, constitute a redefinition of health, one that challenges the dominant meaning constructed in current health promotional discourse. Women smokers (in prison and otherwise) often live through their cigarettes, using cigarettes as a resource to achieve ends they consider important. Smoking often represents something that is 'done' during the day which is not functional as such but which gives the day 'colour' and meaning, and its forbiddance may lead to something akin to depression (Sapsford, 1981). Without cigarettes, smoking women prisoners may not *have* a life, for life would lose the meaning and sense of self that have been constituted *through* cigarettes (Klein, 1993). Strategies directed at smoking cessation may, therefore, serve an important control function.

Much of the same arguments apply to other health-related behaviours such as drinking alcohol, illegal drug-use, disordered eating and self-mutilation which form important alternative coping strategies. If such habits prove resistant to the efforts of 'health-promoters', then it is largely because they are an *effect* rather than a *cause* of the problem.

Health promotional discourses around the prohibition of substances such as tobacco, alcohol and illegal drugs and around health-related behavioural changes may, ironically, serve to underline the meanings of such behaviours, promoting these actions rather than discouraging them. Knowing that certain behaviours are potentially self-harmful may be considered a precondition for taking them up and maintaining them. Klein (1993), for example, points to the contradiction of repression as incitement : the more behaviour is discussed, overtly prohibited, denounced as evil, sinful or health-damaging, the more pleasurable it becomes, especially for those with few other avenues of pleasure. Censorship thus fosters usage.

This then brings us back to the dialectic between repression and the incitement of desire, between rationality and irrationality discussed in chapter one. Health promotional imperatives may thus be conceptualised as an integral dimension of the 'dark pleasures' of the behaviours they seek to prohibit, serving not only to intensify their enjoyment but also, by rendering them 'sins', subjecting them to additional forms of surveillance and disciplinary control.

A medical solution? : Some concluding comments

> I know I'm a smack-head, a muppet, whatever ... but I have no family, no friends, you know what I mean. I'm lonely ... that's my punishment (Jez).

There are a number of conclusions to be drawn from this study on how *not* to promote the health of women prisoners.

Imprisonment, almost by definition, *leads* to ill-health. Women are taken out of society and away from the people and places that characterise their daily lives. In prison, they are subject to processes of control which, beginning with reception procedures, represent tangible sources of suffering that threaten their physical, mental and emotional health.

Prisons have been termed 'schools for crime'. An analysis of women's behavioural reactions indicates that prisons could also be seen as 'schools for health-debilitating behaviour' : disempowered, isolated and insecure, many women relieve their frustrations by the use of substances, by self-mutilation and by the excitement and achievement afforded by kicking-off. Such attempts to assert the self are met with increasingly severe responses aimed at controlling behaviour considered unacceptable and, every day in women's prisons, decisions are made which may further affect women's health and well-being.

In such an environment, is it possible to promote health?

Health promotion, in principle at least, *could* constitute an effective strategy for enhancing the health of women prisoners. However, inappropriate health promotion may have negative effects, by misconstruing and/or ignoring women's health needs, or by reproducing health-damaging tendencies. It is thus important to develop strategies that address women's needs rather than those which *construct* and *re-construct* gender-specific notions around the nature of women's lives : as mothers, as wives, as housekeepers, as carers. Gender stereotypes that view caring and nurturing as 'natural' to women only serve to *legitimise* policies that *create* unhealthy pressures.

Much of what has been said in this thesis is not new or particularly surprising. What is surprising is that it still needs to be said. The needs of women prisoners are clear and the ways to meet them so apparent. Yet, the needs of women in the prison system continue to be overlooked or forgotten. Neither Woodcock nor Learmont, for example, in their reports following the Whitemoor and

Parkhurst escapes considered the needs and interests of imprisoned women (Hayman, 1996). Rather, women continue to be subject to policies and practices directed towards the male prison population, including excessive concerns with security despite the much lower risk to the public which they represent. The shackling of pregnant prisoners and the reductions in home leave provide just two examples of this.

This thesis has been about women prisoners. But it has also been about women in general and the health hazards of *being* a woman. Women prisoners are not qualitatively different from other women : their lives are influenced by the way they are defined, seen and judged in terms of approved gender-specific stereotypes. Women who cannot or will not conform to such stereotypes are at greater risk of harsh treatment from criminal justice, medical and social systems than those women who conform to the approved societal mould. This is not because of some sexist conspiracy on the part of those (men) who operate these systems. Rather, it is likely that social control systems operate *through* deeply embedded discourses around femininity *and* masculinity.

Health promotion, therefore, is only likely to be effective when the *causes* of ill-health are recognised and targeted (rather than the recipients). The health risks that women face often arise from the wider environment which is structured by gender as well as other inequalities. Any genuine attempt to promote women's health must thus tackle the political economy that *produces* ill-health. Doing something about sexism, poverty, racism, unemployment, inequitable access to education and other resources, and the quality of the environment, however, involves notions of planned social and economic change: alterations not likely to be achieved by the cessation of smoking.

Most women in prison are petty offenders who struggle with concerns which may be amenable to social solutions rather than medical ones. Most are young, poor, have children, are single, separated or divorced. Many have a history of unhappy family backgrounds, abuse and disadvantage. Many will leave prison

with nowhere to live, no work and no one to turn to for advice. Though different in degree, the problems facing them in prison seem to be of the same kind as the problems they face in their outside lives and the same kinds of solutions seem to be adapted to deal with them : medicalisation, domestication, individualisation and trivialisation.

Finally, all of the concerns facing women in prison need to be addressed in the light of the answer to one fundamental question : since the majority of women prisoners pose no threat to the public why are so many of them in prison? For rehabilitation? For deterrence? For incapacitation? For justice? Alternatively, do we send women to prison simply because we send men to prison?

Whatever the reasons for sending women to prison, when we do, it is unlikely that they will find better health there, although some of them, against the odds, find themselves (if only there was someone there to listen). I began this odyssey with a quotation from Jez who, in a curious way, has come to stand for all women prisoners. It seems fitting to leave the last word with her :

My body is like an empty shell
Where two different personalities dwell
Fighting each other for the right to be free
To stand up and shout 'Yes, that's me'.

The first one is Jez who's so cock sure
Bristling with confidence so clear and pure
Full of bravado I couldn't give a shit
Big bad girl and proud of it.

The next one is Joan who's shy and polite
Who lets herself be used rather than stand up and fight
Beneath the bravado I'm scared and alone
Longing to have someone to call my own.

All I want is for someone to care
To scratch the surface, to find me there.

(Jez, HMP Styal, 1994).

APPENDIX I

Breaking in : Researching women's imprisonment

Though this be madness, yet there is method in't. (Hamlet)

The purpose of this appendix is to outline the main research strategies employed in the study and the methodological and theoretical issues which have arisen. The first section details the research design, the methods chosen and the reasoning behind the approach. This is followed by a more detailed discussion of the experience of 'doing' the research.

The research question, design and methods

Aims

The research represents an exploratory study of women's health and imprisonment in England and Wales. The study had the following broad aims :

1) To provide information on the health status, health problems and needs of women prisoners and the patterns of response.

2) To explore the interaction between the experience of, and the meanings attached to, imprisonment for women in England and Wales.

3) To obtain the views of prison staff on existing service provision and priorities for service development.

Locating 'the problem'

It is no longer possible to state that there is *no* information on women's imprisonment. The past two decades have seen the publication of an increasing body of academic work on the subject (see Howe, 1994) and there is now a small but growing number of books written by women prisoners and

ex-prisoners themselves (see, for example, Ward, 1993; Maguire, 1994). Moreover, penal politics have, in recent years, been influenced by the radical campaigning of penal reform groups committed to publicising the conditions within women's prisons (see Carlen and Tchaikovsky, 1996).

From the official statistics we know that women form only a small proportion of the prison population, many are first-time offenders and few are held for violent or sexual offences (PAC, 1996). Moreover, women, it seems, are relatively expensive to keep in prison : the cost of holding a woman in custody was, on average, £470 per week in 1993/94 (NACRO, 1995b). There are, of course, other costs incurred by imprisoning women. Separation from families, particularly young children, causes women and their family members suffering. Imprisonment, even for a short period of time, frequently severs the community ties that exist and, through imprisonment, women may lose, if they have them, homes, jobs, family and friends. Furthermore, many women prisoners are those whose biographies include accounts of disadvantage and psycho-social distress, often unrelated to their offences (Carlen 1985, 1988a; Posen, 1988; Mandaraka-Sheppard 1986; Genders and Player, 1987).

Conventional theories of female criminality continue to exert much influence over the nature of regimes for women prisoners. Such theories have all been fundamentally positivistic in their nature : premised upon notions of individual pathology. In contrast, structural analyses of female crime (evidenced in much of the recent work on women offenders) have tended to overlook the individual offender in an attempt to concentrate on the wider social structure, and in particular, the consequences of capitalism and patriarchy.

So, where does all this leave women prisoners? How do women experience imprisonment? What are the implications for their health and well-being? More importantly, how can one account for their experiences without reducing them, on the one hand to the forms of biological determinism characteristic of conventional criminology or, on the other hand, to structural analyses which

overlook the plight of the individual? Is it possible to theorise about women's health and imprisonment without falling into what Worrall (1990 : 3) describes as 'empiricist or reductionist traps'? And, if so, is it possible to relate such theorising to the wider experiences of *all* women? Carlen (1983 : 18), in her seminal text on women's imprisonment, argues that 'the motto of those charged with the penal regulation of deviant women has been "discipline, medicalise and feminise"'. Do these processes differ, however, from those in which *all* women are controlled and constrained?

These were some of the questions that prompted the current study. To explore them further I needed to be able to talk to and, more importantly, to listen to those women (and their keepers) who were experiencing imprisonment (in the formal sense) and were prepared to reflect on their experiences. Smircich (1983) has stated that researchers should aim to :

> [S]ee the world as the organisation's members see it, to learn the meaning of actions and events for the organisation members and to portray these accurately (1983 : 164).

While I wanted to explore the prison domain, my goal was not to become an 'insider'. Rather, I wanted to gain insider perspectives and represent these coherently. Before I could gain insight into the prison world, however, I needed to gain entry into it.

Negotiating Access

Research settings vary considerably in the extent to which they are 'open' or 'closed' to public scrutiny. These differences, in turn, impact upon the nature and degree of negotiation necessary to secure access. The success or failure of research projects largely depend on good access and the dynamics of negotiation can be costly, particularly in small-scale, time-limited projects. However, the negotiatory process in itself constitutes an important element of the research.

Negotiating access into prisons for research purposes can be both time-consuming and problematic (Cohen and Taylor, 1972, 1977; King and Elliott, 1977; Gelsthorpe, 1990; Liebling, 1992a). Prisoners, as Cohen and Taylor (1972) point out, are the 'property' of the Home Office and much research on prisoner populations is conducted 'in-house'. Outside researchers have to receive Home Office approval and the proposed project must be acceptable to, if not specifically requested by a 'customer' at the Home Office (Liebling, 1992a). Liebling (1992a : 123) argues that the 'customer-contractor' principle is applied to research projects, even when sponsorship or funding is not sought, as in my case.

In discussing the problems of access, King and Elliott (1977), in the introduction to their study of Albany, argue that much depends upon the nature of the proposed research :

> Much, of course, depends on what one wants to do. But anyone who wishes to do more than count heads or make pencil and paper tests of abilities, attitudes or opinions with a captive population in a kind of human laboratory, will have to establish, and live, a role which is acceptable both to himself and to his respondents. He will certainly find that he provokes anxiety in those he researches and that no less will he have his own anxieties aroused (1977 : 33).

The formal access procedure necessitates the completion of a detailed application form. The form asks for details of the research, the aims and objectives, the methodological and analytical tools and the proposed format for the dissemination of findings. This process can be time-consuming and I found it difficult to work what were, at that stage, research *ideas* into a shape that would fit a *pro forma*. It is perhaps one of the paradoxes of exploratory research of this nature that the study design essentially develops from *within* the research setting, throughout the course of the study, and yet in order to secure access the design and objectives need to be definitive at the outset.

Various constraints can be imposed upon a research project (see Lee, 1993), aside from the normal ones under which researchers (and research students in particular) have to operate (more of this later). Restrictions may, for example, be imposed on the choice of methods or on how the findings are disseminated, or a reciprocal relationship may arise where access is permitted only in return for research conducted on the gatekeeper's behalf.

No explicit constraints were imposed upon this research and I secured access into three women's prisons[1] - Low Newton, Askham Grange and Styal[2]. In many respects my research was fortuitously timely. In response to a scrutiny report of the then Prison Medical Service (Home Office, 1990), the Directorate of Health Care was, at the time of my seeking access (1992), in the process of developing a strategy for prison-based health promotion. Having recently completed an MSc. in health promotion, I was able to offer some advice and information.

An informal *quid pro quo* relationship developed. The advantage of this for me was that regular contact with Home Office policy-makers ensured that I was kept up to date with policy decisions. At the same time, I gained some insight into the nature of relationships within the Prison Service as well as invaluable advice, information and encouragement.

There are, however, often layers of gatekeepers to negotiate, with hierarchies of authority and power between them, and, once access into a prison has been secured via the Home Office and subsequently the Governor, the researcher then needs to use skills of communication, tact and diplomacy to ensure the co-operation, trust and assistance of *all* the other groups within each establishment (see Jupp, 1989; Carter, 1994).

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1 Thanks to Prof. Roy King for being a gatekeeper to the gatekeepers!

2 Throughout the course of the fieldwork I also visited Holloway, Durham H-wing and Cornton Vale.

In this case, at each level of access, the research and the researcher were scrutinised - 'sussed out' - in relation to formal and informal criteria. Problems could have arisen because of the nature of the relationships between the different levels, which are characterised, as in many big institutions, by a lack of communication and dialogue. I was very aware that the existence of internal frictions could have jeopardised the project.

In each of the three prisons, I endeavoured to overcome these difficulties by spending time at the outset familiarising myself with the organisational routine of the prison and generally 'getting my face known'. I was allocated a 'contact' at each prison, a member of staff who was interested in the research and who helped to orchestrate my visits. At two of the prisons this was a member of the nursing staff (well I was researching health, wasn't I?) and at the third it was a basic grade officer.

Flyers were distributed in each of the three prisons prior to my visits. These posters in many ways 'advertised' the research. They informed prisoners and staff about the project, explained a little about me, and invited participation.

Methodology and methods

While academic, political and popular interest in women's imprisonment has increased in recent years, this has been paralleled by an increasing concern with researching women's lives and experiences from feminist perspectives (see, for example, Roberts, 1981; Oakley, 1981; Stanley, 1983; Stanley and Wise, 1990). Since the 1970s a sophisticated debate has established definitions of 'feminist methodology', 'feminist research practice' and 'feminist epistemology'. This debate very much influenced how I approached my doctoral studies.

At the outset, the most important issue for me was the rejection of distance and objectivity in the researcher-researched relationship. This approach is not, of course, unique to feminist research : from a social constructionist perspective, not only is the world which we study as sociologists constructed through

interaction and negotiation, we, as researchers, are actively involved, with our research subjects, in this process. As Steier (1991) argues :

> The research process itself must be seen as socially constructing a world, or worlds, with the researchers included in, rather than outside, the body of their own research (Steier, 1991 : 2).

Harding (1987) argues that placing the researcher on the same critical plane as her research subjects breaks down the false distinction between the 'subject' and 'object' in research. In traditional research, objectivity and distance between the subject of the researcher and the objects of research are advocated as methods for preventing bias. Feminist sociological theorists argue that all research is biased. In order to understand what these biases are and how they affect the research, the researcher must understand her own previous experiences, prejudices and values.

Jupp (1989), in a discussion of feminist research, argues that :

> Feminist research methods coalesce around the viewpoint that positivist, quantitative approaches are male dominated and by their procedures and structure miss many of the issues which are specific to women. Two aspects of this can be noted. One relates to how data should be collected and from whom. The formal interview is viewed as a form of exploitation stemming from the differential relationship between researched and researcher ... A second, and related, aspect concerns the way in which dominant theories influence the way in which questions are framed, data are collected, and categories for statistical analysis are developed. Such questions, data, and categories are not inherently 'male'. Rather, they can take the form that they do because they are posited on existing theories and research derived from 'malestream' literature (Jupp, 1989 : 66-67).

This, then, lends support to the argument that feminist methods should be essentially 'qualitative'. In this respect, the experiences of women can be explored in their 'true' form rather than being 'distorted, degraded and even hidden by potentially arbitrary and abstract categories used for data collection

and analysis' (Jupp, 1989). I will return to some of these points later on, where I take issue with some feminist theses.

The very nature of the prison setting, however, has important methodological implications. Unlike many other research settings, there exist within prisons situational and institutional factors which inherently impact upon the practical and realistic choice of methods. At an early stage in the fieldwork it became apparent that the use of different, yet complementary, methods would enable a more detailed exploration of my chosen subject, and the methods used very much 'developed' during the course of the study.

The main techniques of data collection used in this research were as follows :

1) **Focused and unfocused group discussions with prisoners;**
2) **Semi-structured, in-depth interviews with prisoners;**
3) **Semi-structured interviews with staff;**
4) **Direct observation and participation;**
5) **Questionnaire survey of prisoners.**

These methods were chosen because it was felt that their respective strengths would allow a greater exploration and depth of information and because they represented realistic, practical and opportunistic options given the nature of the setting.

Interviews with prisoners

Cohen and Taylor (1972) point out that prisoners (and staff) know more about 'the territory' than researchers do. It was important, therefore, to develop an approach that did not constrain them. The study included a grounded theory design and methodology consistent with the generation and analysis of qualitative data (Glaser and Strauss, 1967; Lofland, 1976; Stern and Pyles, 1985; Strauss and Corbin, 1990; Backett, 1990). Grounded theory uses an

inductive approach to generate theories which are relevant to the world from which [they] emerge' (Hutchinson, 1986).

The basis for this method is the semi-structured interview. There is no strict ordering of questions in semi-structured interviews although the researcher sets out with a loose agenda of topics to be covered. Respondents are encouraged to speak freely and spontaneously. Issues which arise during the course of the interview are explored until the topic is exhausted. The flexible approach allows respondents to introduce issues or topics which are important to them, but which may not have been anticipated by the researcher. These issues can then be explored with other respondents in subsequent interviews.

Group discussions and in-depth interviews were chosen as specific forms of qualitative research because I wanted to access detailed information about the complexity of, and interaction between, women's experiences, feelings, beliefs and actions and it was felt that their relative strengths and weaknesses could complement each other.

Group discussions

While group discussions are valuable at any stage in a research project, they are particularly useful in exploratory studies where little is known about the subject of interest (see Stewart and Shamdasani, 1990; McKie *et al.*, 1993). In this study, group discussions were conducted early on in the fieldwork, the analysis of which contributed to the design of the subsequent stages of the project.

Six loosely structured group discussions were held (out of staff earshot) : two in each of the three prisons. A total of thirty-nine women, aged from 16 to 63, participated in the groups (six or seven women per group). The women discussed a range of issues from broad definitions of health to perceptions of being in prison to more focused topics such as self-harm and HIV/AIDS. The discussions lasted between 1 - 2 hours and were peppered with laughter, the occasional shocked tone and much banter.

The groups were informally recruited from women attending education, women on mother and baby units, women on the LTI house (Styal) and women on the pre-release hostel (Askham Grange). To a certain extent the groups could be considered 'natural' in that the participants had some prior knowledge of each other and regularly interacted. Prison, however, is not a 'natural' environment and it would be wrong of me to suggest that the data derived from these discussions was 'natural', that is, that it would have occurred without my input (see Kitzinger, 1994, for a discussion of 'naturalness' in the context of group interviews).

The discussion group method is not without limitations (Stewart and Shamdasani, 1990). Participants were self-selected and it is likely that the environment limited the discussions in many ways. It is possible (although it was not evident) that some women felt unable to share their experiences for fear of social or institutional sanction.

Employing a group discussion method was, however, valuable for several reasons : they encouraged women to draw confidence from one another to talk about issues to do with imprisonment and health; they provided general background information; they generated themes for further exploration; they provided important insights into the institutions, services, facilities and relationships. I learned how respondents talked about different issues and, in general, the groups provided me with a good initiation into prison life.

In-depth interviews

Sixty semi-structured, in-depth interviews were conducted with fifty women prisoners[3] (twenty in Styal, twenty in Askham Grange and ten in Low Newton). Consistent with a grounded theory approach, theoretical sampling techniques were used (Glaser and Strauss, 1967). Theoretical sampling is an on-going process of data collection which is determined by the emerging theory.

[3] Ten of the women were interviewed twice during the fieldwork.

Respondents were recruited and interviewed until it was apparent that no new themes were emerging.

Potential respondents were identified through (but not by) members of staff, invitational flyers, snowball referrals from study participants and through direct approaches. There were no selection criteria. As I was dependent on volunteers, there was no attempt to make the study group 'representative' of the women's prison population. This said, the strategies employed, while often opportunistic, resulted in a fairly diverse group of women (see Appendix II for selected biographical details).

An interview schedule, or topic guide, was developed on the basis of the group discussions and initial sensitising pilot interviews (Appendix IV). The interviews were loosely structured to cover women's experiences and perceptions of imprisonment, prison medical services, health and illness, as well as general background details. While these topic areas were covered with all the women, each individual was encouraged to tell her own story. This allowed the interviews to take the form of a conversation where topics could be changed or introduced as appropriate. Allowing respondents to tell their stories and giving them the power to decline to answer questions means that the researcher-researched power balance becomes less skewed (in theory at least) than that identified in more traditional social research (Oakley, 1981; Roberts, 1981).

Each interview lasted between forty-five minutes and two hours. The women were interviewed in a variety of settings - in their own rooms or cells, in the common room, in the dining room, in the kitchen store room, in the probation officers' room, in the health centre (in two of the prisons I was provided with a room/base at the health centre). It was important to try to create an interview environment in which women felt at ease speaking of often painful and/or traumatic experiences. Given the nature of the setting, this was at times difficult.

Time was taken prior to each interview to discuss the project in some detail, answer any questions, explain my role and interests and discuss confidentiality and anonymity. Every attempt was made to secure 'informed consent', although it is recognised that this is a complex issue, particularly within the prison context (see Liebling, 1992a, for a discussion of this). At the end of the day, respondents consented to talk to me in as much detail as *they* wished. Most respondents were keen to air their views and to talk about themselves with someone not associated with the institution :

> We wouldn't be talking like this with anyone else ... you're not one of them (Discussion Group 2).

> It's good to be able to sit down and talk through a few things because in here you can't do that, you can't talk about the sorts of things we've talked about for fear of it getting all around the prison. There's no one you can talk to in here (Suzanne).

Group discussions and depth interviews were tape-recorded with the women's permission and, apart from a few hiccups introducing the technology - 'the police use them microphones' - the tape-recorder allowed for a relatively relaxed, interactive and conversational interview.

Staff interviews

Liebling (1992a) has highlighted some of the practical difficulties of interviewing prison staff. For several reasons, recruiting staff into this study proved more difficult than recruiting prisoners (see the section on the fieldwork experience). This was certainly not due to prison staff having little to say. On the contrary, they have a *lot* to say and I had many informal and lengthy discussions with officers and civilian staff. On the whole, however, staff seemed more reluctant to commit themselves formally to an interview situation.

That said, semi-structured, tape-recorded interviews were conducted with twenty members of staff : including, three prison doctors, six nurses (including one health care officer), one pharmacist, one Governor, two Senior Officers,

one physical training instructor, three basic grade officers and three members of education staff.

Recruitment strategies largely mirrored those for prisoners and interviews were often arranged after informal discussions over lunch, coffee and in passing. As with the prisoner interviews, a willingness to take part was the only selection criteria. The interviews lasted between half an hour and an hour and a half and were frequently interrupted by telephone calls, knocks on the door and interlopers.

Each interviewee was asked a series of 'quick' questions relating to 'the job' : career history, current duties, perceptions of service provision and priorities for future development. This served as an introduction to a more detailed discussion of 'the women' : the women who caused staff the most work, the likely effects of imprisonment on women and their families, differences between the male and female prison population and so forth.

Direct observation and participation

Other involvement in institutional life included 'shadowing' nurses, health visitors and education staff; sitting in on doctor-patient consultations (with the consent of the women prisoners); attending post-natal sessions on the mother and baby units; participating in reception procedures, mealtimes[4], recreational activities and many other aspects of prison life.

Much time was spent talking informally to staff and prisoners over meals and copious cups of coffee. In two of the prisons I was based in the health centre, where I was able to observe the daily routine and very much became, as one member of the nursing staff put it, 'part of the woodwork'. Although not without limitations, this was one way of exploring general processes of social interaction in prisons as they 'naturally' occurred.

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[4] On one occasion I was invited (and allowed) to have a meal with women lifers at Styal. Having already eaten a huge curry made by one of the women, two Indian sisters then wanted me to taste a 'real' curry. So, not wanting to offend and in the name of 'rapport development', I had two curries within the space of two hours.

I spent many 'quiet' moments with one particular group of long-term prisoners. This was beneficial in that it allowed me to check out many of the themes which emerged during the course of the fieldwork. In many respects these women helped to structure the research and to develop the research questions and this was, I believe, one step towards the form of collaborative research discussed elsewhere (see Lee, 1993). Cohen and Taylor (1972) make the distinction between research *on* prisoners and research *with* prisoners, and by the end of the fieldwork period I felt that these women had almost as much of a 'stake' in the research as I had.

On several occasions I stayed with members of staff, went for end-of-shift drinks and attended nights out. While this was helpful in that it provided me with many 'private' accounts,[5] it meant that I had to 'work overtime' to maintain a research persona (see below).

Informal interaction with staff and prisoners provided me with a wealth of background information. Furthermore, spending periods of time with various individuals throughout the course of the fieldwork allowed me not only to observe their behaviour directly but also to conduct opportunistic, informal interviews.

Throughout the fieldwork, all informal discussions and observations, feelings, emotions and interpretations were recorded in research diaries. As Howell (1994 : 99) has stated, such recordings allow researchers to 'keep track of the analysis by documenting [their] thinking processes and capturing the ideas that elevate the descriptions of empirical events to a theoretical level'. While the fieldnotes represented *my* perceptions and ideas and *my* interactions (as opposed to 'objective' observations), they were grounded in the research field and formed the basis through which to develop analytical ideas.

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5 Cornwell (1984) makes the distinction between 'public' and 'private' accounts in the research context : Public accounts are those replies usually given in response to more formal abstract questions. In contrast, private accounts are more usually given when the respondent has met the interviewer more than once, are often expressed in the form of personalised stories, and explain individual feelings and behaviours.

Questionnaire survey

Towards the end of the fieldwork, a small-scale questionnaire survey was conducted. Self-completion questionnaires were distributed to all women present in each of the three prisons on a specific day. The questionnaire was largely developed on the basis of the group and in-depth interviews and contained indicators of health status, indicators of perceived needs for services and patterns of service use. It included some standard questions about on-going health problems and symptomatic health, questions about access to and use of prison health care services, perceived helpfulness of different kinds of services, current and previous substance use, questions about being in prison as well as questions to elicit general socio-demographic and criminological details.

The questionnaire also included a widely used measure of psychiatric disturbance - the General Health Questionnaire (GHQ). Developed in the United Kingdom (Goldberg and Williams, 1988), the GHQ is a screening instrument used to detect non-psychotic psychiatric disturbance. Used largely within general practice populations, it concentrates on the broader components of psychiatric morbidity, particularly anxiety and depression. A number of formats of the questionnaire are available. In this study, the short-item version, GHQ12, was chosen. Respondents can gain a raw score from 0-12, with a cut-off score of five and over distinguishing 'caseness' (see Bowling, 1991).

The response rate varied between the three prisons (see Table A1.1, below), giving an overall response rate of 57% (n=214). This compares favourably with questionnaire surveys conducted amongst the general population (see Cohen, *et al.*, 1991). Appendix III provides a detailed summary of the survey findings.

Table A1.1 : Percentage of questionnaires returned by prison

Prison	***n***	**% returned**
Low Newton	40	91
Askham Grange	49	53
Styal	125	52

Data analysis and feedback.

Qualitative data analysis

The qualitative data set consisted of verbatim transcripts of interviews and group discussions and field notes.

Consistent with a grounded theory approach, data collection and analysis largely proceeded simultaneously (Glaser and Strauss, 1967; Strauss and Corbin, 1990; Backett, 1990). Analysis was based on the constant comparative method of generating and linking categories. (Glaser and Strauss, 1967). Field notes contained, in embryonic form, an analysis of the events I recorded throughout the fieldwork. Transcribed interviews were read and re-read[6] many times and key themes within the narrative identified and categorised. Inter-relationships between categories were further identified, substantiated and contextualised.

Theoretical relationships inherent in the respondents' accounts were looked for (Glaser, 1992). A fundamental aim in handling the data was to preserve its contextual bases as offered by the respondents and then to re-present their individual accounts from the perspective of shared experience (Roe *et al.*, 1994).

The on-going analysis was designed to be interactive, fostering dialogue between the researcher and the study participants. Respondents contributed to the analytic process in several ways. At the end of each interview respondents were asked if there were any other topic areas which they felt were important that should be explored with other study participants. Their recommendations were important in helping me to identify my own assumptions and

[6] Kelly (1988) has pointed to the problems involved in 'transposing the spoken to the written word'. Throughout the fieldwork and the subsequent period of 'analytical refinement', transcripts were often read at the same time as listening to the tape-recordings so that important contextual factors - background noises, tone of voice, silences and pauses for thought and reflection - were not lost.

misunderstandings. Participants also provided valuable suggestions for ways of approaching often sensitive subjects and probing responses.

As core themes were identified they were fed back informally to prisoner and staff groups and their assessments of the validity of the data and my interpretations were elicited. Frequent visits to each institution over a period of fourteen months provided the opportunity to further clarify interpretations and measure their resonance against the experiences of others.

There are, of course, a number of problems in drawing conclusions, interpretations and findings from people's narratives. Throughout, I have tried not to lose sight of the accounts provided by prisoners and staff - their stories of their experiences - or to attach spurious meanings in an attempt to develop some deeper theoretical framework. Their narratives are driven by their experiences. Each person gave their account from their own perspective. I then had to locate each account within my own perspective. At the end of the day, the stories are their own, the interpretation of those stories is mine.

Quantitative data analysis.

Quantitative data was coded and analysed using a statistical computer package: SPSS for Windows.

Doing prison research : From physical to social access

> Getting into a setting involves a process of managing your identity; projecting an image of yourself that will maximise your chances of gaining access ... you want to convince gate-keepers that you are a non-threatening person who will not harm their organisation (Taylor and Bogdan, 1984, cited Dowell *et al.*, 1995 : 28).

Prison research has, over the last fifty years, tended to focus on (male) prisoners' experiences and perspectives. This has, according to Carter (1994 : 34) :

> Produced an unbalanced perspective upon the institutional cocoons which prisons have become, whereby the staff working in them have been almost ignored.

Researchers, interested in the prisoner's world, have tended to distance themselves from staff so as to develop rapport and credibility with their chosen study group (Goffman, 1961; Cohen and Taylor, 1972). This dissociation from the formal power structures, while understandable, has led to feelings of alienation amongst staff members who feel that their experiences are not properly represented (Kauffman, 1988). This, in turn, has led to a general suspicion of researchers.

The problem for me was that I did not want to alienate either prisoners or staff. The most difficult aspect was learning the 'dos and don'ts'. Liebling (1992a) cites a number of don'ts :

> [D]on't get involved, don't take sides, express opinion, breach confidences or react to very much at all; don't be mistaken for a probation officer, social worker, psychologist, volunteer or governor grade - or 'someone from the parole board' - or identify with any of the last; don't be dependent on the staff, but never overlook them; don't get in the way, but don't neglect to explain yourself, sometimes apologetically, to each individual when they ask : 'Who did you say you were exactly?' (1992a : 118).

I had to overcome the institutional mistrust of outsiders held by both groups. This mistrust needs to be viewed against a backcloth of current penal policies and low morale. Staff and prisoners alike represent the sharp end of recent policies and practices. Many of the staff, for example, were concerned about long-term job security within a constantly changing prison service. Prisoners were, similarly, well aware of (and some had been the subject of) recent

debates about the nature of regimes for the confined. My entry into the prison world coincided with some of the more controversial events in recent penal history. While this was arguably profitable from the point of view of the research, both staff and prisoners were understandably suspicious of strangers, albeit well meaning ones.

Both groups were curious about the nature of my relationship with the Home Office. Outside researchers do, after all, need Home Office approval. They were interested in the purpose of the research and frequently questioned, 'Who did you say you were working for?'. It was, at times, difficult to explain that I did not technically work for anyone.

My motives and independence were occasionally questioned. While all welcomed an 'outsider' willing to listen and to attempt to understand what it was really like, they were concerned about how their views would be represented. Both staff and prisoners wanted to know who would have access to the research findings. These realistic fears may have prevented some (particularly staff) from opening up to me more formally and instead I experienced many informal, 'off record' discussions.

Sparks (unpublished, 1989) has stated that :

> The researcher ... coming into a particular prison for the first time sets out with few natural advantages. He looks naive, 'green', uncomfortable, out of place (cited Liebling, 1992a : 119).

At times, being 'naive' and 'green' can, however, be an advantage and throughout the fieldwork I consciously projected an image of myself as an earnest, sympathetic, if slightly naive, research student, grateful to learn from the experiences of others. When people rightly believed that I was what I claimed to be - an outsider who wanted to learn - they welcomed my interest.

Acceptance into the prison environment can be slow (see Gelsthorpe, 1990), and yet the more I talked to staff and prisoners, the more I was 'sussed out', the more (I think) I got a reputation as a 'good listener' and, as has been suggested, both prisoners and staff (but more so prisoners) were often desperate to out-pour to someone willing to listen.

Managing identities : gender, dress and biography in prison research

> The fieldworker's reception by the host society is a reflection of the cultural contextualisation of the fieldworker's characteristics, which include marital status, age, physical appearance, presence and number of children, and ethnic, racial, class, or national differences as well as gender (Warren, 1988 : 30).

Gelsthorpe (1990), in a discussion of the complexities of 'doing' (feminist) prison research, has argued that the extent to which experience, age, sex and ethnicity influences the field researcher's role is often underplayed, if not ignored, in the research literature despite it being a fundamental issue.

Callaway (1992), similarly, has argued that social researchers should reflect on their own role in *constructing* an image of reality within the interpersonal relations of fieldwork. At every stage of the research I attempted to reflect upon the ways in which aspects of my own social identity impacted upon the data I collected and the image of social reality I subsequently produced. Some of these characteristics are intrinsic to me. Others were situational and interchangeable when dealing with different groups within the prison environment. In my fieldnotes, I was keen to record my own interactions within the prison environment and I noted several aspects which were of relevance : my sex (and gender), age, dress and personal biography.

Stacey (1994) has pointed to the difficulties of women conducting research in institutions and contexts characterised as 'masculine cultures' and quite early on in the fieldwork I, like Gelsthorpe (1990), became aware that not only are women prisoners 'incongruous', but also women researchers are 'out of place'.

Gelsthorpe (1990), however, was researching male imprisonment. I was, after all, interested in women's experiences.

The prison service represents a largely male-dominated institution. In April 1992, only 14% of prison service staff were women (NACRO, 1992a). Staff training is generic for the (male) prison system and, like the police (see chapter two), the prison service is characterised by an 'ethos of masculinity'. Prison research has, similarly, been a traditionally male-dominated field.

Gelsthorpe and Morris (1988) have argued that women researchers have certain advantages in the prison setting and during the initial negotiations for access, I encountered, and was helped by, a generally paternalistic attitude towards women. My initial contacts within the prison service were for the most part men. I was a researcher needing help and they could help me. The help they provided was practical in nature - documentary information; access to other people or contacts and general advice.

I was self-consciously an outsider throughout the course of the fieldwork. My outsider status was occasionally made reference to by male prison officers - 'What's a nice *young lady* like you doing in a place like this?' The impact that my own gender identity had on their concepts of me varied - at times it was assumed that I would view things in a specific way simply because I was a woman. This implicit assumption of 'sisterhood', coupled with the general suspicion of researchers, led, at times, to a belief that I would only represent the prisoner's perspective.

During many of my initial visits to the prisons, I was cast in a number of different roles : I was often mistaken for a social worker or a visitor, for example. It was, however, during the course of the more intensive fieldwork phase that my researcher role became more blurred. Medical staff, for example, at times, introduced me as a nurse, rather than as a researcher. Implicit in this, I felt, was a sense that I was 'one of them', and I was researching health, wasn't

I? As a consequence, there were times when I was pointed in the direction of potential respondents with specific 'medical conditions' : 'so and so is an epileptic on medication, you'll be wanting to talk to her', *et cetera.*

In most instances, I was able to disclaim my (ex-)nurse status quite quickly, but because I did not technically work for anyone, it was then difficult for me to be re-cast in any role. At times, being a student (and my age) seemed to work against me and I encountered some quite patronising attitudes from staff members who seemed to look over my shoulder for an older, more authoritative figure : my 'boss'.

Age was an important factor in my interactions with discipline staff. Carter (1994) believed that his maturity (45+) was an asset. In the prison service promotion is by seniority and 'age ... has always been symbolic of experience, signifying respect and some authority' (Hockey, 1986). Being female and relatively young (28 at the start of the field work) potentially put me in double jeopardy and I encountered a range of responses from the type of paternalism described above to general disregard.

From the prisoner's view point, being young and female may have encouraged them to confide in me, to inform and advise me. Many of the women I spoke to had been in relationships with men characterised by violence and abuse. For many such women masculinity in and of itself represented a threat. It is perhaps a harsh irony that for these women, prison life pervades masculinity. For the most part, positions of power within prisons are held by men.

Self presentation was another important but problematic factor throughout the fieldwork. In my encounters with uniformed staff, I was aware that I needed to present an 'institutional' image. I did not want to appear too 'studenty' (just studenty enough) and I had been warned by Liebling (1992a) of a staff dislike of women in trousers. From the prisoner's perspective, I did not want to be seen to be associated with institutional power. I wanted to seem open and

approachable. Women prisoners wear their own clothes and I felt it important that I looked informal and non-threatening. I therefore needed, at the same time, to identify with, and dissociate myself from, the institution so as not to alienate either prisoners or staff.

Dress is one of the most significant markers of gender identity (see Barnes and Eicher, 1992) and, while I did not want to compromise the research, I also did not want to compromise my feminist values and wear a skirt just to appease masculine perceptions of appropriate femininity. By way of compromise : I did not carry a set of keys, which are emblematic of institutional power within prisons. I did not carry a brief case. I did not wear Dr. Martens or jeans. I did wear what people of a certain age would call 'slacks', a 'nice' shirt, and 'slip-on' shoes!

While the issue of dress may seem trivial, it is, I believe, fundamentally a feminist one, representing as it does wider issues of power. It is an important point which is, however, largely underplayed in the research literature.

Whilst aware of the implications for objectivity, certain biographical aspects contributed to the processes of gaining trust and of overcoming the institutional fear of outsiders. Drawing upon elements of my own experience enabled me at times to move beyond simulated rapport to a more authentic interaction, and helped me to gain access to the feelings, beliefs and experiences of various individuals and groups.

Discipline and nursing staff, for example, appreciated the fact that I had not gone into academia straight from school but had served a form of uniformed (disciplined) apprenticeship. Nursing staff particularly appreciated that I could empathise with the difficulties of 'the job'. Like Liebling (1992a), I found that an acknowledgement of the issues pertinent to staff (overtime, job security, privatisation, limitations of role and so on) helped overcome initial suspicions and hesitations about speaking to me.

In my many interviews and discussions with women prisoners, I felt it was important to provide something of myself. To reciprocate the detailed accounts they provided of their lives. The advantages of this were two-fold : I developed (relatively) trusting relationships in an environment where trust is severely wanting. This, in turn, opened additional doors and many of the respondents were recruited on a rolling or snowballing basis. To provide an example, coming from Wales enabled me to empathise with the sense of hiraeth (a sense of longing or homesickness) expressed by one woman. This particular woman proved to be an important ally and access to other study participants was achieved on the basis of this one relationship.

Developing and managing a research persona

Shaffir *et al.* (1980 : 4) have stated that :

> The intensity of the fieldwork process is typically accompanied by a psychological anxiety resulting in a continuous presentation and management of self when in the presence of those studied.

In order to manage diverse researcher-researched relationships in the field, it seemed necessary to create and maintain a research persona, a researcher self. In many respects, the self I extended whilst in the field was constructed on the basis of what I thought would be acceptable to the person or group I was with at the time.

It was important for me to develop an approach which could be adapted depending on who I was dealing with at the time. I needed to seem sensitive to the problems identified by an individual or group. I also had to consciously distance myself from one group so as to develop a relationship with another. Carter (1994 : 34) has identified this as :

> A game of winning the trust of all the actors, and at the same time identifying oneself with their individual moans, complaints and mistrust of each other, while trying at the same time to remain and be seen as independent.

Attempting to achieve this constituted an additional form of emotional labour.

Throughout the fieldwork I embraced two main types of researcher-researched relationship. The first relationship developed largely through shared experiences, as outlined above. This form of relationship most closely matched my understanding of feminist approaches where rapport and empathy develop through mutual experiences (Oakley, 1981; Roberts, 1981) and were, perhaps, the most enjoyable research relationship.

The second type of relationship was where the respondent and I shared no similar or comparable experiences. Here, it was often the respondent who set the agenda and identified issues important to them. In this relationship, it was difficult to interrupt, clarify or confirm issues raised or to get back onto track. Examples of this type of relationship include an officer who spent much of the interview discussing problems of 'the job' but peppered the discussion with throw away remarks about the prisoners : 'They're all a bunch of bastards, you know'.

During such interactions I had to manage my desire to interrupt and/or pose alternative viewpoints. I wanted to challenge assumptions but had to contain myself and listen with much head nodding and indistinguishable murmuring. My researcher self felt unable to challenge as this might jeopardise the interview/discussion and subsequently the research. These feelings have been noted elsewhere by feminists interviewing men (McKee and O'Brien, 1983) and Carole Smart (1984) describes this as a potentially oppressive and frustrating experience. What was particularly oppressive and frustrating for me was that it was not confined to my interaction with men. This perhaps says more about *institutional* power in the researcher-researched relationship than *gendered* power.

It was necessary for me to move in and out of these different research relationships. Whilst in the 'field' I found I could step into my researcher

persona and take an active interest in what was being said largely because it was data. I was interested in what people had to say and attempted to understand why they held such views for the purposes of the research and ultimately the Ph.D. I utilised my social skills so as to maintain an interested impression. However, the emotional effort of maintaining a non-judgemental role was, at times, difficult.

Ethical considerations

Davidson and Layder (1994 : 86) argue that :

> [E]thics concern the conduct of researchers and their responsibilities and obligations to those involved in the research.

There were occasions where ethical dilemmas arose which related to both *the* research and to the *doing* of the research.

While those involved in the group and depth interviews consented to talk to me in as much detail as they felt appropriate, it remains questionable how far consent can be 'informed' in research of this nature. One outcome of allowing respondents to choose the depth of their disclosures was that some felt greater distress than they might have done in a more structured interview situation. It was, for instance, common for women prisoners to become distressed when discussing certain topics, particularly those relating to their children. This then raises questions about who takes responsibility for the effects of asking respondents to probe painful experiences and emotions (Finch, 1984; Kirkwood, 1993)

In an attempt to overcome some of these issues, I tried to make time at the end of interviews to 'debrief' respondents. While most participants said that they had enjoyed the chance to talk to someone in detail, some acknowledged that they had unleashed memories more powerful and distressing than they had anticipated. Throughout the fieldwork, I was aware of a very fine line between using methods which enabled respondents to speak in as much detail about

their experiences as they wished, and unintentionally steering respondents to experience painful and potentially damaging feelings.

As in Liebling's (1992a) study of suicides in prison, I found that both staff and prisoners said and did things that at times I wished they had not said or done. Examples include one woman - an habitual 'cutter' - who told me she had swapped tobacco for a piece of glass and another woman who described how she and her friends had to share 'works'. Issues of confidentiality prohibited me from doing anything formally with such information. But, where does one draw the line on issues of conscience? Confidentiality within the context of prison research can be problematic (see, Scraton *et al.*, 1991). However, throughout the study, confidentiality and anonymity were assured and maintained for each respondent.

Emotions and fieldwork

> Lacking awareness of [our] own emotional responses frequently results in [our] being more influenced by emotion rather than less (Jaggar, 1989 : 60).

Feminist researchers have identified the importance of addressing the reactions of the researchers to the researched (Kirkwood, 1993). Throughout the fieldwork my emotions and attitudes underwent a tremendous change.

The very act of exploring women's imprisonment was stressful. On the one hand I was inspired and moved by the strength and insights demonstrated by the women prisoners I spoke to and I felt privileged to have been permitted access to their emotions and experiences. On the other hand, I became intensely aware of the fact that, given certain circumstances, any woman might find herself in a similar situation. These were not unusual women. I saw aspects of myself, my friends and my relatives in the women I interviewed. In some respects, this realisation encouraged me to listen more closely to their accounts.

Ultimately, my emotions and reactions, recorded in field notes, led me (I hope) to a fuller understanding of the subjective reality for prisoners and staff alike. But, I could not have divorced my reactions from the research process. Instead, a recognition of the importance of researcher involvement allowed me to utilise my reactions as a valuable analytical tool by deepening my awareness of the issues raised and which are discussed throughout this thesis.

Concessions and compromises in post-graduate research : 'I'm going home I've done my time'

Lee (1993 : 175) has argued that when researchers stress the problematic nature of field-research, the picture which they portray is often one of an :

> heroic tale in which the reluctance of those being studied is overcome as a result of the researcher's diligence, cleverness or artifice.

This is *not* an 'heroic tale' and there were times when I failed to manage my researcher self appropriately in a way which shaped the research process. Researching within male-dominated institutions and dealing with disparate groups is an emotionally exhausting experience. Negotiating and re-negotiating both physical and social access with different, potentially antagonistic groups, within a confined environment can be problematic. In this instance, the problematic nature of the research needs to be viewed within the context of an environment characterised by a fear of 'outsiders', low morale and political change.

More generally, I hope to have pointed to some of the theoretical and philosophical concessions which have to be made before and during the research process. Issues to do with power and the various roles researchers have to play in 'the field' can constitute an additional emotional burden. The researcher's role in the negotiations for, and the maintenance of, both physical and social access is, however, one of the realities of social research which remains largely hidden in the processes of 'writing up'.

I experienced tensions in what I assumed to be a feminist methodological approach, finding feminist research principles inadequate to the task of countering power in diverse researcher-researched relationships. Much of the feminist research literature *assumes* women to be a powerless social group in their encounters with researchers (Finch, 1984; Oakley, 1981) and suggests that feminist approaches redress power imbalances. This was not my experience and, despite explicit attempts to address such issues in the research design and practice, I found many elements of the research over which I simply had little or no control. I encountered both the powerful and the powerless and the daily grind of switching frameworks raises issues about the on-going nature of social access negotiation. Here, feminist research needs to become more sensitive to, and explicit about, the nature of interconnections between gendered and institutional power relationships.

Finally, on reflection, the management of the self in the field in many ways parallels the management of the self as a post-graduate researcher. One has to manage a whole gamut of emotions and experiences in the course of an academic apprenticeship : getting funded, working in isolation, taking flak, and so forth. For Ph.D. students the desire to complete the apprenticeship and acquire accreditation can lead to theoretical compromises which may ultimately reshape the research itself.

APPENDIX II

Dramatis personae

> There's women in here with children. I mean what's it doing to them (Diane).

This thesis is based primarily on the oral accounts of the fifty women prisoners who took part in tape-recorded in-depth interviews. The women are all referred to by fictitious names. Selected details of their biographies are as follows :

Angie, aged 43, was serving a life sentence for her role in the murder of her husband. Her brother and co-accused was also in prison serving a life sentence. Angie had been the victim of repeated physical and sexual assaults by her husband : 'I had broken ribs, broken fingers, broken arms ... what more can I say?' She had four children, one of whom she gave birth to in prison and who had subsequently been adopted.

Ann, aged 31, was serving a twelve month sentence for theft and deception associated with her previous employment as a clerk. She was married with two children, the youngest of which was with her on the mother and baby unit.

Anna, aged 28, was serving an eighteen month sentence for theft. She was single with one child.

Anwen, aged 43, was serving six months for defrauding the Department of Social Security : 'It was benefit books, social security. It just seemed so easy. I was short of money, you've got nothing and somebody offers you a chance to earn extra money.' She was divorced with four children, having experienced a particularly violent relationship with her ex-husband : 'It wasn't so much that he abused me. I weren't bothered about the belt, it was mental cruelty ... that did my head in more than the beatings. I think I could have lived with the belts, but not the mental thing'.

Barbara, aged 31, was serving a life sentence for the murder of her alcoholic violent partner. Her only child had been adopted and she had lost all contact with him : 'I've missed him growing up'.

Beth, aged 40, was serving a six month sentence for the supply and possession of cannabis. She was single with one child.

Brenda, aged 32, was serving a twelve month sentence for fraudulently trading under the Company Act, 1986 : 'I am serving a sentence for all those small businesses who lost business because of the recession'. Brenda was single, but had met a man whilst in prison (via the local chapel) and with whom she hoped to live post-release : 'It's a bit of an expensive dating agency'

Carole, aged 42, was serving her second custodial sentence for fraud and deception : 'I got made redundant [from factory work] and then started doing wrong. I had problems with money, problems managing just on social security and I think that leads to crime really, not being able to manage'. Divorced with two children, Carole and was serving a sentence of twelve months.

Carolyn, aged 37, was married with one child. She was serving a twelve month sentence for the supply of drugs.

Chris, aged 41, was serving a life sentence for her part in the murder of her husband. Her co-accused was also in prison serving life : 'He's obsessed with me and that's my biggest fear, that he'll come looking for me when I get out'. Chris's two children were with foster parents.

Claire, aged 46, was serving a six year sentence for manslaughter. Divorced with two children, Claire had experienced violent relationships with both her ex-husband and with her partner of five years when 'things just came to a head one night'. She stabbed her partner and killed him following a particularly vicious beating.

Darelle, aged 36, was serving an eight year sentence for arson and manslaughter. She was married with four children, all of whom were currently with her husband in Nigeria.

Dawn, aged 39, was serving eighteen months for handling stolen goods. Cohabiting and with four children, her partner was also in prison serving a two and a half year sentence. She described a violent relationship with her partner : 'I don't know if I'll have him back'.

Diane, aged 19, was serving a life sentence for a murder committed when she was sixteen. Her school years had been characterised by 'wagging off', minor criminal activities and running away from home (and a mentally ill, alcoholic mother) : 'I think if life's bad to you, especially if you've had a bad background, I think it twists you up and ... I thought that life had been absolutely awful to me, and, no matter what I did, it kept knocking me back down and knocking me back down ... an then one day I just exploded and it was like when you shake a bottle up and you take the top off and it just explodes. That's what it was like and then it was too late'.

Debbie, aged 26, was separated from her second husband and had been the victim of violence in both her marriages. At the time of the interview, she was on remand (and on Rule 43) charged with the murder of her two children (a

third had died on a separate occasion). She was subsequently convicted of the murders and is now serving a life sentence.

Emma, aged 33, was serving a nine month sentence for robbery from her place of work. Emma's husband was co-accused and was also in prison.

Fiona, aged 29, was serving a five year sentence for sexual offences. She had a long-term partner with whom she usually lived and two children. Her partner was also in prison. Fiona was on Rule 43 at the time of the interview : 'It's like a prison within a prison'.

Glen, aged 24, was interviewed on the mother and baby unit where she was serving her third custodial sentence for burglary : 'Prison is not a deterrent because it's better than circumstances outside.' Currently serving a five year sentence, Glen was single and homeless. She had no contact with her family or the baby's father.

Gwen, aged 46, was on remand charged with criminal damage. She had a history of 'heavy drinking' and had been remanded to prison once before. Gwen described a violent relationship with her long-term partner (who was also in prison). She had three children.

Helen, aged 38, was serving four years for the importation of drugs. She was married with two children, although she had, at the time of the interview, received no word of, or from, them.

Iris, aged 34, was serving eight years for armed robbery. She was married with four children. She described her husband as 'a little heavy handed'.

Jackie, aged 36, was a single woman with three children. She was serving a five year sentence for the importation of drugs.

Jan, aged 18, was serving a twelve month sentence for theft and violence. She was single and homeless. As a child and young adult, she had been sexually abused by a member of her family until she ran away from home. She had not had any contact with her family since.

Jane, aged 40, was interviewed the day before she was due to be released having served sixteen months of a two and a half year sentence. She was divorced with one child.

Jen, aged 38, was interviewed on the mother and baby unit, where she was serving a two year sentence for fraud and deception. Divorced, Jen had experienced a number of short-term relationships with men, one of which was particularly violent : 'Most of them bastards'. She had lost contact with the father of her only child.

Jez/Joan, aged 29, was, as we know, serving her fifth custodial sentence for shoplifting. She was single, had no children and was homeless.

Jo, aged 21, had been in prison on three previous occasions and was on remand at the time of the interview. She was charged with theft. A single mother, Jo had one child.

Judy, aged 24, was in prison for the third time serving a twelve month sentence for theft. She was 'single-ish' and 'officially homeless'.

Julie, aged 26, was serving her second custodial sentence of three years for burglary. Single with two children, she had been the victim of violence in a previous relationship.

Karen, aged 42, was serving a life sentence for the murder of her second husband who she stabbed and killed in an incident following years of beatings and kickings from him. She had three children.

Kirstie, aged 43, was serving nine months for fraud and deception associated with her previous occupation as an accountant. Divorced with two children (one mentally handicapped), she had experienced a violent relationship with ex-husband : 'I was beaten black, blue and purple'

Kym, aged 31, was serving a life sentence for her role in the murder of her husband. A former stripper, she had experienced violence in relation to her occupation and also in her relationship with her husband : 'I was beaten up by my husband. I went through a bad time in the marriage, beaten up and raped'. Her three children had been adopted and she had since lost contact with one of them.

Liz, aged 30, was serving a third custodial sentence of twelve months for theft. She was separated with three children.

Lyn, aged 25, was remanded into custody charged with theft. She was single but had a 'steady relationship'. Officially homeless, Lyn 'dossed on people's floors'.

Mair, aged 46, was serving two years for supplying drugs. Married with three children, her husband and co-accused was also in prison.

Meg, aged 27, was serving a twelve month sentence for deception. She was single but had a boyfriend who was unaware that she was in prison : 'He thinks I've gone to India to take home my mother's ashes'. Meg was pregnant at the time of the interview.

Molly, aged 35, was serving an eighteen month sentence. She was single but with a partner (also in prison) and one child.

Nia, aged 29, was on remand charged with burglary. She was married with one child.

Olga, aged 44, was serving a life sentence for her role in the murder of her husband. Her co-accused, an ex-boyfriend, was also in prison serving a life sentence. She had lost contact with her two children.

Pam, aged 33, was serving a five year sentence for the manslaughter of an ex-partner. She had been the victim of a vicious sexual assault and a burglary in the week prior to the offence. She was divorced with one child.

Pippa, aged 26, was serving three years for robbery and actual bodily harm. She was married with three children.

Sarah, aged 29, was serving two and a half years for actual bodily harm. She had experienced violence related to her occupation as a taxi driver and was so badly beaten up one day that she and her boyfriend 'went after revenge'. Living alone with her two children, Sarah was 14 weeks pregnant at time of interview : 'it's horrible being pregnant in prison'. Her boyfriend and co-accused and was also in prison.

Sharon, aged 42, was serving a three year sentence for causing death by reckless driving : 'I passed out at the wheel and had an accident. A pedestrian was killed'. She had been the victim of violence both outside and inside prison. Sharon was single and had two children.

Steph, aged 45, was serving a two year sentence for sex offences. She was married with a daughter. Her husband and co-accused was also in prison. Steph was on Rule 43 at the time of the interview.

Sue, aged 48, was serving a life sentence for conspiracy to murder her husband. She had two children both of whom she had lost contact with.

Suzanne, aged 22, was a single woman with no children. She was serving a five year sentence for arson. Suzanne had been the victim of both physical and sexual abuse and she was now an habitual 'cutter'.

Sylvia, aged 44, was serving a two year sentence for the possession of drugs, obstruction and assault (of a police woman). Single and with three children, Sylvia had a history of depression following the murder of her brother.

Tracy, aged 24, was serving a two year sentence for actual bodily harm. A persistent 'cutter' with a history of violent relationships, she was divorced and homeless.

Tricia, aged 18, was on remand charged with burglary. Her boyfriend and co-accused was also in prison. Tricia had one child and was pregnant at the time of the interview.

Wendy, aged 33, was serving a two and a half year sentence for threats to kill her ex-husband. She was homeless and her two children lived with their father. She had a history of violence in her relationship with her husband : 'I worry about the kids and what he's doing to them'. She was interviewed on the hospital wing where she was on Rule 43 following an assault on her by other prisoners.

APPENDIX III

Questionnaire survey : Summary statistics[1]

Section 1 : The Sample

1) Age

***Table A3.1* : Age distribution of respondents**

Age	Number	% of total sample
under 16	1	0.5
16 - 20	32	15
21 - 25	56	26
26 - 30	39	18
31 - 35	24	11
36 - 40	28	13
41 - 50	17	8
over 50	9	4
not recorded	8	4
TOTAL	214	100

2) Marital Status

***Table A3.2* : Marital status of respondents**

	Number	% of total sample
Single	86	40
Cohabiting	44	21
Married	26	12
Divorced	23	11
Widowed	12	6
Separated	15	7
Not recorded	8	4
TOTAL	214	100

[1] Columns do not always add up to 100 (%) because of roundings.

3) Ethnic Origin

Table A3.3 : **Ethnic origin of respondents**

	Number	% of total sample
Black British	10	5
White British	165	77
Caribbean	5	2
Asian	1	0.5
African	12	6
European	5	2
Irish	2	1
Other	3	1
Not recorded	11	5
TOTAL	214	100

4) Children

One hundred and thirty-seven women (64% of the total sample) reported having children. Of these women, 78% reported that their children normally live with them.

Table A3.4 : **Respondents with children**

	Number	% of women with children
Women with children under 16	102	74
Women with children over 16	19	14
Women with children under 16 and over 16	13	9
Age/s not recorded	3	2
TOTAL	137	100

Table A3.5 : **Current location of respondents' children**

	Number	% of women with children
Mother and baby unit	1	1
With partner	18	13
With relative	53	39
With friend	2	1
With foster parents	20	15
Adopted	6	4
Combination of the above (inc. those with children on M & B unit)	18	13
Other (inc. those with children in other countries)	15	11
Not recorded	4	3
TOTAL	137	100

5) Social and economic characteristics.

Table A3.6 **: Socio-economic characteristics**

	% of sample
School leaving age : 16 and under	77
No qualifications	41
Not working prior to imprisonment	62
Owning own home	16

6) Normal place of residence

Table A3.7 **: Normal place of residence**

Place of residence	Number	% of sample
Wales	11	5
Scotland	1	0.5
North East England	53	25
North West England	33	15
Midlands	16	8
South West England	5	2
South East England	6	3
London	9	4
Africa	8	4
Asia	1	0.5
South America	3	1
Other/Not recorded[1]	68	32

[1] This was a difficult question for many of the women to answer. In feedback discussions with women serving long-term sentences and life some of them said that they had few geographical ties. This category also includes those who reported having no fixed abode and those who answered that they lived with their parents but gave no location.

7) Usual accommodation

Table A3.8 **: Usual type of accommodation**

Accommodation	% of sample
Owned/mortgaged by self or family	16
Rented from council	41
Rented from private landlord	19
Rented from housing association	6
No fixed abode	9
Other (inc. caravan, bed and breakfast)	2
Not recorded	7

8) Usual occupation

Table A3.9 : **Usual occupation**

Occupation	% of sample
Crime	6
Manual	13
White collar	20
Professional	6
Housewife	15
At school/college	1
Unemployed	28
Other (inc. work abroad)	4
Not recorded	8

Section 2 : Criminological data

One hundred and forty-five women (**67.8 %**) had <u>not</u> been in prison before. Seventeen (**7.9%**) had been in prison once before, fifteen (**7%**) had been in prison twice before and thirty-two (**14.9%**) had been in prison three or more times.

1) Current status

Table A3.10 : **Current status**

Status	Number	% of sample
Remand	24	11
Sentenced	183	86
Not recorded	7	3
TOTAL	214	100

2) Sentence length

Table A3.11 : **Sentence length**

Sentence	Number	% of those under sentence
Up to & including 6 months	28	15
Over 6 months, up to 12 months	32	18
Over 12 moths, up to 18 months	27	15
Over 18 months, up to 3 years	37	20
Over 3 years, less than life	45	25
Life	13	7

3) Main offence/charge

Table A3.12 : **Main offence/charge category**

Offence/charge[1]	Number	% of sample
Theft (including handling, fraud & forgery)	50	23
Burglary	7	3
Robbery	11	5
Violence against the person (including murder & manslaughter)	60	28
Sexual	1	0.5
Drugs	43	20
Drugs combination (including theft, robbery, burglary and violence)	13	6
Arson	3	1
Other	9	4
Not recorded	17	8
TOTAL	214	100

[1] Apart from offences involving drugs, combined offences have been categorised according to the most serious. Many of the violent offences were combined with theft, burglary or robbery.

4) Rule 43 (a & b)

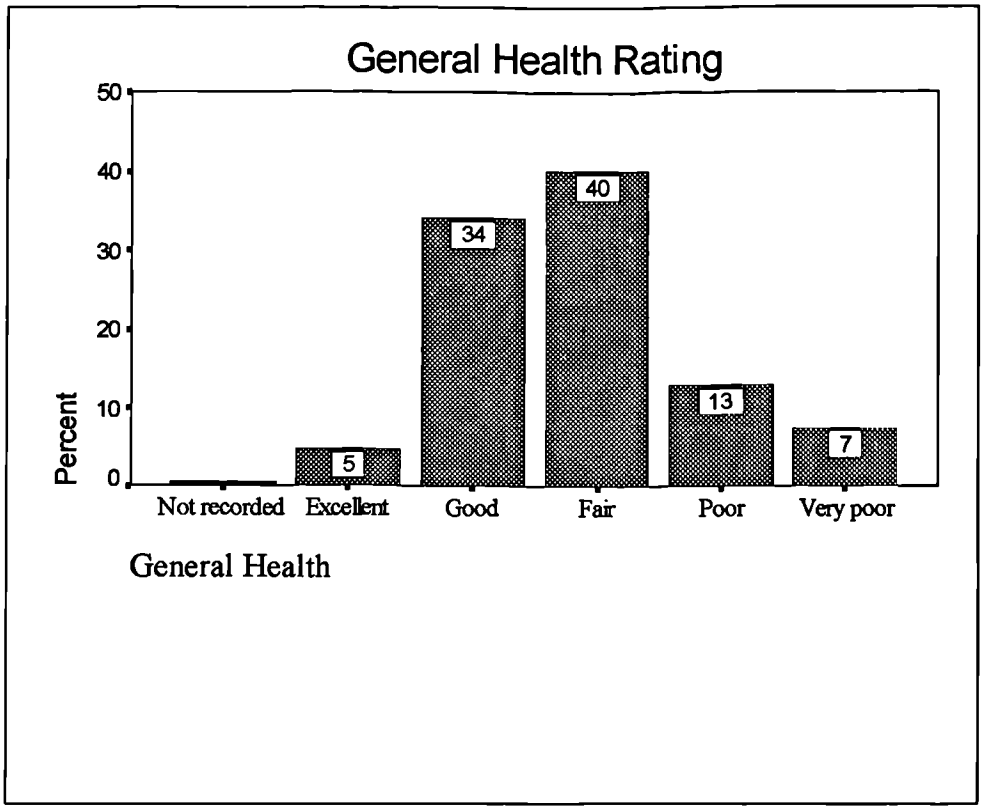
Table A3.13 : **Prison status**

	Number	% of sample
Rule 43	17	8
General population	180	84
Not recorded	17	8
TOTAL	214	100

Section 3 : Reported on-going health problems

- Respondents were asked to describe their general health.

Figure A3.1. **General health rating**



The questionnaire also contained a question about the presence of a long-term illness, health problem or handicap.

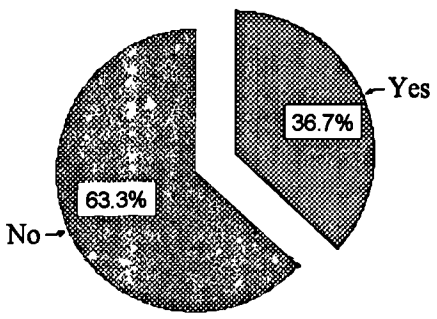


Fig. A3.2 Respondents reporting having any long-term health problem or handicap.

A separate question asked respondents whether they currently had any of a list of 15 specific illnesses or health problems.

Table A3.14 : **Respondents reporting having the following health problems:**

Health problem	Number	% of sample
Asthma/bronchitis	65	30
Epilepsy	6	3
Arthritis	21	10
High blood pressure	18	8
Anxiety/depression/bad nerves	100	47
Stomach problems	41	19
Period problems	85	40
Problems with the menopause	17	8
Diabetes	2	1
Back ache	76	36
Difficulty seeing	49	23
Difficulty hearing	15	7
Heart problems	4	2
Kidney problems	10	5
Bladder problems	12	6

When compared with the findings of a health survey incorporating similar questions conducted within the general population[2], respondents reported higher rates of asthma; epilepsy; high blood pressure; anxiety, depression and bad nerves; stomach problems; period problems; menopausal problems; sight and hearing problems and kidney and bladder problems.

Section 4 : Reported minor illness

Table A3.15 : **Percentage of respondents reporting having had the following over the past two weeks :**

Persistent cold/flu	34
Skin problems	41
Persistent cough	26
Diarrhoea or sickness	15
No appetite/off food	30
Difficulty sleeping	64
Feeling tired	62
Sore throat	22
Constipation	26
Headache	57
High temperature	8

[2] Hopton, J.L. (1994) *Assessment of health needs applicable to the provision of primary care*, Unpublished report of a health survey conducted in Lothian.

Section 5 : Psycho-social distress

Respondents were given a list of common psycho-social problems or concerns and were asked which, if any, they had experienced within the past two weeks.

***Table A3.16* : Respondents' reporting of psycho-social concerns over the past two weeks**

Concerns about :	Number	% of sample
A relationship	106	50
Money	77	36
Housing	67	31
Children	117	55[1]
Other family members	123	58
Violence or the threat of violence	17	8
Death of somebody close	30	14
[1] 85% of those with children reported having concerns about them.		

Twenty-eight percent of the sample reported having spoken to someone about one or more of the above concerns within the past two weeks. Fifty percent reported having been unsure about where they might get help from if they had really needed it within the past two weeks.

The General Health Questionnaire (GHQ)

The questionnaire included a widely used measure of psychiatric disturbance : the GHQ. Developed in the UK, the GHQ is a screening instrument used to detect non-psychotic psychiatric disturbance. Developed largely for use within general practice populations, it concentrates on broader components of psychiatric morbidity, particularly anxiety and depression (Goldberg and Williams, 1988). A number of formats of the questionnaire are available. In this study, the short-item version, GHQ12, was chosen. Respondents can gain a raw score from 0-12, with a cut off score of five and over distinguishing 'caseness'.

The GHQ indicated non-psychotic psychiatric disturbance in 107 respondents (50%). This compares with a case prevalence of 23.3% in women within the general population (Goldberg and Huxley, 1980)[3].

Section 6 : Use of medications

Ninety-five respondents (44.4%) reported that they were currently taking medications prescribed by a doctor. Table A3.17 indicates the types of medications prescribed.

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[3] Goldberg, D. and Huxley, P. (1988) *Mental illness in the community.* London : Tavistock

Table A3.17 : **Prescribed medications**

Type of medication	Number	% of those on prescribed medications
Anti-depressants	17	18
Sedatives/hypnotics	13	14
Analgesics	5	5
Anti-biotics	7	7
Combination of medications	19	20
Other (inc. drug substitutes, inhalers, pregnancy-related)	31	33
Not recorded	3	3
TOTAL	95	100

Section 7 : Substance use

Table A3.18 : **Current and previous substance use**

Substance	% reporting current use	% reporting use in the past
Tobacco	75	4
Alcohol	2	43
Marijuana	17	25
Cocaine	1	24
Barbiturates	2	14
Amphetamines	2	26
Heroin	6	21
Solvents	2	8
Crack	-	4
Other illegal drugs	2	4

Section 8 : Access to health care

Medical examination

Respondents were asked how quickly they could get to see the Prison Medical Officer when they had a problem (see Table A3.19).

Table A3.19 : **Access to medical officer by prison**

	Low Newton (% of those at L.N.)	Askham Grange (% of those at A.G.)	Styal (% of those at Styal)	% of total sample
Same day	n = 4 (10%)	n = 4 (8%)	n = 5 (4%)	**6**
Next day	n =31 (78%)	n = 15 (31%)	n = 15 (12%)	**29**
2 or more days	-	n = 27 (55%)	n = 99 (79%)	**59**
Don't know/not recorded	n = 5 (13%)	n = 3 (6%)	n = 6 (5%)	**7**
TOTAL	40 (100%)	49 (100%)	125 (100%)	**100**

Eighty-six respondents (40.2%) reported having had difficulties getting to see a doctor since being in prison.

Contact with Medical Officer

Table A3.20 indicates the number of contacts made with Prison Medical Officers within the last six months or since being in prison (which ever represented the shorter time period).

Table A3.20 : **Contact with Medical Officer**

Number of contacts	% of sample
None	6
One or two	36
3 - 5	24
6 - 10	17
More than ten	15
Not recorded	2

Reasons for the most recent contact with the Medical Officer, where stated, included reception/certifying 'fitness' (10.5%); depression (10.5%); sleep problems (8.7%); drugs-related (5.8%); nerves/panic attacks (4.6%); pregnancy-related (1.7%), as well as more general consultations.

The majority of Prison Medical Officers are men. In July 1986 there were 107 part-time and 98 full-time doctors in post, fourteen of which were women. In each of the three prisons the medical officer in post at the time of the survey was a man. Respondents were asked if they would prefer to see a male or female doctor[4] (Table. A3.21).

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[4] It is likely that the preference for a male or female doctor very much depends on the nature of the consultation. In British general practice, for instance, there are indications that women favour female physicians for gynaecological problems, cervical smears and contraceptive advice (Miles, A., 1991). In the current study, the question asked did not distinguish between different types of consultation and so the response must be seen as general. Many women wrote-in 'it depends'.

Table A3.21 : **Preferences for a male or female doctor**

Preferred doctor	Number	% of sample
Male	5	2
Female	94	44
No preference	109	51
Not recorded	6	3

Contact with other health professionals

Table A3.22 : **Percentage of respondents reporting having seen the following health professionals within the past six months or since being in prison (which ever was the shorter time period).**

	% of sample
Nurse	88
Dentist	36
Optician	22
Chiropodist	10
Physiotherapist	5
Counsellor	13
Health Visitor	3
Psychiatrist	28
Hospital Doctor (outside prison)	26
Other	8

Respondents were asked to rate the health care they had received in prison in relation to other care they had received in the past.

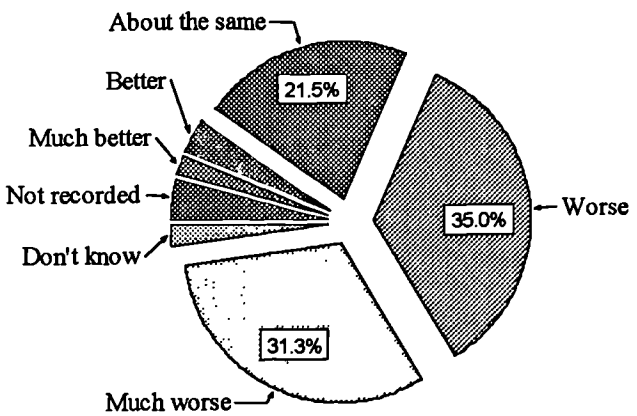

Figure A3.3 Health care rating

Section 9 : Perceived helpfulness of different kinds of service

This section outlines responses to a question which gave respondents a list of different kinds of help and asked them to say, for each kind of help, how helpful it would be to them at the moment[5].

Table A3.23 : **Percentage of respondents reporting that the following would be of some help or great help to them at the moment.**

	% of sample
Help/advice about HIV and AIDS	23
Help/advice about giving up smoking	34
Help/advice about drinking alcohol	15
Help/advice about diet	36
Help/advice about exercise	49
Help/advice about coming off or cutting down on medicines which are prescribed	17
Help/advice about coming off or cutting down on illegal drugs	23
Help/advice about coping with stress	64
Regular health checks	73
Help/advice about feeling depressed or anxious	68
Being able to talk through a problem with someone	77
Advice about money	42
Advice about benefits	46
Help/advice about the death of someone close	35
Help/advice about problems with your partner	32
Help/advice about problems with your children	40
Help/advice about being released	54
Help/advice about violence or the threat of violence	29
Information about cervical or breast screening	49

5 It is important to note that while respondents may report that something would be helpful, it is not necessarily the case that additional service provision would be utilised or that it would necessarily prove effective.

Section 10 : Being in prison

Respondents were given a list of 18 aspects of prison life and were asked to rate how good or bad they considered them to be.

Table A3.24 **: Percentage of respondents reporting how good or bad they considered the following aspects of prison life to be.**

	Very good	Quite good	Rather bad	Very bad	Don't know/no experience
Cell/room facilities[1]	15	47	19	16	-
Washing facilities	19	39	20	17	1
Toilet facilities	18	43	23	12	-
Canteen facilities	12	36	31	15	1
Library facilities	22	53	93	8	3
Visiting room facilities	13	45	15	19	4
Recreation facilities	16	42	21	15	1
Food	7	25	26	36	-
Physical education	19	46	14	10	7
Education	24	39	14	12	7
Drug/treatment classes	7	24	17	17	31
Vocational classes	8	38	15	11	24
Workshops	10	29	19	15	22
Access to chaplain	32	41	7	3	12
Access to welfare or probation staff	22	41	20	7	6
Access to personal officer	21	36	16	15	8
Access to senior officers	17	35	26	8	9
Access to governor grades	11	23	23	24	14

[1] 22% of respondents reported having their own room; 22% reported sharing with one other; 13% shared with two others; 5% shared with three others, and 35% reported sharing with between 4-9 others.

Concerns in prison

Respondents were provided with a list of eight common concerns within prison and were asked to indicate whether or not they were concerned about any of them at the moment.

Table A3.25 **: Percentage of respondents reporting to be very or rather concerned about the following at the moment.**

Concerned about :	% of sample
Safety	60
Physical health	73
Mental health	57
Drugs and alcohol	39
Sex	22
Cutting-up, self-harm or suicide	31
Being moved around the prison system[1]	58
Release	54

[1] 149 respondents under sentence and 1 on remand (70% of the total sample) reported having been in other prisons during the current sentence. Of these, 68% had been in one other prison; 25% had been in two other prisons, 6% had been in three, and 1% reported having been in four or more.

Access to help

76 respondents (36%) reported that there had been times, since being in prison, when they had tried to get help with something but could not. Respondents were further asked how they would deal with a serious problem in prison.

Table A3.26 **: Percentage of respondents who reported that they would deal with a serious problem in prison in the following way:**

	% of sample
Keep it to yourself	24
Discuss it with family or friends	9
Discuss it with another prisoner	19
Discuss it with a member of staff	20
Combination of the above	25
Not reported	3

Finally, respondents were asked to describe the relations between staff and prisoners.

Table A3.27 **: Staff-prisoner relations.**

	Number	% of sample
Very good	27	13
Quite good	115	54
Rather bad	48	22
Very bad	16	7
Not Reported	8	4
TOTAL	214	100

APPENDIX IV

Interview guide : prisoners

INTRODUCTORY STATEMENT

I'm going to ask you some questions about your health and about being in prison. I'm very keen to find out as much as I can about your experiences so if you feel that I've missed something important just mention it. Also, please bear in mind that I'm not associated with the Prison Service or the Home Office. I'm a student at the University of Wales. I'm interviewing women at three prisons and the research forms part of my studies.

All the information you give me is strictly confidential and the tape will only be heard by me. So feel free to make your answers as detailed as you wish.

BACKGROUND INFORMATION

Would you like to start by telling me a little bit about yourself :

1) How old are you?

2) Where do you come from?

3) Do you have a partner? Where is your partner now? Are they able to visit?

4) Do you have any children?
- How old are they? Are they able to visit?
- Do they normally live with you?
- Who is looking after them now?
- How often do you receive news of them?

5) Do you usually care for anybody else?

6) How old were you on leaving school?

7) Have you had a paid job since leaving school?
- Have you ever had any problems getting by? How did you cope?

EXPERIENCE OF BEING IN PRISON

1) Is this the first time you have been in prison?
- Have you been in trouble with the police before?

2) How long is your present sentence?

- How much of it have you served?
- Do you have any idea when you might be released?

3) How long have you been at A.G./S./L.N?
- How does this prison compare with others that you have been to?

4) Can you tell me a little about how you came to be in prison?
- PROBE : Nature of the offence, court experience, police etc.
- How much did you understand about your court appearance?
- Have you learned much about the law since then?

5) What happened when you first arrived at prison?
- Was there anything which you had any particular problems with?

6) How do you feel about being in prison?
- What is the worst thing about being here?
- Do you think that someone like yourself should be sent to prison?

7) Describe a typical day in A.G./S./L.N.

GENERAL HEALTH

1) How would you describe your general health?

2) Do you normally find it easy or difficult to stay healthy?

3) Do you have any long-term illnesses or health problems?

4) Have you had much contact with hospitals/Drs./health services in the past?

5) What affects your health and how you are feeling?

6) Do you think that stress plays a part in your life?
- How have you coped with this?

7) Is there anything which you do, or have done in the past, which you know yourself has had an affect on your health?

8) Have you ever been in a situation where you have been the victim of violence?

PRISON MEDICAL SERVICES

1) How has your health been since you have been here?

2) Have you had any illnesses/health problems? How have these been dealt with?

3) Have you had to see a doctor or nurse about anything to do with your health?

4) Did you see a Dr/nurse when you first arrived here?

5) How easy is it to see the Dr?
- What is the Dr like?
- How does this compare with Drs you have seen in the past?
- Would you prefer to see a woman Dr?

6) Have you seen anybody else in relation to your health or health matters since you have been here?

7) Have you been to any health-related sessions or groups or have you attended any courses or programmes?

8) Do you feel that you have been given enough advice or information about health matters?

9) Do you feel that your health and well-being are up to yourself to look after?

10) How much control do you feel that you have over your own health?

11) Have there ever been times when you have felt down or depressed? How have you coped with this?

12) Do you think that women encounter any specific problems when sent to prison? (Probe : process - police, courts, etc.)

13) Do you feel that women in prison have any particular health needs?

MEDICATIONS

1) Are you currently taking any medications?
- Do you know what they are for?
- What effects do they have?
- How do you feel about taking them?

2) Have you been given any medications since you have been here?

IN GENERAL

1) Who would you go to first if you had a problem?

2) And what about your partner/family - how much help have they been able to give when you have had problems/worries?

3) How much control do you feel you have over what happens in your life?

4) Do you think much about your life outside prison?

4) How, if at all, has being in prison affected you?

5) Has it had any affect on your relationships with people outside?
- What about other aspects of your life outside?

6) What, if anything, have you learnt from your experiences of being in prison?

THE FUTURE

1) How do you see your future when you leave prison?

2) **Release :** Is there anything which you have any concerns about in relation to your release.

3) **IF RELEVANT :** How did things go for you the last time you were released from prison?
- Did you experience any particular problems?
- What might have prevented you from coming back?

FINALLY

1) Is there anything else you would like to add about women being sent to prison?

THANK YOU FOR YOUR HELP

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